Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jordan White a prisoner at HMP Durham on 7 August 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*

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 Jordan White died on 7 August 2018 at HMP Durham due to the effects of a combination of buprenorphine, diazepam and alprazolam (which he had obtained illicitly). He was 32 years old. I offer my condolences to Mr White's family and friends.

I am satisfied that Mr White received appropriate advice and support to help address his drug misuse problems and that staff could not have prevented his death.

I remain concerned, however, that, despite wide-ranging local policies and the efforts of staff to prevent the supply of and demand for illicit substances, Mr White was able to obtain drugs at Durham with apparent ease.

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. Mr Jordan White was remanded to HMP Durham on 18 May 2018, after being charged with grievous bodily harm. At reception health screens, Mr White said that he used cocaine, cannabis and benzodiazepines (sedatives) and a drug test was positive for these substances.

2. During Mr White's induction, he received advice from the drug and alcohol recovery team on the risks of taking illicit substances and harm minimisation, but he declined formal support. He refused a further offer of support in early July, after a compliance check revealed that some of his prescribed medication was missing from his cell. However, he completed some of the drug and alcohol service's workbooks in his cell.

3. Mr White subsequently referred himself to the drug and alcohol team and began sessions with a recovery worker on 18 July. He told her that his drug use had increased in the last two months. A mandatory drug test taken that day was negative. He had another session on 3 August and there were no specific concerns.

4. At approximately 8.15am on 7 August, Mr White was found unresponsive in his bed. Healthcare and prison staff did not attempt resuscitation, as there was evidence of rigor mortis.

Findings

5. Durham has comprehensive policies to minimise and treat illicit substance misuse. Despite this, Mr White was able access drugs that had not been prescribed to him.

6. Although Mr White had a history of substance misuse, there was no evidence of drug taking during this period of custody until he admitted it to his support worker in July. We are satisfied that he received appropriate advice and support to help address his problems and that staff could not have prevented his death.

7. We are, however, concerned that a prisoner with a history of substance misuse was initially assessed as suitable to hold pregabalin (a drug that is misused and highly tradable in prison) in his possession. We are pleased to note that Mr White's pregabalin prescription was stopped in June 2018, after some tablets could not be accounted for.

8. Mr White's family knew about his death before the prison's family liaison officers arrived. This was beyond the control of the prison, as the staff had left the prison promptly to break the news.

Recommendations

- The Governor should ensure that the key drug issues at Durham are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

- The Head of Healthcare should ensure that prisoners only receive in-possession medication after a consistent recorded risk assessment that is regularly reviewed.

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 her. No one responded.

10. The investigator obtained copies of relevant extracts from Mr White's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr White's clinical care at the prison.

12. The investigator and clinical reviewer jointly interviewed five members of staff at Durham on 17 October. Another investigator took over the latter stages of the investigation.

13. We informed HM Coroner for Durham and Darlington of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator contacted Mr White's mother to explain the investigation and to ask if she had any matters for the investigation to consider. Mr White's mother wanted to know generally about Mr White's care and management and the circumstances leading to his death. We have provided that information in this report.

15. Mr White's mother received a copy of the initial report. She had concerns that information reported by Mr White's cellmate, might not be entirely accurate and the report has been amended to reflect this.

16. We shared the initial report with HM Prison and Probation Service (HMPPS). They found one factual inaccuracy and the report has been amended accordingly. The HMPPS action plan has been annexed to this report.

Background Information

HMP Durham

17. HMP Durham is a reception prison for adult and young adult men. It holds around 990 prisoners. G4S provides primary nursing care and Spectrum provides GP and pharmacy services. Mental health services are provided by Tees Esk and Wear Valley NHS Foundation Trust.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Durham was in September and October 2018. Inspectors reported that safety had been seriously undermined by the ready availability of drugs and they were concerned about the number of suspected drug-related deaths. They found that 47 per cent of prisoners were being seen by the drug and alcohol recovery team and 30 per cent said they had developed a drug problem at Durham. The security and substance misuse services worked cooperatively and a comprehensive drug and alcohol pathway policy was in place. However, although joint working was reasonable, the drug and alcohol recovery team was not always aware of all drug-related incidents on the wings, so it was difficult to provide timely support. An in-possession medications policy was in place, but was not always adhered to.

19. The inspection report concluded that one of the most pressing needs was to reduce the supply of drugs and the prison had put in place a good strategy to address this. However, modern equipment to help with this had been diverted for use in another prison. Inspectors were disappointed to see that recommendations from previous Ombudsman's investigations had not been addressed with sufficient vigour or urgency.

Independent Monitoring Board

20. 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 2018, the IMB reported that the change in function to a reception prison had led to an increase in staff workload. The Board was particularly concerned about the large increase in the use of illegal drugs and positive drug tests. They were impressed with the commitment of the drug and alcohol recovery team (DART). Although the prison had put in place strategies to detect drugs, the Board felt they needed better technology to help tackle this.

Previous deaths at HMP Durham

21. There have been 20 deaths at Durham since January 2017. At least four were drug-related. We have made previous recommendations about the need for effective measures to reduce the supply of and demand for drugs.

Key Events

22. Mr Jordan White was remanded to HMP Durham on 18 May 2018, on charges of grievous bodily harm. It was not his first time in prison.

23. At an initial health screen with a nurse, Mr White reported a history of anxiety, depression and substance misuse. He said he used cocaine, cannabis and benzodiazepines (sedatives). He also said that he was taking prescribed medication, including pregabalin (a drug used to treat several disorders, such as epilepsy, nerve pain and anxiety) and lansoprazole (to reduce stomach acid). Mr White was assessed as suitable to keep his medication in his cell. The nurse referred Mr White to the mental health team.

24. During the first night procedures, a peer mentor from the Drug and Alcohol Recovery Team (DART) gave Mr White advice about harm reduction, overdose risks, tolerance levels, illicit use and the risks of taking psychoactive substances. Mr White signed the drugs and violence compact, but said he did not want support from DART.

25. A prison doctor, a member of the DART team, assessed Mr White on 19 May. Mr White said he occasionally used cocaine and had taken two diazepam (Valium) tablets the previous week to get to sleep. However, he did not feel that he had a drug or alcohol problem. The doctor noted that Mr White looked well and there was no evidence of withdrawal, sedation or intoxication. A urine test was positive for cocaine, benzodiazepines and cannabis, but no opiates or buprenorphine (Subutex) were detected.

26. As part of the induction process, Mr White had a meeting with a DART support worker on 21 May. He reiterated that he did not want to engage with DART and the support worker repeated the information on harm reduction.

27. Later that day, a prison GP reviewed Mr White's community medical records. They confirmed that he had been prescribed pregabalin, but the GP could see no reason for this. He wrote to Mr White, offering to follow this up.

28. The mental health team considered Mr White's referral on 31 May. He was placed on the waiting list to be assessed for cognitive behavioural therapy by Rethink Mental Illness, a mental health charity that works with mental health teams. (Mr White failed to attend several Rethink appointments in June and July. Reasons included the times conflicting with visits, work and association and, on one occasion, wing staff could not find him when the psychologist arrived on the wing. After failing to reply to a letter, asking if he still wished to be seen, the mental health team discharged him on 31 July and advised him how to re-refer if he wished to.)

29. On 5 June, the prison GP and Mr White discussed the request for pregabalin. Mr White presented as intensely anxious. The GP informed him of the hazards and contra-indications and noted that he would restart the prescription, "with some considerable reluctance", and review Mr White in three weeks.

30. On 22 June, a compliance check of prisoners who held medication in their cells revealed that 6-8 of Mr White's pregabalin tablets were missing. (Pregabalin is

commonly traded in prisons.) He said this was due to a recent cell move and that he would prefer not to keep them in his cell, as he felt safer collecting them from the medication hatch.

31. As a result of Mr White's non-compliance and loss of the tablets, the GP stopped prescribing pregabalin on 25 June. He discussed this with Mr White the following day and replaced the pregabalin with citalopram (an antidepressant).

32. A DART worker visited Mr White on 6 July. He was still opposed to engaging with the team. However, he completed some in-cell workbooks on cocaine awareness and harm reduction and asked for extra books.

33. Mr White subsequently referred himself to DART and a DART worker completed an assessment and induction on 17 July. Mr White confirmed that he understood the harm reduction information provided on psychoactive substances awareness, tolerance levels and withdrawal symptoms.

34. On 18 July, Mr White's DART recovery worker introduced herself to him. Mr White told her that his drug use had increased in the last two months because of relationship problems. The DART recovery worker reinforced the advice he had been given and agreed to issue in-cell booklets, to be reviewed at a later session. A mandatory drug test taken on that day was negative.

35. Mr White and his DART recovery worker met again on 3 August. He fully participated in the session and there were no concerns. The plan was for Mr White to continue working through the foundation recovery booklet. As the DART recovery worker was due to go on leave, she told Mr White how to request support if he needed it in her absence.

36. A security intelligence report on the same day, suggested that Mr White had a mobile phone in his cell and recommended a cell search or use of a detection device. (Possession of mobile phones in prison is often linked to illicit activity, such as drug dealing.) The security threat/impact was recorded as low.

Events of 6/7 August

37. Mr White shared a cell. His cellmate said that he had gone to bed at around 11.00pm on 6 August and assumed Mr White was asleep. When he woke up the next morning, he looked at Mr White and immediately knew he was dead as his face was grey and his lips were blue.

38. At around 8.15am, an officer saw a group of prisoners outside Mr White's cell talking through the hatch. One of the prisoners went to the wing office and told him that a prisoner was cold and not moving. The officer and a supervising officer went to the cell and found Mr White lying on his back, unresponsive. The officer radioed a code blue and the control room called an ambulance immediately. The officers tried to straighten his legs to lay him flat and open his airway, but they could not move him. As rigor mortis was evident, they did not start cardiopulmonary resuscitation.

39. The clinical team leader, who was the emergency response nurse that day, arrived with another nurse, substance misuse team leader. One of them described Mr White as very cold and blue to his face and hands. She said that

rigor mortis had set in and there was evidence of livor mortis (discolouration due to blood pooling) to his arms and legs. As Mr White was clearly dead, the nurses did not attempt resuscitation and asked for the ambulance to be stood down. A prison GP confirmed Mr White's death at 8.30am.

Contact with Mr White's family

40. A prison chaplain and an officer were appointed as the prison's family liaison officers. At 10.00am, they arrived at the address listed in prison records for Mr White's partner, his nominated next of kin, but she had moved home. The new occupant was reluctant to disclose Mr White's partner's new address, but agreed to take them there. On the way, they saw Mr White's mother, who had already heard the news of her son's death and was distressed.

41. Mr White's mother invited the family liaison officers into her house. As they had no other details for Mr White's partner, they confirmed that Mr White had died. They apologised that his mother had heard the news before they told her and offered support. Other family members and friends arrived. The family was unwilling to give contact details for Mr White's partner.

42. When they returned to the prison, the prison chaplain tried, without success, to contact Mr White's father, who had also been listed as a contact in Mr White's prison records. In the afternoon, Mr White's father telephoned the prison chaplain, who gave him information and answered his questions.

43. Mr White's funeral was held on 23 August. In line with national policy, the prison contributed to the costs.

Support for prisoners and staff

44. After Mr White's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising. She offered the support of the staff care team.

45. Mr White's cellmate was immediately given access to staff support and a Listener (confidential peer support). The prison posted notices informing staff and other prisoners of Mr White's death, and offering support.

Post-mortem report

46. The post-mortem report concluded that Mr White's death was due to the effects of a combination of buprenorphine, diazepam and alprazolam. (Buprenorphine, also known as Subutex, is an opioid drug used in the treatment of heroin addiction. Alprazolam, also known as Xanax, is a benzodiazepine which is not available on the NHS, but can be prescribed privately.)

47. The pathologist said that benzodiazepines and opioids share the same side effects. This includes slowing down the central nervous system, leading to low and shallow breathing, coma and potentially death and the likelihood of side effects is increased when more than one substance is used. The levels of the drugs present were relatively low, but as Mr White was said to have taken them the evening before, the levels were likely to have been higher at their peak.

Cocaine was also detected in his urine, which indicated that he had used the drug not long before his death.

Findings

Drug strategy at HMP Durham

48. Following an inspection at Durham, completed in October 2018, HM Chief Inspector of Prisons was concerned that safety had been seriously compromised by the ready availability of illicit drugs. The prison has a comprehensive *Drug and Alcohol Pathway Policy*, highlighting several measures to reduce the demand and supply of illicit drugs and a *Reception and Treatment Pathway for Substance Misusers*. However, it is a concern that in spite of this, Mr White was able to obtain illicit drugs. This suggests that much more needs to be done to tackle the issue of drugs at Durham.

49. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

50. In relation to reducing the supply of drugs, we note that the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We, therefore, recommend:

The Governor should ensure that the key drug issues at Durham are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

Support for substance misuse

51. Mr White had a history of substance misuse. When he first arrived at Durham, he was offered the opportunity of support from the drug and alcohol recovery team and advice on risks and harm reduction. He refused to engage with the team that day and on subsequent occasions, until 17 July.

52. When an audit of prescribed medication found that several pregabalin tablets dispensed to Mr White were missing, the prison GP immediately took preventative measures by withdrawing them and prescribing a substitute. Shortly afterwards, DART offered him another chance to receive support.

53. Security intelligence reports during Mr White's previous periods in custody implicated him in dealing Subutex and other drugs. There was no explicit suggestion of this during his final period in custody before his death, although intelligence received four days before his death indicated that he might have a mobile phone.

54. The investigation found that Mr White was given opportunities to engage with the drug and alcohol team to reduce the risk of harm from illicit drugs. Although he initially declined their support in May and early July, the team gave him appropriate advice to help him to keep safe. When he finally referred himself in July, the DART team responded promptly and he began to work with them. His drug recovery worker was on leave at the time of his death, but she had told him how to access help while she was away. We do not know how Mr White obtained the drugs that led to his death, but we are satisfied that staff at Durham could not have predicted or prevented his death.

Allegation of drug use on 6 August

55. Mr White was said to have moved cells on 6 August, the day before his death, but there is no record of this. His cellmate said they had known each other for around 15 years and that Mr White had moved into his cell, after being sacked from his job as a cleaner due to being under the influence of drugs. He did not know what Mr White had taken, but said that he seemed to be under the influence when he arrived at the cell, as his speech was slurred and his eyes were rolling. He said Mr White did not use psychoactive substances, but sometimes took 'Valium' (the brand name for diazepam).

56. The prison has no record of the cell move, or the reasons for it, nor any record of the suspicion Mr White had taken drugs. No officers recalled these events. An entry in the security intelligence system, dated 6 August, noted that Mr White was a cleaner, but no other information was recorded. (Mr White's mother had been told that his cellmate had actually moved into Mr White's cell and that it was some time before 6 August.) The investigation was unable to resolve this issue or determine the reliability of the cellmate's claim.

Clinical care

57. When Mr White arrived at Durham, healthcare staff conducted appropriate health screens. There were no significant concerns about his physical health, but he was referred to the mental health team due to a history of anxiety and depression. The prison GP correctly checked Mr White's claim that he had been prescribed pregabalin in the community, before agreeing to re-prescribe it.

58. We agree with the clinical reviewer's conclusion that Mr White's care was of a good standard and equivalent to that he could have expected to receive in the community.

59. We are, however, concerned that Mr White was assessed as suitable to hold pregabalin in his possession given his history of substance misuse. Pregabalin is both misused and highly tradable in prison because of its euphoric effects, especially when combined with other drugs, and it is difficult to understand why it was considered safe for Mr White to hold it in his possession. The fact that some

of Mr White's pregabalin was missing when a check was conducted on 22 June, suggests that he was either misusing it himself or was trading it.

60. We are pleased to note that the prison GP stopped prescribing pregabalin after this and we regard this as an example of good practice.

61. We recommend:

The Head of Healthcare should ensure that prisoners only receive in-possession medication after a consistent, recorded risk assessment that is regularly reviewed.

Contact with Mr White's family

62. The prison's family liaison officers travelled from Durham to Newcastle and arrived at the address given for Mr White's ex-partner within an hour and a half of Mr White's death. They were told that she had moved home, but attempted to locate her with the help of the new occupant. In the meantime, Mr White's mother and other family members had learned of Mr White's death.

63. As Mr White had been in prison for less than three months, it was reasonable to assume that his next of kin details were up to date and there is no evidence that Mr White had notified staff of the change of address. It is unfortunate that his family found out about his death before the family liaison officers could tell them, but we are satisfied that this was beyond the control of the prison and that the family liaison officers had left the prison promptly to break the news.

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