Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Foreman a prisoner at HMP Durham on 26 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Foreman died on 26 May 2018 at HMP Durham, a week after arriving at the prison. A post-mortem examination identified his cause of death as bronchopneumonia due to the effects of a combination of heroin, zopiclone, pregabalin and diazepam. Mr Foreman was 32 years old. I offer my condolences to his family and friends.

Prison staff searched Mr Foreman's cell on the afternoon before his death and found what appeared to be drugs. I am concerned by the ease with which he obtained more drugs in the short time before he was locked in his cell for the night. Durham has a drugs supply reduction strategy but there should be more focus on stopping the diversion and trading of prescription medication.

I am also concerned that experienced prisoners, rather than an appropriate member of staff, assess newly arrived prisoners and recommend whether they should be referred to the prison's Drug and Alcohol Recovery Team.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Sue McAllister CB
Prisons and Probation Ombudsman **June 2019**

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Summary

Events

1. On 19 May 2018, Mr Darren Foreman was remanded in custody to HMP Durham. He did not report any health problems on arrival at the prison and said that he did not use drugs. An experienced prisoner, in the role of a Peer Information Desk (PIDs) worker, assessed whether Mr Foreman should be referred to the Drug and Alcohol Recovery Team (DART). He recorded that Mr Foreman did not need treatment.

2. On 23 May, a prison chaplain told Mr Foreman that his mother had died on 20 May.

3. On the afternoon of 25 May, prison staff searched Mr Foreman's cell after they had earlier seen several prisoners standing outside it. They found what appeared to be drugs. Mr Foreman's cellmate told us that Mr Foreman obtained more drugs from other prisoners on the wing before they were locked in their cell for the night.

4. Mr Foreman's friend, who was also a prisoner on the wing, went into his cell when it was unlocked at around 9.50am on 26 May and found that he had died. A prison doctor confirmed the death shortly afterwards.

Findings

Availability of illicit drugs

5. We are concerned about the evident ease with which Mr Foreman obtained illicit medication and drugs on the afternoon before his death. Durham's drug strategy appropriately focuses on preventing illicit drugs being smuggled into the prison but there should be more emphasis on the risks presented by diverted medication.

First night drugs questionnaire

6. While experienced prisoners can provide an important role in supporting a prisoner during their first night in custody, they should not be tasked with assessing new prisoners' drug use and determining whether these prisoners should be referred to the Drug and Alcohol Recovery Team. This should be the responsibility of a member of prison or healthcare staff.

Emergency response

7. While the response of prison staff when Mr Foreman was found to have died was mostly effective, they used an emergency radio code that is no longer recognised. We have raised this issue with Durham following previous deaths in custody and the prison has told us they will take additional measures, including providing further training for staff on the appropriate use of emergency medical codes.

Informing Mr Foreman of his mother's death

8. Nearly 48 hours passed between Mr Foreman's brother contacting the prison to say that their mother had died, and prison staff informing Mr Foreman. This is an unacceptable delay and it should have been a priority for staff to inform him.

Recommendations

- **The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs, including diverted medication.**
- **The Governor and Head of Healthcare should ensure that initial DART assessments and referrals are completed by an appropriate member of staff.**
- **The Governor should ensure that staff inform prisoners of the death of a close family member as soon as possible.**

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Durham on 5 June. He obtained copies of relevant extracts from Mr Foreman's prison and medical records, and interviewed one prisoner.

11. The investigator interviewed nine members of staff at Durham on 2 July.

12. NHS England commissioned a clinical reviewer to review Mr Foreman's clinical care at the prison. She joined the investigator for interviews with staff.

13. We informed HM Coroner for Durham and Darlington of the investigation, who provided a copy of the post-mortem report. We have sent the Coroner a copy of this report.

14. The investigator wrote to Mr Foreman's father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He asked some questions that we have addressed through separate correspondence.

15. We shared the initial report with HM Prison and Probation Service (HMPPS). They pointed out one factual inaccuracy and we have amended the report accordingly.

16. We shared the initial report with Mr Foreman's father. He raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. We have amended one factual inaccuracy.

Background Information

HMP Durham

17. HMP Durham, which holds up to 1,000 men, is a reception prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the biggest security threat to the prison was the supply of drugs. Nearly half of prisoners said that it was easy to get illegal drugs at Durham, and too many prisoners tested positive during mandatory drug tests. Inspectors found that the Drug and Alcohol Recovery Team (DART) offered a comprehensive range of educational and treatment options. They also reported that Peer Information Desk (PIDs) workers were an integral part of prison life and provided valuable support, although prison staff should have undertaken some of their tasks.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to October 2017, the IMB reported that DART carried out excellent rehabilitative work.

Previous deaths at HMP Durham

20. Mr Foreman was the nineteenth prisoner to die at Durham since May 2015. In our report into the death of a man in October 2016, we recommended that the prison ensure it had an effective drugs supply and demand reduction strategy. We have also previously made recommendations about staff using the appropriate medical emergency response code. Durham accepted these recommendations.

Key Events

21. Mr Darren Foreman served several prison sentences from 2000 onwards. In August 2017, an offender manager recorded that Mr Foreman said that he occasionally used cocaine at weekends and was a recreational cannabis user. Mr Foreman said that he had reduced his drug use significantly in recent years. On 12 August, prison staff found him under the apparent influence of drugs. Mr Foreman was released from this last period in custody on 18 August 2017.

HMP Durham

22. On 19 May 2018, Mr Foreman was remanded in custody to HMP Durham to await trial on charges of theft, burglary and assault.

23. A nurse assessed Mr Foreman in reception. He recorded that Mr Foreman did not have any physical or mental health issues and did not take any medication. The nurse recorded that Mr Foreman said that he had not recently used drugs.

24. Prison staff allocated Mr Foreman a cell on E Wing, which is the first night centre and induction unit. An offender supervisor completed a basic custody screen (which is completed to identify a prisoner's needs while in custody). He recorded that Mr Foreman said that he did not take drugs and had never had any contact with a drug or alcohol agency.

25. Newly arrived prisoners see a Prisoner Information Desk (PIDs) worker on their first night in custody. PIDs workers are experienced prisoners who provide information and advice about services at Durham. The PIDs worker also completes a Drug and Alcohol Recovery Team (DART) induction form. This includes an explanation of DART services and support available, as well as the provision of harm reduction and overdose risk information. There is a tick box with options for whether or not a prisoner wants to engage with DART, and a third option for where there is no need for substance misuse treatment. Once completed, PIDs workers pass the forms to a member of staff in the DART team to process. The PIDs worker who completed Mr Foreman's DART induction form ticked the third box, to say that he did not need treatment.

26. On 21 May, Mr Foreman's brother telephoned Durham and said that their mother had died the previous day. When a relative of a prisoner dies, control room staff (or whoever receives the information) are required to "investigate and confirm" the death. The Operations Manager at Durham, told us that this might involve telephoning the hospital at which the person died or the funeral directors at which the body is held. He said this should be done very quickly.

27. When they have confirmed the death, the member of staff who received the information should tell a prison chaplain, who then visits the prisoner to inform them. The Operations Manager said that they should inform the duty manager if there is no chaplain on duty.

28. An officer recorded that he made several calls on 21 and 22 May in an attempt to confirm the death. He recorded that he spoke to a hospital doctor at 4.45pm on 22 May, who confirmed that Mr Foreman's mother had died.

29. At 7.55am on 23 May, a prison chaplain recorded that control room staff had informed him of Mr Foreman's mother's death. The chaplain told us that there were no chaplains in the prison when the control room confirmed the death the previous afternoon. He visited E Wing and recorded that he had informed Mr Foreman of his mother's death at 8.45am. Prison staff allowed Mr Foreman an additional telephone call to his brother that morning.

Events of 25-26 May 2018

30. A Supervising Officer (SO), an E Wing manager, told us that on 25 May, wing staff saw several prisoners around the cell that Mr Foreman shared with another prisoner. She asked an officer to search the cell that afternoon. The officer found a quantity of blue tablets, a brown substance wrapped in plastic, and some tobacco. (As Durham is a non-smoking prison, prisoners are not allowed to have tobacco.) The officer recorded that Mr Foreman's cellmate said that the items belonged to him. (After Mr Foreman's death, the cellmate told an officer that he brought the items into the prison with him when he was remanded in custody on 21 May.) The officer reported the find to the SO. She charged Mr Foreman with an offence against prison discipline and downgraded him to the basic level of the Incentives and Earned Privileges scheme (IEP, which aims to encourage and reward responsible behaviour in prisons). No one asked Mr Foreman if he had taken drugs or referred him to the DART service.

31. After Mr Foreman's death, his cellmate told an officer that later on the afternoon of 25 May, Mr Foreman obtained drugs from his friends on the wing. The cellmate said that this included diazepam (a sedative usually used to treat anxiety), gabapentin (medication used to treat epilepsy, anxiety and nerve pain) and cannabis.

32. The prisoners were locked in their cells for the night at around 5.00pm on 25 May. Mr Foreman's cellmate told the officer that he and Mr Foreman shared the drugs that Mr Foreman had obtained. The cellmate said that he fell asleep shortly afterwards and did not wake up until the events of the following morning.

33. An officer was the night patrol officer on 25-26 May. He completed counts of prisoners at 9.45pm and 5.05am. The officer said that he could not remember what Mr Foreman was doing at these times.

34. At 6.50am on 26 May, a different officer completed a count of prisoners. She told us that she could not remember what Mr Foreman was doing at the time.

35. At around 9.50am, another officer began to unlock cells on Mr Foreman's landing. Mr Foreman's friend also lived on the landing, and the officer unlocked his cell before Mr Foreman's. When his cell was unlocked, his friend went to Mr Foreman's cell. He looked in the flap, and saw that Mr Foreman and his cellmate both appeared to be asleep. He told us that he walked away, but instinct told him to quickly return to the cell. Mr Foreman's friend arrived back as the officer unlocked the cell, and went in. He said that Mr Foreman appeared to have died. He shouted for the officer.

36. The officer went into the cell and told us that Mr Foreman was "ice cold" and appeared to have rigor mortis. He was not carrying a radio and left the cell to

shout to other staff for assistance. An SO was one of the staff to respond, and she radioed a medical emergency code black. (This is an old code, indicating a life-threatening situation, that has been replaced at Durham by the nationally-recognised code blue.) The control room operator recorded the message at 9.55am, and telephoned an ambulance immediately. No one initiated cardiopulmonary resuscitation as it was apparent that Mr Foreman had died.

37. At around 10.00am, a prison GP confirmed that Mr Foreman had died. The control room operator cancelled the ambulance.

Contact with Mr Foreman's family

38. A prison family liaison officer (FLO), and chaplain visited Mr Foreman's father on 26 May, and informed him of Mr Foreman's death.

Support for prisoners and staff

39. After Mr Foreman's death, an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prisoner who was Mr Foreman's friend said that he was supported by several prison staff, including the chaplaincy team, after his friend's death.

Post-mortem report

41. Post-mortem and toxicology examinations established the cause of death as bronchopneumonia due to the effects of a combination of heroin, zopiclone (a sleeping pill), pregabalin (used to treat epilepsy, anxiety and nerve pain) and diazepam. The toxicology examination also found that Mr Foreman had used amphetamines (a stimulant drug) and cannabis. The examination found that his heroin use was historic rather than recent.

Findings

Availability of illicit drugs

42. Toxicology tests identified that Mr Foreman had used several illicit substances in the period before his death. Some of these were prescription medications (none of which Mr Foreman was prescribed) and others were illegal drugs.

43. Illicit drugs were found in Mr Foreman's cell late on the afternoon before his death. Despite this, Mr Foreman was seemingly able to obtain more drugs in the short period before he was locked in his cell for the night. HM Inspectorate of Prisons, in their most recent inspection, found that nearly half of prisoners said that it was easy to obtain drugs at Durham and that too many prisoners tested positive for drugs.

44. Durham is currently revising its drugs strategy. The draft strategy, dated June 2018, details several actions that the prison intends to take by the end of the year to eliminate the supply of drugs, reduce demand and promote user recovery.

45. Most of the illicit drugs identified at Mr Foreman's toxicology were prescription medications. While we cannot be sure how he obtained these, it is possible that they were diverted and traded by other prisoners who are prescribed these medications. Although there is a clear focus at Durham on stopping drugs being brought into the prison through various means, the drugs strategy does not cover the risks presented by diverted medication or methods to reduce their supply. The Head of Security told us he did not think the prison had a real problem with prisoners misusing prescription medication and that healthcare staff were able to control this.

46. Nevertheless, it is concerning that Mr Foreman was seemingly able to obtain illicit drugs so quickly and easily before his death. We consider that further work is required to reduce the availability of illicit drugs and diverted medication, and we make the following recommendation:

    The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs, including diverted medication.

First night drugs questionnaire

47. Newly arrived prisoners see a PIDs worker on their first night in custody. One of their tasks involves providing information about DART services and harm reduction. PIDs workers question new prisoners about their drug use and whether they wish to be referred to the DART team. They then complete a form that identifies new prisoners who need a referral and those who do not need treatment. Although the form says that it is a record of contact between DART and the newly arrived prisoner, it is completed by a PIDs worker.

48. We appreciate that PIDs workers can play an important role in welcoming new arrivals, giving them information and helping them settle into prison. However, information about new, and potentially vulnerable, prisoners' drug use and treatment needs should be confidential. It should be the responsibility of prison

or healthcare staff to ensure that new prisoners are properly assessed and to make appropriate referrals. In their most recent inspection, HM Inspectorate of Prisons also found that PIDs workers undertook some tasks that should have been the responsibility of prison staff. We make the following recommendation:

The Governor and Head of Healthcare should ensure that initial DART assessments and referrals are completed by an appropriate member of staff.

Emergency response

49. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It requires an ambulance to be called immediately if an emergency code is radioed. Staff should ensure that there are no delays in calling an ambulance and that it should not be a requirement for a member of the healthcare team or a manager to attend the scene before calling an ambulance.

50. Local policy at Durham is set out in Governor's Order 08.15 which instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when a prisoner has difficulty breathing or is unconscious. A SO radioed "code black" when she arrived at Mr Foreman's cell. This is an old code no longer in use at Durham. While staff appeared to understand the nature and intent of the message, this might not always be the case in future and it is important that staff use the correct radio codes to ensure that prompt and appropriate action is taken.

51. In two recent investigations at Durham, we recommended that the Governor ensure all prison staff are made aware of and understand their responsibilities during medical emergencies, including that they use the appropriate emergency medical code to effectively communicate the nature of the emergency. We made the second of these recommendations in June 2018, after Mr Foreman died. Durham accepted the recommendation and submitted an action plan in which they identified several measures they would take to implement it. These included additional training for staff and issuing guidance cards to radio carriers. We therefore make no further recommendation.

Informing Mr Foreman of his mother's death

52. Mr Foreman's brother telephoned Durham on 21 May to say that their mother had died. Prison staff did not inform Mr Foreman of this until 23 May. While we appreciate that staff need to ensure the accuracy of reports, this took too long to complete. Durham told us that there was a further delay because there was no chaplain in the prison when the death was confirmed. In fact, a member of prison staff such as a family liaison officer or a wing manager could have broken the news to Mr Foreman. We make the following recommendation:

The Governor should ensure that staff inform prisoners of the death of a close family member as soon as possible.

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