

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Stewart a prisoner at HMP Durham on 9 March 2019

A report by the Prisons and Probation Ombudsman

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.

Our 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 Derek Stewart died on 9 March 2019, after he was found hanging in his cell at HMP Durham. He was 37 years old. I offer my condolences to Mr Stewart's family and friends.

Mr Stewart had been at Durham for only two weeks. He had been moved there temporarily from HMP Edinburgh so that he could appear before an English court for further alleged offences.

There was little indication that Mr Stewart was at imminent risk of suicide and I am satisfied that staff could not have foreseen his actions.

However, Mr Stewart had told staff that he felt under threat at Durham and I consider that more could have been done to understand his fears and put appropriate measures in place.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

October 2019

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Summary

Events

1. Mr Derek Stewart arrived at HMP Durham on 20 February 2019. He had been moved there temporarily from HMP Edinburgh so that he could appear before an English court for alleged further offences.
2. Mr Stewart had a history of alcohol and drug misuse. At Edinburgh, he was kept separate from mainstream prisoners because he feared for his safety. He had enemies within the prison and it was suspected he had run up drug debts.
3. Around one week after arriving at Durham, Mr Stewart submitted a complaint form saying he wanted protection. He told an officer that he had been on a protection wing at Edinburgh and wanted the same at Durham. On 3 March, he told a prison chaplain that prisoners were making threats against him and he was worried about his safety.
4. On 8 March, Mr Stewart was moved to the prison's Separation and Care Unit (SACU) after he fought with his cellmate.
5. At 11.28pm, an officer found Mr Stewart hanging in his cell. Staff and ambulance paramedics were unable to resuscitate him, and at 12.18am on 9 March, he was pronounced dead.

Findings

6. There was little indication that Mr Stewart was at imminent risk of suicide. We are satisfied that staff could not have foreseen his actions.
7. When Mr Stewart told staff at Durham he was being threatened, they submitted intelligence reports and started violence reduction procedures. The procedures say that the prisoner should be interviewed as soon as possible by a member of the safer custody team. While Mr Stewart was referred for an interview, the member of staff responsible was not available for several days. This meant that Mr Stewart was not interviewed before he died. Had he been, staff would have had a better understanding of why he felt under threat and it would have been an opportunity to assess whether he was at risk of suicide and self-harm.
8. The Person Escort Record (PER) that accompanied Mr Stewart when he arrived at Durham said he had been 'segregated' at Edinburgh prison (kept apart from mainstream prisoners). We consider that the reception officer should have asked Mr Stewart about this. Had the officer done so, Mr Stewart might have disclosed that he also felt under threat at Durham and measures to protect him could have been considered.

Recommendations

- The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:
 - Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.
 - Staff consider whether victims are at increased risk of suicide and self-harm.
- The Governor should ensure that reception staff consider all the information in a prisoner's PER and action accordingly, including discussing issues of concern with the prisoner where appropriate.

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 Stewart's prison and medical records. She also obtained information about Mr Stewart's time at HMP Edinburgh.
11. NHS England commissioned a clinical reviewer to review Mr Stewart's clinical care at the prison.
12. They jointly interviewed seven members of staff on 30 April, and the investigator interviewed 7 members of staff and a prisoner at Durham on 1 May.
13. We informed HM Coroner for Durham and South Darlington of the investigation. The coroner gave us Mr Stewart's post-mortem and toxicology reports. We have sent the coroner a copy of this report.
 - One of the Ombudsman's family liaison officers contacted Mr Stewart's family, to explain the investigation and to ask if they had any matters, they wanted the investigation to consider. Mr Stewart's mother asked the following: Why Mr Stewart was transferred to Durham;
 - Whether he routinely received methadone at Durham;
 - Whether Mr Stewart had a history of depression;
 - Why Mr Stewart had a change of cellmate just before he died;
 - What the fight was about and whether it was drug-related;
 - Whether Mr Stewart was monitored in the segregation unit; and
 - Why paramedics did not arrive at the prison until 2.30am?

We have addressed these questions in this report.

14. Mr Stewart's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Durham

15. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Durham was in September and October 2018. Inspectors' overriding concern was the lack of safety in the prison. Since their last inspection in 2016, there had been seven self-inflicted deaths, and inspectors were disappointed that the prison's response to the PPO's recommendations had not been addressed with any vigour or urgency. Inspectors concluded that PPO recommendations were not sufficiently prioritised. The inspectors were concerned that there had been a further five deaths in eight months where it was suspected that illicit drug use had played a part.
17. Inspectors found that illicit drugs were regularly available at Durham. Two thirds of prisoners told inspectors how easy it was to obtain illicit drugs and 30 per cent said they had acquired a drug habit since arriving at Durham.
18. Inspectors noted that there had been an increase in violence at the prison which they attributed (possibly) to inexperienced staff who were not confident in using de-escalation techniques. Also, safety had been undermined by the widespread availability of illicit substances.
19. The report said that living conditions in the Separation and Care Unit (SACU) were reasonably good and relationships between prisoners and staff were positive and supportive. However, inspectors reported that the SACU regime was poor and, at most, prisoners could take a shower, make a telephone call and exercise for an hour every day. Prisoners' isolation in the SACU was exacerbated as they had little access to education, in-cell work or the gym.

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 31 October 2018, the IMB reflected on the change in Durham's role to a reception prison (in May 2017). They noted that, consequently, the prison had reported an increase in deaths in custody and illicit drug use.
21. The IMB reported safety as an issue. This was in response to the prison's re-role which meant there had been an increase in the number of prisoners passing through reception, that it took an excessively long time for prisoners to be processed, and prisoners stayed at Durham for a shorter time. The IMB noted reception had made some minor changes which had slightly improved this.
22. The IMB were satisfied with the conditions, facilities and security within the Separation and Care Unit (SACU) and found staff professional.

Previous deaths at HMP Durham

23. Mr Stewart was the 19th prisoner to die at Durham since March 2017. Of the previous deaths, seven were self-inflicted, seven were from natural causes, three were drug-related and in one, the cause of death was unascertained. Two prisoners have died since Mr Stewart, both from natural causes. There were no similarities between the findings we have made in Mr Stewart's case and those made in previous investigations.

Psychoactive Substances (PS)

24. Psychoactive substances (formerly known as new psychoactive substances (NPS) or 'legal highs') are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
25. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
26. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Segregation units

27. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. They can also make applications to attend corporate worship once a week, subject to an approved risk assessment.

Key Events

28. On 30 October 2018, Mr Derek Stewart was sentenced to two years imprisonment for breaching bail, assault and carrying a bladed article. He was sent to HMP Edinburgh.
29. On 8 February 2019, Mr Stewart was told he had a court hearing at North Tyneside Magistrates' Court on 12 March, for alleged offences committed in England. He was told he would be moved to HMP Durham temporarily so he could either attend the hearing in person or appear by videolink. (Prisoners in Scotland cannot appear by videolink for court hearings in England.)
30. Mr Stewart was moved from Edinburgh to Durham on 20 February. His Person Escort Record (PER – a form that accompanies prisoners between police custody, courts and prisons, which sets out the risks they pose) noted that Mr Stewart had a history of violence, and alcohol and drug use. It also noted that Mr Stewart had been in segregation at Edinburgh due to “non-offence protection”. (Edinburgh told us that Mr Stewart had not been in their segregation unit but had been classed as a non-offence protection (NOP) prisoner and kept apart from mainstream prisoners. He was classed as a NOP because he had made enemies in the community, who he might come across in prison, and had probably incurred drug-related debts.)
31. A nurse carried out Mr Stewart's reception health screening at Durham. The nurse noted that Mr Stewart had no current thoughts of suicide or self-harm and appeared “mentally calm and settled”.
32. Mr Stewart was placed on the First Night Centre (FNC) on E Wing. Later that evening, a nurse practitioner reviewed Mr Stewart's medical record. She noted that he was prescribed 40mls of methadone daily, and he had received his medication that day. Mr Stewart continued to be prescribed 40mls of methadone at Durham.
33. On 21 February, a member of staff from the Drug and Alcohol Recovery Team (DART) saw Mr Stewart as part of his induction at Durham. He gave him information about drug tolerance, overdoses and the risks of using psychoactive substances (PS).
34. A recovery coordinator for DART, met Mr Stewart on 25 February. They agreed on a treatment plan, which would look at ways to address Mr Stewart's previous drug use in the community. They were scheduled to meet again on 18 March. He told the investigator that Mr Stewart did not appear low in mood and spoke about how he was looking forward to returning to Scotland.
35. At the end of February, Mr Stewart submitted a complaint form (dated 26 March, which was clearly an error). He wrote, “Can I please have protection, I'm being blamed for something that was not me.” A Supervising Officer (SO) remembered having a conversation with Mr Stewart. He told her he was not a sex offender but had been on a protection wing in Scotland and would like the same at Durham. The SO told the investigator that she probably had a conversation with the SO on the vulnerable prisoners (VP) wing about moving Mr Stewart, but a manager on the VP wing, could not recall this.

36. On 3 March, Mr Stewart told a prison chaplain, that he was worried about his safety. He thought other prisoners were making threats against him because they thought he was a sex offender. He was unable to be specific or give names. He said he “just had a feeling” they were in Durham. Mr Stewart thought his current cellmate was plotting against him while he was asleep. The prison chaplain submitted an intelligence report (IR) and told a SO about their conversation. Mr Stewart submitted a form asking to move wings and said he felt under threat.
37. The IR was assessed by the security manager, and he forwarded it to the area office, the wing manager and the safer custody team. Durham’s violence reduction policy says a member of the safer custody team should interview prisoners making allegations of bullying. The IR on Mr Stewart was forwarded to an officer on 6 March, for action. The officer was deployed to work elsewhere in the prison on 6 March, so did not pick up the email. The next day she was off duty and on 8 March, she was on external training. This meant that Mr Stewart was not seen.
38. On 6 March, Mr Stewart was moved to B Wing. He was put in a shared cell. Mr Stewart complained to a nurse that his current methadone prescription was not “holding” him. A nurse reviewed Mr Stewart’s medical records and increased his methadone to 45mls daily.
39. On 7 March, a member of staff from B Wing asked a mental health nurse, to assess Mr Stewart because they were concerned about the way he was acting. She noted that he presented well, although his pupils appeared dilated. Mr Stewart said he had not taken any illicit substances. He spoke about feeling scared and paranoid on the wing, because it was so loud and busy. He said it made him feel anxious and asked if he could move to a quieter wing. Mr Stewart said he had no thoughts or history of suicide or self-harm, but he received methadone at irregular times which made him “feel funny”. She told Mr Stewart it was too late to move him to a different wing, but she would try the next day. Mr Stewart said that would be okay and thanked her. The nurse the SO on B Wing. There is no record of any action.
40. Mr Stewart’s cellmate told the investigator that Mr Stewart had appeared down on 7 March. He was taken out of the cell to attend a videolink court hearing in the morning and, as he left, Mr Stewart began shouting and kicking the cell door, asking to speak to staff. Later that day, Mr Stewart threatened to smash up his cell. He told his cellmate that staff were annoying him. The cellmate said Mr Stewart liked to use ‘Spice’ (PS) and asked whether he had any, but he said no.
41. Mr Stewart telephoned his mother at 4.44pm, on 7 March. The call lasted ten minutes and they spoke about general matters. Mr Stewart’s last telephone call was to his sister at 8.55pm. They spoke about his pending court date, but the call cut off as Mr Stewart had reached his telephone credit limit.
42. At approximately 10.00pm, the cellmate pressed his cell bell. Two officers responded. They saw Mr Stewart was holding a flask and a weapon, made from a razor blade melted into a toothbrush, and his cellmate had visible cuts to his chest, arms and face. They radioed for the manager on duty to attend and a CM arrived at the cell. An officer told Mr Stewart to put down the weapons and then

- opened the door. He kicked the blade out of the cell and took the cellmate to another cell.
43. The cellmate told staff that Mr Stewart had started pacing around the cell, breathing heavily and holding his head. He told him to “chill out” and Mr Stewart “just lost his head” and attacked him with the blade and a flask. He said that Mr Stewart had acted strangely the past two days. The CM decided to leave Mr Stewart in a cell on B Wing that night and planned to move him to the Separation and Care Unit (SACU) the next morning. The cellmate told the CM they were fighting about what to watch on television. Although staff suspected the argument might have been about drugs, there was no evidence of any drug use in the cell.
 44. A little later, an officer responded to Mr Stewart’s cell bell. He asked how his cellmate was and the officer said he was receiving treatment. She asked what had happened and Mr Stewart said he had been lying on his bed when his cellmate attacked him with a blade. Mr Stewart said he had defended himself which is why he had not sustained an injury. Mr Stewart would not say what the fight was about, and the officer was unable to determine whether either prisoner appeared under the influence of drugs, as she did not know them.
 45. The next morning, Friday 8 March, Mr Stewart was moved to the SACU. A nurse completed an Initial Segregation Health Screen and assessed that there were no medical reasons to advise against segregation.
 46. Staff conducted five roll checks (counts of prisoners) in the SACU during 8 March and reported no issues with Mr Stewart.
 47. At 8.30pm, while an officer was carrying out a roll check, Mr Stewart asked him if he could have a book. An officer said he could not open cell doors (as the prison was in night state) but it might be possible if healthcare staff arrived with medication later (for any prisoner who had not received medication during the day).
 48. The officer saw Mr Stewart again at 10.00pm. The officer told the investigator he seemed okay and was just pacing around his cell.
 49. At 11.28pm, the officer checked on a prisoner who was being monitored under suicide and self-harm procedures. As he walked past Mr Stewart’s cell, he noticed his cell light was on, so looked through the observation panel. The officer could see that Mr Stewart was hanging from a ligature made from a bedsheet, tied to some telephone trunking on the wall of the cell. His face seemed discoloured and he was against the cell wall with his legs underneath him.
 50. The officer immediately radioed an emergency code blue (which indicates a prisoner is unconscious or not breathing and an ambulance should be called immediately) while shouting for Mr Stewart and kicking the cell door. The officer was working alone in the SACU and held a sealed pouch containing cell keys to use in an emergency. The officer broke open the pouch and unlocked Mr Stewart’s cell, as a second officer arrived. They went into the cell together.

51. The officer cut the ligature around Mr Stewart's neck and the second officer checked for signs of life. He found none so started cardiopulmonary resuscitation (CPR). A CM arrived at the cell and advised the officers to move Mr Stewart out onto the landing, so they had more room to carry out CPR. They did so, and continued CPR.
52. A nurse heard the code blue call and went immediately to the SACU. Another nurse arrived with an emergency bag a few seconds later. The nurses gave Mr Stewart oxygen and then applied the defibrillator. The CM assisted in giving oxygen. The machine first advised to shock Mr Stewart, which they did. This surprised a nurse, who thought the defibrillator might have given a faulty reading. Staff continued CPR until paramedics arrived, and the defibrillator did not advise to shock again.
53. The CM had arranged for staff to open all gates so the paramedics and ambulance would not be delayed reaching Mr Stewart's cell. Paramedics arrived there at 11.40pm and took over CPR. Another ambulance crew arrived at 11.55pm. However, they were unable to resuscitate Mr Stewart and at 12.18am on 9 March, he was pronounced dead.

Contact with Mr Stewart's family

54. A prison chaplain and an officer visited Mr Stewart's mother at 6.30am on 9 March, to break the news of her son's death. The prison contributed to Mr Stewart's funeral, in line with national guidance.

Support for prisoners and staff

55. After Mr Stewart's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Stewart's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Stewart's death.

Post-mortem report

57. Mr Stewart's post-mortem report records he died from hanging. Mr Stewart's toxicology report shows that he had methadone and mirtazapine (antidepressant) in his system, both of which he had been prescribed. Promazine (antipsychotic) or promethazine (an 'over the counter' anti-histamine (anti-allergy), anti-emetic (anti-sickness) and sedating (sleep aid) drug which is also the active component of many cold and flu preparations such as 'Night Nurse') were possibly also present, but they were at such a low concentration that the toxicologist was unable to confirm this finding or say exactly which drug was present.

Findings

Risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, lists a range of risk factors and potential triggers for suicide. It instructs staff to start suicide and self-harm monitoring (known as ACCT) whenever they assess that a prisoner is at risk of suicide or self-harm.
59. Mr Stewart had never been monitored under suicide and self-harm prevention measures at Edinburgh and when he arrived at Durham, he had no significant risk factors for suicide. There was little indication that Mr Stewart was at imminent risk of suicide and self-harm at Durham and we are satisfied that staff could not have foreseen his actions.

Allegations of bullying

60. At the end of February, Mr Stewart submitted a complaint form asking for protection. A few days later, he told a prison chaplain that he was being threatened, although he was unable to name the alleged perpetrators. The prison chaplain submitted an IR. Mr Stewart also submitted a form asking if he could move wings.
61. A PPO publication in October 2011, *Violence reduction, bullying and safety*, noted the links between bullying and violence and self-inflicted deaths of prisoners of all ages. In our PPO thematic report into self-inflicted deaths in 2013-2014, we highlighted how important it is that reports or suspicions that a prisoner is being threatened are recorded, investigated and responded to robustly.
62. Durham's Violence Reduction Strategy, dated October 2015-2016, sets out the process for raising and investigating any identified or suspected act of aggression, bullying, intimidation or violence. It says alleged victims will be supported and managed by staff and a mandatory action is for the prisoner to be interviewed as soon as possible. Durham said the initial interview should be carried out by a member of the safer custody team. Although an IR was submitted and it was forwarded to the safer custody office for action in Mr Stewart's case, there were no staff available from the safer custody team to speak to Mr Stewart. This was because the staff member who had been sent the information had been deployed to work in another part of the prison and was then out of the prison until after Mr Stewart died.
63. We consider that the prison missed opportunities to assess and investigate Mr Stewart's allegations of threats against him. Mr Stewart clearly felt vulnerable and at risk, whether those threats were real or perceived. Although Durham followed their policy (which included sending the information about Mr Stewart to the violence reduction officer) nobody spoke to Mr Stewart about his worries. It is apparent that Mr Stewart remained concerned about his safety during this time. We make the following recommendation:

The Governor should ensure that all information about bullying and intimidation is fully coordinated and investigated, including that:

- **Apparent victims are effectively supported and protected with meaningful, long-term solutions, which address their individual situations.**
- **Staff consider whether victims are at increased risk of suicide and self-harm.**

64. The PER that accompanied Mr Stewart from Edinburgh to Durham noted that he had been segregated at Edinburgh for “non-offence protection”. In fact, he had not been segregated but he had been kept apart from mainstream prisoners due to fears for his safety. We consider that reception staff should have asked Mr Stewart about this and noted any concerns he might have had about his safety. We make the following recommendation:

The Governor should ensure that reception staff consider all the information in a prisoner’s PER and action accordingly, including discussing issues of concern with the prisoner where appropriate.

Mental health

65. Mr Stewart told staff at Durham that he had been prescribed antidepressants in the community, but not since October 2017, and he had not been prescribed any at Edinburgh. On arrival at Durham, Mr Stewart did not mention any thoughts of suicide or self-harm or that he felt depressed, and staff did not identify any risks or any mental health issues. The clinical reviewer considered that this was appropriate and there was no evidence that Mr Stewart required a mental health referral when he was assessed in reception at Durham.
66. Mr Stewart was assessed by a member of the mental health team on 7 March, after an officer made a referral. The nurse found no evidence of self-harm or suicidal thoughts. The clinical reviewer considered that this mental health assessment was timely and appropriate. She concluded that the care Mr Stewart received for his mental health was equivalent to that he could have expected to receive in the community.

Substance misuse

67. Mr Stewart had a history of using illicit drugs and alcohol. He had been on a methadone detoxification programme in the community, which he continued at Edinburgh and then at Durham. However, Mr Stewart said his methadone was not administered at regular times, which sometimes made him feel unwell. The clinical reviewer found that methadone dispensation could vary at times, depending on Durham’s regime, but found no evidence that this was a problem.
68. Mr Stewart engaged with DART at Durham, who told him about harm minimisation, tolerance of drugs, overdosing and risks associated with substance misuse. The clinical reviewer concluded that the support he received for his substance misuse was equivalent to that he could have expected to receive in the community.

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