

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Sayers, a prisoner at HMP Durham, on 16 June 2020

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*



© Crown copyright, 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or email the Copyright Team at psi@nationalarchives.gov.uk

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

When you use this information under the Open Government Licence, you should include the following attribution: Independent investigation into the death of Mr Daniel Sayers, a prisoner at HMP Durham, on 16 June 2020, Prisons and Probation Ombudsman, March 2021, licensed under the Open Government Licence..

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 Daniel Sayers died in hospital from the effects of psychoactive substances (PS) on 16 June 2020, while a prisoner at HMP Durham. He was 36 years old. I offer my condolences to Mr Sayers' family and friends.

On 12 June, several prisoners at Durham were taken ill after taking PS. While staff were checking on all prisoners' welfare, they found Mr Sayers unresponsive in his cell. He was taken to hospital but died four days later.

The availability of illicit drugs has been an ongoing issue at Durham. While I am concerned that Mr Sayers and others were able to access PS, I recognise the challenges facing Durham, a busy local prison. I note that Durham has a comprehensive drug strategy and that measures introduced to tackle drug supply appear to be having an impact. However, Durham will need to keep its drug strategy under regular review.

Mr Sayers had a history of illicit drug use and was under the care of the substance misuse team. The investigation found that the support Mr Sayers received was equivalent to that he could have expected to receive in the community.

However, I am concerned that Mr Sayers had no key worker sessions in the three months before he died.

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

March 2021

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	8

Summary

Events

1. On 3 August 2018, Mr Daniel Sayers was remanded in prison custody and sent to HMP Durham. On 28 January 2019, he was sentenced to ten years in prison for wounding with intent.
2. Mr Sayers had a history of substance misuse and had been in and out of prison on short sentences for many years. Although he engaged with substance misuse services on previous sentences, he was often found to be under the influence of drugs. However, during his most recent sentence, he had not been found under the influence of drugs since early 2019.
3. On 12 June 2020, several prisoners were taken ill after taking psychoactive substances (PS). At around 5.53pm, while staff were checking on the welfare of all prisoners, an officer found Mr Sayers unresponsive in his cell and called for assistance. Other officers and healthcare staff attended and started cardiopulmonary resuscitation (CPR). Paramedics attended promptly as they were already at the prison dealing with the other emergencies. They took Mr Sayers to hospital.
4. Mr Sayers did not regain consciousness and died in hospital on 16 June. The post-mortem report concluded that Mr Sayers died from the effects of PS.

Findings

5. The availability of illicit drugs has been an ongoing problem at Durham. While we are concerned that Mr Sayers and others were able to access PS, we recognise that Durham, a busy local prison, faces considerable challenges in tackling drug supply. We note that it has a comprehensive drug strategy and that measures introduced to tackle drug supply appear to be having an impact.
6. The clinical reviewer concluded that the support Mr Sayers received with his substance misuse was equivalent to that he could have expected to receive in the community.
7. Mr Sayers did not have any key worker sessions after 13 March 2020. Although the prison was operating a restricted regime due to the COVID-19 pandemic, we are aware that staff were able to hold key worker sessions by telephone. We are therefore concerned that Mr Sayers did not have any key worker sessions in the three months before his death.

Recommendations

- The Governor should ensure that during a restricted regime, key worker sessions continue wherever possible, by telephone if necessary, and that staff are clear of what is expected of them in their key worker role.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Sayers' prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Sayers' clinical care at the prison.
11. The investigator and the clinical reviewer interviewed seven members of staff at HMP Durham in October 2020. All interviews were conducted by telephone due to the COVID-19 pandemic restrictions.
12. We informed HM Coroner for County 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.
13. One of the Ombudsman's family liaison officers tried to contact Mr Sayers' partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. However, the family liaison officer was unable to make contact as Mr Sayers' partner did not answer her phone and letters were returned undelivered.
14. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this 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. Spectrum Community Health CIC provides primary nursing, GP, clinical substance misuse, pharmacy and sexual health services. Tees, Esk and Wear Valley NHS Trust provide mental health services.

HM Inspectorate of Prisons

16. The most recent full inspection of HMP Durham was in September and October 2018. Inspectors were concerned about the ready availability of illicit drugs. Two-thirds of prisoners reported that it was easy to get drugs and almost one in three said they had acquired a drug habit since coming into the prison. Inspectors reported that the prison's approach to reducing drug supply was well thought out, but action taken was undermined by the lack of up-to-date drug detection equipment. The flow of intelligence was good and systems for processing and analysing data were robust.
17. HMIP carried out an Independent Review of Progress at Durham in July 2019. Inspectors found that good progress had been made in stemming the supply of illicit drugs. A body scanner had been effective in deterring drug supply and finding illicit items. Additional security equipment had been installed including netting over exercise yards and additional cameras. Mandatory drug test results showed that the use of psychoactive substances (PS) had declined since the previous inspection in 2018.

Independent Monitoring Board

18. 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 2019, the IMB commended the prison for the work of the dedicated search team in reducing the number of positive mandatory drug tests. The Board was concerned that, while prisoners found the key worker scheme beneficial, the level of delivery had fallen.

Previous deaths at HMP Durham

19. Mr Sayers was the 16th prisoner to die at Durham since June 2018. Five of the previous deaths were from natural causes, seven were self-inflicted and three were drug-related. We have raised concerns previously about the availability of drugs at Durham. We have previously made recommendations about the key worker scheme.
20. There have been four deaths at Durham since Mr Sayers': two were self-inflicted, one was from natural causes, and in the other, the cause of death has not yet been ascertained.

Psychoactive Substances (PS)

21. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious 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.

22. 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.

The key worker system

23. The key worker system is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's Manage the Custodial Sentence Policy Framework. This says:
- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
24. Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting the prisoner's individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

2018-19

25. On 3 August 2018, Mr Daniel Sayers was remanded in prison custody and sent to HMP Durham. He had been released from Durham three months previously.
26. Mr Sayers had a history of illicit drug use and staff referred him to the substance misuse team.
27. On 6 August, a substance misuse nurse assessed Mr Sayers and prescribed 35ml methadone (an opiate substitute). The nurse arranged for a Drug and Alcohol Recovery Team (DART) review to take place in 13 weeks.
28. On 18 December, Mr Sayers failed a mandatory drug test. Staff placed him on a disciplinary charge and submitted an intelligence report.
29. On 28 January 2019, Mr Sayers was sentenced to ten years imprisonment for wounding with intent. He remained at Durham.
30. Over the next few months, records show several incidents of Mr Sayers being found under the influence of illicit drugs. Staff assessed him appropriately and submitted intelligence reports in line with the prison's drug strategy.
31. By June 2019, staff had increased Mr Sayers' methadone dose to 60ml at his request. He said that he felt stable on that dose and staff recorded no further incidents of illicit drug use. Mr Sayers continued to attend his 13-week reviews with DART and no further concerns were noted.
32. From around July 2019, Mr Sayers began working as a cleaner on the substance misuse wing, D Wing.

2020

33. On 13 March 2020, Mr Sayers met with his key worker, an officer who had been his allocated key worker since February 2019. (Records show that Mr Sayers had regular contact with his key worker from when he arrived at Durham.) Mr Sayers' key worker noted that Mr Sayers was looking forward to starting a football course and had received many positive comments from staff about his work. Mr Sayers' key worker said he would see Mr Sayers the following week, but no further key worker sessions were noted.
34. Due to the COVID-19 pandemic, the prison started a restricted regime. Records show that staff from the safer custody team carried out welfare checks on prisoners at the start of the new regime. Safer custody staff saw Mr Sayers on 26 March, 30 March, 2 April and 22 April. Mr Sayers reported that he was coping with the new regime and staff had no concerns about him.
35. On 8 April, Mr Sayers told a substance misuse nurse that he was ready to start reducing his methadone dose. The nurse agreed a plan with him to reduce by 5ml every fortnight with a view to maintaining at a dose of 45ml.

36. By 21 May, Mr Sayers had been on a 45ml maintenance dose of methadone for one week, but he asked for a further reduction to 35ml. A nurse reduced the dose to 35ml.
37. Records show continued positive entries from staff about Mr Sayers' attitude and work ethic. Staff noted no further concerns about illicit drug use.
38. On 8 June, Mr Sayers told a substance misuse nurse that he was struggling on 35ml and asked for his methadone dose to be increased again to 45ml. A nurse increased the dose to 45ml from 11 June.

12 June

39. Shortly before 5.30pm on 12 June, staff called a code blue (a medical emergency code which tells the control room that a prisoner is unresponsive or not breathing and an ambulance needs to be called immediately) after a prisoner on D Wing was found to be under the influence of illicit drugs. While staff administered treatment to the prisoner, they became aware that two other prisoners on D Wing had taken illicit drugs and required emergency treatment. A prison manager told staff to carry out welfare checks on all prisoners in their cells.
40. At around 5.53pm, while staff were checking on the welfare of all prisoners, an officer found Mr Sayers unresponsive in his cell and called for assistance. Other officers and healthcare staff attended and started cardiopulmonary resuscitation (CPR). Paramedics attended promptly as they were already on site dealing with the other emergencies. They took Mr Sayers to hospital. Mr Sayers did not regain consciousness and died in hospital on 16 June.
41. Records show that several prisoners took PS from the same batch. Three other prisoners required hospital treatment, but they recovered and returned to Durham.

Contact with Mr Sayers' family

42. At around 8.45pm on 12 June, the prison's family liaison officer contacted Mr Sayers' partner by telephone to let her know that he had been taken to hospital. The prison's family liaison officer continued to offer support to the family after Mr Sayers died. The prison contributed towards the cost of the funeral in line with national instructions.

Support for prisoners and staff

43. After Mr Sayers' 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.
44. The prison posted notices informing other prisoners of Mr Sayers' 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 Sayers' death.

Post-mortem report

45. The post-mortem report concluded that Mr Sayers' death was caused by the effects of synthetic cannabinoids (psychoactive substances - PS).

46. Mr Sayers tested positive for COVID-19 when he was admitted to hospital. There is no evidence that he had shown any symptoms of COVID-19 at Durham. COVID-19 was not listed as a cause of his death, or as a contributory factor.

Findings

Availability of psychoactive substances (PS)

47. On 12 June 2020, several prisoners at Durham were taken ill after taking psychoactive substances (PS). Mr Sayers was one of four prisoners taken to hospital, though the other three recovered and returned to Durham. Mr Sayers' post-mortem report concluded that he died from the effects of PS.
48. The ready availability of illicit drugs has been an ongoing issue at Durham. In its last full inspection of Durham in September and October 2018, HMIP highlighted that illicit drug use was very high. There were five drug-related deaths at Durham in 2018. However, HMIP's Independent Review of Progress in July 2019 found that Durham had made good progress in stemming the supply of drugs, and mandatory drug test results showed that the use of PS had declined.
49. Durham has a comprehensive drug strategy, but it is apparent that drugs, including PS, continue to enter the prison. The deputy governor told the investigator that Durham receives 80-100 new prisoners a week, and this number did not reduce significantly during the national COVID-19 lockdown in place from March to July 2020. It is therefore a challenge to tackle drug supply, given Durham's high turnover of prisoners.
50. The deputy governor said that Durham had a range of measures in place to tackle drug supply, including a body scanner in reception, photocopying normal mail and checking legal mail had come from a legitimate source, netting over the exercise yards to prevent throwovers, a dedicated search team, access to a drug dog search team, additional cameras at the perimeter and mandatory drug testing (though testing was suspended during the lockdown).
51. While we are concerned that Mr Sayers was able to access PS, we are satisfied that Durham has an appropriate drug strategy in place and that measures introduced to tackle drug supply appear to be having an impact. We make no recommendation, though Durham will need to keep its drug strategy under regular review to ensure it is tackling the key issues.

Substance misuse care

52. Mr Sayers had a long history of substance misuse both in prison and in the community. Although he engaged with substance misuse support services, he often relapsed. However, he had begun to make good progress on his most recent sentence. His last positive mandatory drug test was in December 2018 and there were no records of him being under the influence of drugs after early 2019. Staff had no current concerns about his substance misuse and he had regular reviews of his methadone treatment.
53. The clinical reviewer considered that the support Mr Sayers received with his substance misuse was equivalent to that he could have expected to receive in the community.

Key worker support

54. The 'Manage the Custodial Sentence Policy Framework' sets out the minimum requirements needed to deliver a custodial sentence and case manage those in custody from reception to the end of post-release supervision. Included within this framework is the Offender Management in Custody (OMiC) model, part of which brought in the gradual introduction of the key worker role from September 2018. The framework says that, 'all prisoners in the male closed estate must be allocated to a key worker whose responsibility is to engage, motivate and support them throughout the custodial period' and, 'Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role which includes individual time with each prisoner'.
55. Mr Sayers' last key worker session was on 13 March. Mr Sayers' key worker said that he was then away on leave and working night shifts until the end of April.
56. The prison introduced a restricted regime in March, due to the COVID-19 pandemic. Safer custody staff carried out welfare checks on prisoners at the start of the new regime and Mr Sayers was seen on 26 and 30 March, and 2 and 22 April. However, no one saw Mr Sayers for a key worker session after 13 March. Mr Sayers' key worker told the investigator that although the restricted regime prevented face-to-face key worker sessions, they could be held over the telephone. It is unclear why this did not happen.
57. We accept that there were challenges in maintaining the prisoner/key worker relationship during the restricted regime, but we are concerned that Mr Sayers had no key worker sessions in the three months before his death. While a telephone session might not be as beneficial as a face-to-face session, we consider that it is important to continue key worker sessions wherever possible. We recommend:

The Governor should ensure that during a restricted regime, key worker sessions continue wherever possible, by telephone if necessary, and that staff are clear on what is expected of them in their key worker role.

**Prisons &
Probation**

Ombudsman
Independent Investigations