Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Reed, a prisoner at HMP Durham, on 17 February 2019

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 Richard Reed died on 17 February 2019 after being found hanged in his cell at HMP Durham. He was 39 years old. I offer my condolences to Mr Reed's family and friends.

Mr Reed was recalled to prison on 4 February. The prison received credible intelligence from local police that Mr Reed had deliberately engineered his return to Durham in order to bring in drugs and mobile phones. He was kept in the segregation unit and almost 20 packages of different drugs and two mobile phones were recovered from him during the course of the next two weeks. He appeared intoxicated for much of this period and his methadone prescription was withheld to reduce the risk of overdose.

Mr Reed had many risk factors for suicide and self-harm that should have prompted Durham to consider monitoring him under Prison Service suicide and self-harm procedures (known as ACCT). We have noted many times in individual investigation reports, thematic reports and annual reports, that staff too often focus on the prisoner's presentation and whether he says he has any thoughts of suicide or self-harm and overlook known risk factors, which increase risk.

We have found poor quality risk assessments in previous investigations at Durham and two recent HMIP inspections have found the same problem. Our investigation into the death of a prisoner who died in Durham a week before Mr Reed found the same failings. These failings are again apparent to an extent in Mr Reed's case.

I am aware that Durham identified a significant training need in suicide and self-harm risk assessment following the previous death, and my investigation welcomed recent efforts to put this right through extensive re-training. Given that Mr Reed died so soon after the previous death, I do not make a repeat recommendation in his case but I will expect to see significant improvements in future.

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 **February 2020**

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Summary

Events

1. Mr Reed had a history of poly-substance misuse, including opiates, crack cocaine and benzodiazepines (tranquilisers). He had served several short prison sentences and had been in Durham before, most recently in November 2018 when he was released after receiving a suspended sentence of ten weeks for burglary. Mr Reed was arrested again on 3 February 2019. The suspension on his sentence was lifted at Newcastle-upon-Tyne Magistrates Court on 4 February and he was returned to prison custody in Durham.

2. The police shared credible intelligence with the prison that Mr Reed had deliberately engineered his return to custody in order to bring drugs and mobile phones into Durham. The body orifice scanning system (BOSS) chair – which detects metal objects - showed Mr Reed had items concealed in his body. He was taken immediately to the segregation unit.

3. Over the next two weeks, officers searched Mr Reed and his cell regularly and found packages of different drugs and two mobile phones. Mr Reed appeared intoxicated on multiple occasions and nurses withheld his methadone prescription in case of overdose. He was monitored regularly by officers, nurses and the substance misuse team. SACU staff tried to find out whether Mr Reed was at risk because he had lost the drugs he had brought in, but they did not think that he was at risk of harming himself.

4. At about 5.10am on 17 February, the night patrol officer found Mr Reed hanging in his cell. Cardio-pulmonary resuscitation (CPR) was given promptly and an ambulance was called. Paramedics arrived quickly and took Mr Reed to hospital, but he was pronounced dead at 6.40am.

5. Letters from Mr Reed discovered in the outgoing mail indicated that he intended to take his own life.

6. A post-mortem examination gave Mr Reed's cause of death as pressure on the neck due to hanging.

Findings

7. Mr Reed had a number of risk factors that indicated his risk of suicide and self-harm might be raised. These factors should have caused concern for his well-being and suicide and self-harm monitoring procedures considered. Staff placed too much reliance on his presentation and what he said.

8. There is no evidence that Mr Reed was monitored in line with national guidance on his first night in the segregation unit. His segregation safety health screen was not completed in a timely manner and one of the questions was answered wrongly.

9. The investigator experienced some difficulty obtaining information from the prison after the original liaison officer went off sick for a significant period and was not given CCTV of the segregation unit or a definitive answer as to whether it was

available. Investigators in our other investigations into deaths in Durham in 2019 also experienced some disruption in the information gathering process and we seek an assurance from the Governor that a single point of contact will be appointed going forward.

Recommendations

- The Governor should ensure that segregated prisoners who arrive during night state are monitored every 30 minutes and a segregation safety health screen is completed as soon as possible the next day in line with national guidance.
- The Governor should confirm to the Ombudsman that, following a death in custody, a single point of contact appointed by the Governor will respond promptly to all the Ombudsman's requests for information, in line with the requirements of PSI 58/2010.

The Investigation Process

10. 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.

11. The investigator obtained copies of relevant extracts from Mr Reed's prison and medical records. She watched body-worn camera footage from 17 February and listened to the emergency radio traffic. The investigator asked the prison for CCTV footage from the segregation unit from 16-17 February. The prison initially said this was available, but it was not passed to the investigator despite repeated requests.

12. NHS England commissioned a clinical reviewer to review Mr Reed's clinical care at the prison. The investigator and clinical reviewer jointly interviewed three members of staff at HMP Durham in March 2019. The investigator interviewed a further five members of staff.

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

14. We wrote to Mr Reed's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Reed's next of kin, raised a number of questions:

    - Was the prison aware that Mr Reed suffered from depression?
    - Was the prison aware Mr Reed had previously attempted suicide?
    - Was Mr Reed subject to ACCT monitoring?
    - Did anyone notice that his mental state was poor?
    - When was Mr Reed given methadone?
    - Was Mr Reed assaulted in HMP Durham before he died?

15. We have answered her questions in this report and in separate correspondence.

Background Information

HMP Durham

16. HMP Durham is a designated reception prison which holds up to 996 men who are on remand or licence recall, and serves the courts of Durham, Tyneside and Cumbria. G4S provide primary care nursing and clinical drug and alcohol services (DART). Spectrum Healthcare provide GP and pharmacy services. Tees, Esk and Wear Valley NHS Trust provide mental health services.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Durham on 24 September to 5 October 2018. Inspectors found a high number of self-inflicted deaths, high levels of violence and self-harm, and that illicit drugs were prevalent and readily available. Inspectors found that Durham had developed a strategy to address the issue of drugs but had no modern technology available to them to reduce the flow of drugs into the prison. Inspectors noted that Durham should have received modern technology equipment, however, this had been diverted for use in another prison.

18. A follow up inspection, in June 2019, found that the prison had made good progress in their recommendation that the supply of illicit drugs should be reduced, including the introduction and use of more sophisticated drug detection equipment.

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, published in March 2019, the IMB found that the violence which resulted from the trade in illicit drugs, and the use of those drugs, had led to an unstable prison. The IMB noted that Durham was making strenuous efforts to prevent drugs coming into to the prison, but that better technology needed to be provided to tackle the problem.

Previous deaths at HMP Durham

20. Mr Reed's was the seventh death at Durham since January 2018 in which illicit substances played some part. In previous investigations we made recommendations about the assessment of risk and availability of drugs. Two prisoners have died at Durham since Mr Reed's death and both prisoners were in the segregation unit. Our investigations into those deaths are on-going.

Management of prisoners suspected of holding drugs internally

21. Prison Service Order (PSO) 1700 governs prisoners kept in segregation. It says that, if it is believed a prisoner is holding drugs internally (through secreting or swallowing) that they intend to take themselves or distribute to other prisoners, the prisoner should be kept in segregation under Prison Rule 45 (good order and discipline – GOOD) until it is believed he/she no longer holds the drugs. Segregation under Rule 45 should be for the shortest period of time consistent with the reason for segregation in the first place.

Key Events

22. Mr Reed had served several short prison sentences and had been in Durham before, most recently in November 2018, when he was released after receiving a suspended sentence of ten weeks for burglary. He had a history of poly-substance misuse, including opiates, crack cocaine and benzodiazepines. His family told us that he had previously attempted suicide outside prison but we have seen no evidence that the prison was aware of this.

23. On 3 February 2019, Mr Reed was arrested and taken into police custody. The suspension on his sentence was lifted at Newcastle-upon-Tyne Magistrates Court on 4 February and he was sent back to Durham. He was due to be released on 23 February 2019. Mr Reed was previously prescribed methadone (an opiate substitute), anti-depressants and pregabalin (for anxiety) but did not have a current prescription for any medication.

24. Mr Reed arrived at HMP Durham at 6.15pm on 4 February. During his initial search in reception, the prison's Body Orifice Scanning System (BOSS) chair indicated the presence of a metal object or objects. Mr Reed denied he had any unauthorised items and blamed the positive result on metal in his leg. The police shared credible intelligence with the prison that Mr Reed had deliberately engineered his recall to prison in order to traffic drugs into Durham.

25. At 8.00pm, officers escorted Mr Reed to the segregation unit (known as the separation and care unit - SACU – at Durham) because they wanted to stop him distributing contraband to the general prison population. Mr Reed refused an initial health assessment by a nurse. As it was out of the core day, no one from healthcare completed a segregation safety health screen to assess if Mr Reed was fit to be segregated. A nurse monitored Mr Reed overnight and recorded on his medical record at 10.44pm, 1.08am and 5.33am that he was sleeping normally.

26. On 5 February, Mr Reed's urine tested positive for cocaine, opiates, benzodiazepines (tranquilizers) and methadone. He told a prison GP that he used illicit methadone and crack cocaine daily, with occasional benzodiazepines and dihydrocodeine (an opiate painkiller). The prison GP recorded that Mr Reed was slightly sweaty and slightly restless. He started Mr Reed on a methadone daily maintenance programme of 20mg daily.

27. At 2.40pm, a nurse completed an initial health assessment. Mr Reed said that he was withdrawing from drugs but denied any physical health issues. He gave a history of post-traumatic stress disorder (PTSD) and anxiety and said that he wanted to see the drug and alcohol recovery (DART) team. He denied any thoughts of suicide or self-harm. The nurse also assessed Mr Reed using the segregation safety health screen and concluded he was fit to remain in the SACU. She incorrectly answered 'no' to question 3 about Mr Reed's physical condition which included whether he was within four weeks of detoxification or stabilisation.

28. A drug and alcohol recovery team (DART) worker attempted to assess Mr Reed for substance misuse services on 5 February but an officer found a white tablet on the floor of his cell and postponed the assessment. (A DART worker tried

again on 6 and 7 February but was unable to see Mr Reed for operational reasons.)

29. Mr Reed received his first dose of methadone at the evening medication round on 5 February and said that he felt a lot better afterwards. Healthcare staff checked Mr Reed daily on 6 and 7 February and observed him overnight in line with the prison's substance misuse strategy. He showed only mild withdrawal symptoms and received 20ml methadone both days.

30. On 7 February, officers searched Mr Reed. On the way from his cell to the search area he attempted to swallow a package and handed over another package to prison staff during the search. Mr Reed was placed on a disciplinary charge for breaking the prison rules and his disciplinary hearing was referred to an independent adjudicator (a judge) and adjourned until 21 February. At 5.03pm, a nurse completed another segregation health screen. She too incorrectly answered 'no' to question 3 about Mr Reed's physical condition which asked whether he was within four weeks of detoxification or stabilisation.

31. On 8 February, the drug and alcohol recovery team arrived to assess Mr Reed because he had attempted to pass something under his door to the prisoner next door. Mr Reed told her he was prescribed 30mg methadone daily in the community, but this had been withdrawn in January. He said that since then, he had smoked £20 worth of crack cocaine, taken two valium (diazepam) tablets to come down and smoked two cannabis joints daily. He said he felt quite low in mood but denied any thoughts of suicide or self-harm.

32. A nurse completed a five-day substance misuse assessment that afternoon. Mr Reed was alert and orientated with no signs of sedation or intoxification. The nurse increased his methadone to 30mg. Mr Reed said that he did not want a higher dose because he wanted to take buprenorphine (another opiate substitute) on his release from prison.

33. The night patrol officer noticed Mr Reed attempting to pass items to the prisoner in the cell next door. Mr Reed's segregation record shows he attempted the same thing several times every night before he died.

34. Mr Reed received 30mg methadone on 9 and 10 February as planned. There are no entries about Mr Reed's physical or mental health on his clinical record or NOMIS record for these days (a weekend). His segregation history sheet recorded that he had his television removed and replaced with a radio on 9 February.

35. A Custodial Manager (CM), who was the SACU manager, told the investigator that on 11 February, Mr Reed was looking forward to Newcastle United's football match that night and seemed in good spirits. The CM said he had a good rapport with Mr Reed because they were both Newcastle fans. Mr Reed had a dry sense of humour and every time he saw the CM he would set him a trivia question on the history of Newcastle United. He was an experienced prisoner and was not a problem to manage.

36. At 2.45pm on 11 February, Mr Reed gave a nurse a wrap of what he said was cocaine and admitted he had concealed other drugs. During a subsequent

search, officers found two more wraps of powder and a mobile phone. Later that afternoon, Mr Reed told a healthcare assistant, that he had concealed cocaine and buprenorphine but that staff had recovered it all. She said his speech was slow and slurred.

37. At 7.00pm, an officer found Mr Reed with a number of packages in his cell. As he and other officers entered the cell, Mr Reed first attempted to conceal some of the packages inside his body but then handed the officer two packages. The officer said he intended to turn on his body-worn camera to record the incident but realised later that he had hit the lens instead of the 'on' button. A full body search recovered another two packages. Officers also found several more packages concealed in Mr Reed's cell and two blue tablets on his bed.

38. Prison disciplinary hearings relating to the recovery of the packages were adjourned and the matter was referred to the police because of the large quantity of drugs involved.

39. A nurse checked Mr Reed during the night and noted that he was sitting up in bed showing no signs of intoxication or sedation. Mr Reed remained awake during the night and paced his cell from 3.00am. At 5.26am on 12 February, the nurse described him as slightly intoxicated with slurred speech but not sedated. At 8.45am, officers recovered another mobile phone from Mr Reed. A prison disciplinary hearing was adjourned and referred to the independent adjudicator.

40. At 10.45am on 12 February, a healthcare assistant said Mr Reed was clearly sedated, unsteady and unable to balance when standing. His speech was slurred and his pupils were dilated. Mr Reed told the healthcare assistant that he had taken benzodiazepines.

41. Mr Reed refused to speak to a substance misuse nurse prescriber, who was also present. The nurse prescriber observed Mr Reed through the observation hatch and spoke to SACU officers. He decided to withhold Mr Reed's methadone for safety reasons until he was alert and not intoxicated. At 4.30pm, Mr Reed told a healthcare assistant that he had taken an unknown amount of diazepam (a benzodiazepine) the day before. At about 10.30pm, a nurse said Mr Reed appeared slightly intoxicated but alert and orientated.

42. During his morning round on 13 February, a prison GP recorded that Mr Reed was "still off his face, slurred speech, obviously intoxicated and unsteady on his feet". That afternoon, a nurse reported that Mr Reed was sedated, unsteady, poorly coordinated and had bloodshot eyes and slurred speech.

43. Officers called the duty mental health worker that afternoon after Mr Reed asked for a mental health nurse. A nurse, who was the clinical team lead for secondary mental health, said she prioritised the call because Mr Reed was in the SACU. She read his medical notes and then went to see him immediately, but Mr Reed was unable to talk coherently and appeared under the influence of an unknown substance.

44. The nurse went to see Mr Reed a second time a bit later and said he appeared more alert. She knew he had been referred for a mental health assessment, so she decided to complete one. They spoke in an interview room in the SACU with

an officer present. Mr Reed's speech was slurred but he said this was because he had just woken up. Mr Reed said that he suffered from anxiety and PTSD but was unable to give her details of either. His main issue was that he had not had methadone for three days and she said that he was fixated on being prescribed pregabalin (which is often abused and illicitly traded in prison) and methadone. Mr Reed became very agitated towards the end of the assessment, so the nurse asked for a GP to review him to see if he could have some methadone. She said he was pale and sweaty, but she did not know whether this was withdrawal from methadone or from something else he had taken.

45. The nurse referred Mr Reed to Rethink (primary mental health services) for low intensity cognitive behavioural therapy for anxiety management. She told the investigator that her contingency plan was for Prison Service suicide and self-harm monitoring procedures (known as ACCT) to be considered if Mr Reed remained agitated after receiving further medication. She did not think Mr Reed was at risk of suicide or self-harm when she spoke to him. A prison GP prescribed symptomatic medication for relieving opiate withdrawal symptoms the same afternoon.

46. On 14 February, officers searched Mr Reed's cell again. This time they found blue tablets (believed to be diazepam), a quantity of a green leafy substance (believed to be a type of psychoactive substance - PS) and a vape machine cartridge modified for smoking drugs. Disciplinary hearings were adjourned for the independent adjudicator on 22 February.

47. The substance misuse nurse prescriber reviewed Mr Reed and noted that officers had removed tablets and what appeared to be PS from his cell that morning. He appeared intoxicated but not as badly as before. Mr Reed said that he had not taken any drugs, but his speech was slurred, his eyes were bloodshot and his co-ordination was poor. He said the confiscated drugs were steroids to pay a drug debt. He said he felt it was not safe to re-introduce methadone, which is a significant respiratory depressant, because he was not sure what Mr Reed had taken. (The risk of respiratory depression, a reduction in the rate and depth of breathing, is increased when certain drugs are taken together, and can lead to coma and death.) He told Mr Reed that he would prescribe symptomatic medication for his withdrawal symptoms and would review him again the following morning.

48. A substance misuse worker was present when the substance misuse nurse prescriber reviewed Mr Reed that afternoon. A healthcare support worker took his blood pressure and noted that it was low and that Mr Reed was unable to balance when standing and appeared confused and sedated. Later on, a nurse examined Mr Reed at her request. The nurse said Mr Reed denied using illicit drugs. He cried and said that he was "rattling" (suffering withdrawal symptoms). His speech was slightly slurred and his pupils dilated. She thought Mr Reed must be withdrawing from methadone. Mr Reed took the medication prescribed for his withdrawal symptoms.

49. A prison GP reviewed Mr Reed's methadone prescription that evening and decided it was not clinically safe to give him methadone. A nurse checked Mr Reed later that night. She said he remained sedated with slurred speech.

50. At 8.00am on 15 February, the substance misuse nurse prescriber reviewed Mr Reed as planned. He said that Mr Reed looked a bit better than the previous day. He described Mr Reed as "intoxicated – slurred speech, slavering, demanding methadone", but he could not see any evidence that Mr Reed was suffering from opiate withdrawal, even though he had not received methadone for five days. (This suggested that Mr Reed had recently used opioids.) SACU officers told the substance misuse nurse prescriber that Mr Reed had tried to pass items to the prisoner in the next door during the night. He said he was not happy to restart Mr Reed's methadone due to the ongoing risk that he was consuming illicit substances and the fact he had no signs of opiate withdrawal. A substance misuse worker was also present.

51. Mr Reed's substance misuse keyworker attempted to see him as well but Mr Reed was asleep. He recorded that he would try again on Monday 18 February (the next working day). An officer also said that Mr Reed appeared quite happy during the afternoon of 15 February. He asked for the materials to write a letter and told the officer that he was writing about trying to get access visits to his son.

52. A CM said he and others talked to Mr Reed on several occasions about whether he was in debt and under threat as a result of being caught with the contraband he had brought into prison, but Mr Reed did not appear unduly concerned. He said that he was happy to go to a standard wing. The CM said the only reason Mr Reed remained in the SACU was because they thought he still had drugs in his possession. As soon as he was satisfied that they had retrieved all of them, he planned to move Mr Reed to a standard wing.

16-17 February

53. There are no entries about Mr Reed's physical or mental health on his clinical record or NOMIS record for Saturday 16 February. SACU records showed that about 1.00pm, an officer caught Mr Reed trying to pass something to the prisoner in the cell next door. A nurse was one of the nurses on duty. He told the investigator that Mr Reed did not appear unsettled when he checked him throughout the day. Mr Reed accepted the symptomatic medication prescribed by the substance misuse nurse prescriber and the nurse, and the officer was not concerned by Mr Reed's presentation. A nurse also checked Mr Reed on 16 February. She said he was always polite and gratefully accepted his symptomatic medication. He showed no extra signs of withdrawal, distress or anxiety and gave her no cause for concern.

54. An officer, who was the night patrol officer between 11 and 17 February, said he saw Mr Reed under the influence of drugs on several occasions that week. He said he spoke to him most nights. Sometimes Mr Reed was more coherent than others, but he did not appear to be distressed. The officer said he used to work with the substance misuse team and in his opinion, Mr Reed was going through withdrawal that week, but he did not know whether that was from not receiving his methadone or from the other substances he had been found with.

55. On 16 February, the officer came on duty while another officer was still doing the paperwork associated with the packages recovered from Mr Reed. The prisoner in the cell next door to Mr Reed was serving a punishment of cellular confinement that week and the officer was required to check him every hour. He

said a nurse had asked him to keep an eye on Mr Reed because his methadone had been stopped so he checked Mr Reed almost every time he checked the prisoner next door. We asked to see the CCTV footage of the officer's checks that night, but the prison has not provided it.

56. The officer said Mr Reed was no different that night to any of the other nights that week. He thought he last spoke to Mr Reed at about 3.30am when Mr Reed asked him to put a letter in the post for him. Nothing about Mr Reed's behaviour that night made the officer concerned for his welfare, although he did remember Mr Reed being noisy and shouting to another prisoner earlier. The officer said he could not make out what Mr Reed was shouting about, but his tone sounded angry and he assumed it related to him being under pressure because he had lost the drugs he came into prison with.

The emergency response

57. At about 5.10am, the officer began a roll check of all the prisoners in the SACU. He started at Mr Reed's cell and found Mr Reed hanging from the window by a sheet. The officer radioed a code blue medical emergency and asked for staff assistance. He radioed a CM, who was the night orderly officer, and asked for permission to enter Mr Reed's cell. The CM told the officer to wait for other staff to arrive. The officer broke open his sealed pouch containing a cell key in readiness to open the door. He unlocked Mr Reed's cell as soon as he saw other staff enter the SACU.

58. The control room log shows that the control room officer called an ambulance at 5.11am as soon as the code blue was received. The ambulance dispatcher gave an estimated time of arrival of 12 minutes.

59. The officer used his cut down tool (known as a fish knife) to release the sheet from around Mr Reed's neck. He said Mr Reed was still pink but looked unconscious and was not breathing. A second officer helped the officer put Mr Reed on the floor and the officer began cardio-pulmonary resuscitation.

60. Two nurses heard the code blue when they were on E wing and went straight to the SACU. They arrived as Mr Reed was being placed on the floor. A nurse applied defibrillator pads and the other nurse gave Mr Reed oxygen. They completed five rounds of CPR according to current recommended guidance, but the defibrillator did not detect a shockable rhythm.

61. Ambulance records show the first responder arrived at the prison at 5.15am and was with Mr Reed five minutes later, followed shortly by an ambulance crew. Paramedics took over resuscitation. At 6.11am they took Mr Reed to hospital, but at 6.40am, a doctor confirmed that he had died.

62. Safer custody officers spoke to the prisoner next door to Mr Reed. He said that Mr Reed had been "packed with drugs" but had run out and was "rattling". He said he had shouted at Mr Reed to be quiet in the early hours of 17 February because Mr Reed was banging and shouting in his cell. He thought this was between midnight and 1.00am. He said that Mr Reed had told him that he intended to take his own life, but he thought this was the effect of withdrawing from drugs and he did not take the threat seriously or tell the officer.

63. Three letters from Mr Reed to his former partner and his former mother-in-law were recovered from the out-going post. In an undated letter to his former partner he said, “Caught with everything and 2000k on me head” and, “I’m exp 6-8 yrs for all this but I’ll not live much longer.” In another to his former partner, dated 17 February, he said, “I’m in bits, can’t stop crying, no meth, no vapes or sleep since 11/2/19.” He also said he would “wait a week” but then listed the songs he wanted played at his funeral. In an undated letter to his former mother-in-law he said, “It’s 4.50am and 4th night no sleep because I’m off my script” but also said he would write a proper letter if he received a reply.

Contact with Mr Reed’s family

64. The prison appointed an officer as the family liaison officer (FLO). The FLO and the prison chaplain drove to Mr Reed’s next of kin’s house and arrived at 10.30am. They found that local police had already broken the news of Mr Reed’s death. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

65. After Mr Reed’s death, the duty governor and a CM, 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.

66. The prison posted notices informing other prisoners of Mr Reed’s death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Reed’s death.

Post-mortem report

67. The pathologist concluded Mr Reed died from pressure on the neck due to hanging.

68. Toxicology tests showed no evidence that drugs were directly implicated in Mr Reed’s death. Urine samples indicated non-recent use of morphine. Low concentrations of methadone and diazepam in blood samples indicated therapeutic use.

Findings

Assessment of Mr Reed's risk of suicide and self-harm

69. Prison Service Instruction (PSI) 64/2011 lists a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. Mr Reed had a number of these factors including; substance misuse, anxiety, depression, withdrawing from drugs and early days in custody.

70. Prison Service Order (PSO) 1700, which governs management of prisoners in segregation, also recognises that prisoners undergoing the clinical management of substance misuse are particularly vulnerable to suicide and self-harm early on in custody.

71. Additionally, Mr Reed was at risk from the packages he had ingested bursting or leaking into his system and from multi-drug toxicity if he mixed any of the drugs with his prescribed methadone. There is also evidence that he was in debt and potentially at risk because had been discovered with the drugs he had brought in to prison to pay that debt.

72. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. None of the staff who had contact with Mr Reed considered him to be at risk of suicide and self-harm, despite the range of his risk factors listed above. We consider that these factors alone should have caused concern and there was too much reliance on what he said.

73. While a prisoner's presentation is obviously important and shows something of their level of risk, it is only one piece of evidence in judging risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm. (We note that on 13 February, a nurse planned to consider ACCT monitoring if symptomatic medication did not reduce Mr Reed's anxiety. It is not clear how this plan was to be followed up or what the time frame was.)

74. Although he was not subject to ACCT monitoring, Mr Reed was monitored on a regular basis by SACU officers, healthcare staff and the substance misuse team. Indeed, there is evidence of good partnership working in his case. Nevertheless, much of the interaction with Mr Reed was through his observation panel and not in a confidential setting. An ACCT assessment by a trained assessor would have enabled a thorough and confidential assessment of his risk.

75. In our investigation into the self-inflicted death of a prisoner who died at Durham in February 2019, a week before Mr Reed, we identified a similar failure to identify known risk factors that might indicate increased risk of suicide or self-harm. After that previous death, Durham identified a significant training need in this area and immediately introduced refresher training to put this right. As this additional training had not had time to have an effect by the time of Mr Reed's death a week later, we have not made a recommendation in this case. We will, however, expect to see improvements in risk assessment at Durham in future.

Segregation safety health screen

76. PSO 1700 details the procedures to follow when segregating prisoners. A qualified healthcare professional (nurse or doctor) must complete a segregation safety health screen for all segregated prisoners. The purpose is to make a snapshot assessment of a prisoner's physical, emotional and mental well-being when deciding whether to segregate them. The health screen must be completed within two hours of the prisoner being segregated. If a nurse or doctor is not available to complete the screen, for example at night, the prisoner must be observed every 30 minutes. The screen must still be completed as soon as possible and a record kept in the prisoner's medical record.

77. Mr Reed arrived in the segregation unit during night state, but his segregation health screen was completed after 2.00pm the following day and not first thing in the morning as it should have been. SACU records provided to the investigator did not include the first night observation page. We have not been able to verify how often Mr Reed was checked during his first night, although a nurse recorded three checks on his medical record. We make the following recommendation:

The Governor should ensure that segregated prisoners who arrive during night state are monitored every 30 minutes and a segregation safety health screen is completed as soon as possible the next day in line with national guidance.

Prison liaison

78. The investigator requested a copy of CCTV from the SACU from the night before Mr Reed's death and the emergency response. She was initially told this would be available, but it was not provided to her and she did not receive confirmation of whether it in fact existed or not, despite several requests.

79. Historically Durham has provided a very good standard of liaison with the Ombudsman and we are aware that some difficulties were caused because, sadly, the original liaison officer was absent on sick leave. While some circumstances are obviously impossible to legislate for, investigators in our other investigations there this year have also experienced similar issues as a result of the replacement liaison officer moving to a new role part way through investigations. We want to raise the issue at an early stage and make the following recommendation:

The Governor should confirm to the Ombudsman that, following a death in custody, a single point of contact appointed by the Governor will respond promptly to all the Ombudsman's requests for information, in line with the requirements of PSI 58/2010.

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