Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charlie Todd, a prisoner at HMP Durham, on 2 September 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 Charlie Todd was found hanged in his cell at HMP Durham on 2 September 2019. He was 18 years old. I offer my condolences to Mr Todd's family and friends.

I am satisfied that Mr Todd had given no indication to staff or other prisoners that he was low in mood and that staff could not reasonably have foreseen his actions.

I am, however, extremely concerned that when Mr Todd was moved to the segregation unit, he was not assessed by a nurse in person, as he should have been. The investigation also found that his medical records did not comply with national standards.

Mr Todd had not seen his key worker in the seven weeks before his death. This was a missed opportunity to assess his risk of suicide and self-harm.

I am also concerned that, despite wide-ranging local policies and the efforts of staff to prevent the supply of and demand for illicit substances, Mr Todd was able to obtain drugs at Durham with apparent ease. However, I note that HMIP concluded in July 2019 that Durham was making good progress in tackling the availability of drugs in the prison.

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 **September 2020**

Contents

Summary

Events

1. On 25 April 2019, Mr Todd was remanded into custody at HMP Durham, charged with burglary and motoring offences. He was 18 years old. Mr Todd had been in prison before. He had a history of substance misuse and depression.

2. Mr Todd had a history of self-harm but was not assessed as posing a risk to himself. He was warned by staff about his poor behaviour, though this improved once he shared a cell with his brother. Mr Todd engaged well and had a good rapport with his key worker, until July when his key worker sessions stopped.

3. On 31 August, staff searched Mr Todd's cell and found an illicit substance, believed to be a psychoactive substance (PS).

4. On 2 September, Mr Todd admitted being in possession of an illicit substance and was given the penalty of five days cellular confinement and 14 days loss of privileges. At 10.00am, Mr Todd was moved to a cell in the segregation unit. No one completed the required hourly checks that afternoon.

5. At 4.05pm, during the doctor's rounds on the segregation unit, staff found Mr Todd hanging from the light fitting. Staff requested an ambulance and began cardiopulmonary resuscitation. Paramedics arrived at 4.30pm and at 4.56pm, they confirmed Mr Todd had died.

Findings

Assessment of risk

6. We found that Mr Todd had some risk factors for suicide and self-harm, possibly compounded by his illicit drug use, but that staff could not reasonably have foreseen his death on 2 September.

7. We cannot say why Mr Todd took his own life, his concern about his forthcoming trial or drug-related debts may have played a part.

8. We are very concerned that a nurse assessed his suitability to be segregated without seeing him in person.

Key Worker Scheme

9. In line with national guidance, key workers should see their allocated prisoners on a weekly basis. We found that Mr Todd had not seen his key worker for the seven weeks before his death. This was a missed opportunity to assess his risk of suicide and self-harm.

Cellular Confinement Checks

10. National instructions state it is mandatory for a prisoner placed in cellular confinement to be checked hourly by staff. We found that the staff on duty on 2 September had not completed and recorded the hourly checks after midday as required. As a result, Mr Todd was not seen for nearly two hours before he was

found hanging. It is impossible to know whether the outcome may have been different for Mr Todd if the checks had been done.

Psychoactive Substances

11. Mr Todd had a significant history of illicit drug abuse but he initially declined support and advice from the substance misuse team. He chose to accept support from 4 July, and we are satisfied that appropriate advice and support was offered to him.

12. Durham has comprehensive policies to minimise and treat illicit substance misuse. Despite this, Mr Todd was able to access and use drugs with apparent ease.

Clinical care

13. The clinical reviewer concluded that the care provided to Mr Todd was of mixed standard and partly equivalent to that which he could have expected to receive in the community. Mr Todd had a history of substance misuse and engaged with the substance misuse service. Mr Todd had a history of depression, was seen by a doctor and prescribed antidepressants.

14. However, Mr Todd's medical records did not comply with national standards

Recommendations

- The Head of Healthcare should initiate an investigation into a nurse's failure to assess Mr Todd in person on 2 September, with a view to considering whether disciplinary action is appropriate.

- The Governor should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

- The Governor should ensure that segregated prisoners subject to cellular confinement are monitored every hour, in line with national guidance.

- The Governor should commission an investigation into the segregation unit officers' failures to check Mr Todd hourly on the afternoon of 2 September, with a view to considering whether disciplinary action against named individuals is appropriate, and let the Ombudsman know the outcome.

- The Head of Healthcare should ensure all health care providers record all interventions in a prisoner's primary medical records (SystmOne) so all information is documented enabling appropriate holistic care for each prisoner.

The Investigation Process

15. 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.

16. The investigator visited Durham on 5 September 2019. She obtained copies of relevant extracts from Mr Todd's prison and medical records.

17. The investigator interviewed 14 members of staff and six prisoners at Durham in September and October. NHS England commissioned an independent clinical reviewer to review Mr Todd's clinical care at the prison. They jointly interviewed healthcare staff. Another investigator interviewed two members of staff in November.

18. We informed HM Coroner for County 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.

19. The Ombudsman's family liaison officer contacted Mr Todd's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Todd's next of kin wanted to know what help him received for his mental health issues, what substances had he taken and what assessments and checks were done while he was in the segregation unit.

20. Mr Todd's next of kin received copies of the initial report. The solicitor representing Mr Todd's next of kin wrote to us indicating that he had identified no factual inaccuracies. The solicitor representing Mr Todd's other next of kin wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Durham

22. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. G4S provides primary nursing and clinical drug and alcohol services. Spectrum Healthcare provides GP and pharmacy services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

HM Inspectorate of Prisons

23. The most recent full 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. 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.

24. Inspectors found that illicit drugs were readily 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.

25. 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. Safety had also been undermined by the widespread availability of illicit substances.

26. The report said that living conditions in the segregation unit were reasonably good and relationships between prisoners and staff were positive and supportive. However, inspectors reported that the segregation unit 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 segregation unit was exacerbated as they had little access to education, in-cell work or the gym.

27. HMIP carried out an Independent Review of Progress in July 2019 to review the progress made in achieving the key recommendations from the 2018 inspection. They found good progress had been made in stemming the supply of illicit drugs. As a result, the prison was now better controlled and supervised.

28. However, weaknesses in the suicide and self-harm prevention measures remained a significant concern and required urgent attention. Three prisoners had taken their own lives in the last nine months and attention to reviewing the implementation of PPO recommendations from previous reports was still insufficient. Despite efforts to improve the quality of ACCT, procedures were not yet delivered well enough to provide effective care. More multidisciplinary planning and working were required to safeguard prisoners in crisis who had complex personal needs or were repeatedly self-harming.

Independent Monitoring Board

29. 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.

30. 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 the prison's reception had made some minor changes which had slightly improved this.

31. The IMB were satisfied with the conditions, facilities and security within the segregation unit and found that segregation staff were professional.

Previous deaths at HMP Durham

32. Mr Todd was the 25th prisoner to die at Durham since March 2017. Of the previous deaths, nine were self-inflicted. There are no similarities with those previous deaths.

Assessment, Care in Custody and Teamwork (ACCT)

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

34. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

Psychoactive Substances (PS)

35. 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.

36. 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.

37. 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

38. 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 should be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.

39. 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.

The key worker scheme

40. The key worker scheme 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 scheme 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.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting 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

41. Mr Charlie Todd had spent a great deal of his adult and teenage life in custody, and had previously been in custody at HMYOI Wetherby and HMP Durham. He had a history of mental health problems from childhood and had previously self-harmed, including cutting and the use of ligature while at Wetherby in 2017. He said that he had taken an overdose in the community in August 2018. He also had a history of drug and alcohol misuse.

42. At Durham in February 2019, staff opened an ACCT as Mr Todd cut his neck and was "low" in mood. Staff closed this ACCT on 13 February and he was released from HMP Durham on 26 February.

43. On 25 April, Mr Todd was remanded to custody and taken back to Durham. He had been charged with burglary and motoring offences. His Person Escort Record (PER) noted that he had cut his arms in 2016 and had gone on live railway tracks in March 2019. He told court staff that he had no thoughts of suicide or self-harm and had only been on railway tracks because he was being chased. In reception, Mr Todd told an officer that he had no thoughts of suicide or self-harm. He also said he had no next of kin. The officer recorded that Mr Todd appeared settled.

44. During an initial health screen with a nurse, Mr Todd said he heard voices due to smoking cannabis. He said he was prescribed sertraline (an antidepressant). Mr Todd said he had last self-harmed three months previously, but had no thoughts of suicide. He said he did not want to be referred to the mental health team and said he knew how to self-refer if he needed to. A nurse recorded that Mr Todd provided a negative drug test.

45. On 26 April, a substance misuse support worker saw Mr Todd as part of the induction process. Mr Todd said he did not want support from substance misuse services. She recorded that she explained the risks of using illicit substances, including PS.

46. On 1 May, Mr Todd told an officer that he had a four-month-old baby, with whom he had contact when his partner allowed it. He said that he was diagnosed with depression, anxiety and psychosis because he heard voices. Mr Todd said he had no thoughts of suicide or self-harm. He said he used cannabis and crack cocaine in the community, but did not think it was an issue, so did not want support from prison substance misuse services. He said he knew how to self-refer should he change his mind.

47. On 2 May, an officer introduced himself as Mr Todd's key worker. Mr Todd told him that he had pleaded guilty to the burglary and driving charges and was expecting a sentence of 18 to 26 months. He said his next of kin would be coming to visit him in the next few days.

48. The officer saw Mr Todd again on 10 and 22 May. They discussed his family support and his trial, which he thought would be in August. Mr Todd said he did not speak to either of his parents. The officer also asked Mr Todd about behaviour warnings in his prison record and reminded him of the importance of following prison rules.

49. On 23 May, a prison doctor reviewed Mr Todd, as he said he was low in mood. Mr Todd said he had been previously prescribed sertraline (an antidepressant) for two years but had not had any since April. He said he occasionally heard voices. The prison GP recorded that Mr Todd showed no symptoms of paranoia or psychosis. The prison GP prescribed an increasing dose of sertraline for Mr Todd's low mood.

50. On 27 May, an officer saw Mr Todd for a key worker session. Mr Todd said he was due a legal visit on 3 June, and hoped he would know when his trial would be. The officer talked to him about further negative entries in his prison record and warned Mr Todd about the consequences of poor behaviour. The officer recorded that Mr Todd saw everything as a joke. The next day, Mr Todd was made subject to the basic regime as he would not follow staff instructions and had had previous behaviour warnings.

51. Between 13 June and 24 June, the officer had three further key worker conversations with Mr Todd. They talked about the support from his brother (his cellmate at that time) and the resultant improvement in his behaviour. Mr Todd appeared to be happy and keen to become a wing cleaner. He was frustrated that he still did not know when his trial would be.

52. On 25 June, an officer recorded in Mr Todd's prison computer record that he provided a negative drug test.

53. On 27 June, a class instructor recorded that Mr Todd had been warned for disruptive behaviour and foul language and was eventually removed from the classroom by an officer.

54. During a key worker session on the evening of 2 July, the officer told Mr Todd that he had read the previous entries in his prison record and that swearing at staff was completely unacceptable. The officer warned Mr Todd that he would end up subject to the basic regime again if his poor behaviour continued. Mr Todd said he had a three-day trial listed at Teeside Crown Court on 27 August.

55. On 4 July a substance misuse recovery worker saw Mr Todd after a referral from security staff. Mr Todd said he had been using cannabis daily since the age of 13 and crack cocaine over the last year, up to £400 daily when in the community. He told her that he had been using Subutex (a heroin substitute) and PS while in prison. They discussed his reduced tolerance levels. Mr Todd said he had no thoughts of suicide or self-harm. He said he had no concerns about his current mental health, but asked for a review of his antidepressants. She told Mr Todd that he would remain on her caseload and they would focus on substance awareness and his motivation to change.

56. On 17 July, an officer saw Mr Todd for a key worker session. Mr Todd said he was back on basic regime as he had been in a fight with another prisoner. The officer recorded that Mr Todd did not seem "bothered" about this. Mr Todd said that he was worried about his baby son who was in hospital. The officer told the investigator this was the last time he saw Mr Todd.

57. On 25 July, Mr Todd was involved in a violent incident towards another prisoner. As a result, he moved from A Wing to B Wing and officers opened a Challenge,

Support and Intervention Plan (CSIP, designed to manage prisoners assessed as at raised risk of harming others). At a disciplinary hearing two days later, Mr Todd was found guilty of assaulting another prisoner and lost his pay for seven days, along with canteen and association. He also received seven days cellular confinement which was suspended until 27 October. The same day, officers submitted a security intelligence report after a prisoner claimed that Mr Todd had been threatened by another prisoner.

58. On 29 July, the substance misuse recovery worker saw Mr Todd and referred him to the illicit drug users group to help address his ongoing illicit drug use.

59. On 30 July, the officer went to see Mr Todd for a key worker session but he was not there as he had been escorted to hospital to have a hand injury looked at. The officer said that did not see Mr Todd again as he was not allocated any time to undertake weekly key worker sessions after this until the middle of November 2019.

60. On 4 August, a Supervising Officer (SO) recorded that Mr Todd had submitted a statement saying he was under threat on B Wing. Mr Todd was offered a move to C Wing, but said he was "fine". Staff notified the safer custody team.

61. On 12 August, staff submitted an intelligence report indicating that Mr Todd was associating with a prisoner who was suspected of supplying drugs. The same day, a member of staff from the substance misuse team recorded that Mr Todd had refused to start a methadone programme.

62. On 13 August, staff submitted an intelligence report recording that they had found an anonymous note saying that Mr Todd would be involved in an assault on another prisoner.

63. A prisoner shared a cell with Mr Todd for the last two weeks of August. He told the investigator that Mr Todd seemed "alright" and did not seem "suicidal" or "depressed". They spoke about their offences and Mr Todd said he was going to get on with his sentence. He said Mr Todd was supposed to have another trial at court but it got adjourned to a later date. He said that Mr Todd was disappointed about the delay because he wanted to move to another prison but could not do so until after his trial.

64. Mr Todd told his cellmate that he did not get much support from his family. He said that Mr Todd used PS several times a day. He did not know how Mr Todd paid for this. He did not think that Mr Todd was being bullied and thought he got on well with other prisoners. He said that he got the impression that staff did not like Mr Todd as he was difficult to manage.

65. Prisoners described Mr Todd to the investigator as a "typical young offender, cheeky and always smiling". They thought he seemed in "high spirits" before he died and no one was concerned that he was at risk of suicide. While some prisoners said that they did not know he took PS, others said he was a regular user.

66. On 18 August, Mr Todd refused to return to his cell after collecting his medication. He was subsequently restrained and returned to his cell. On 20 August, he was found guilty at a disciplinary hearing and received a caution.

67. On 22 August, the substance misuse recovery worker saw Mr Todd for a substance misuse review. She recorded that he was visibly under the influence of drugs and Mr Todd confirmed this was the case. Mr Todd said he was using PS most days and Subutex occasionally. They discussed the risks associated with using PS and other drugs.

68. On 26 August, at 12.00pm, during a full search, officers found an unknown substance in Mr Todd's sock.

69. On 27 August, the Head of Residence, authorised Mr Todd's basic regime to be extended past 28 days due to numerous negative comments in his prison record mainly about disruptive behaviour in class, abusive behaviour to staff and refusal to comply with prison rules), and being found in possession of an unknown substance on 26 August. Mr Todd was moved to the segregation unit. At 11.40am, a nurse assessed Mr Todd as fit to be segregated.

70. At a disciplinary hearing on 28 August, Mr Todd admitted that he had had PS in his socks. A prison GP reviewed Mr Todd in the segregation unit and noted he was "fine". Mr Todd went back to B Wing.

71. On 30 August, Mr Todd asked another prisoner for some PS, but the prisoner said he did not have any so Mr Todd went away. The prisoner noticed that Mr Todd seemed under the influence of an illicit substance a short time later.

72. On 31 August, at 10.50am, an officer searched Mr Todd and found a wrap of leafy green substance. He charged Mr Todd with possession of an unknown substance and submitted an intelligence report. His cellmate said that Mr Todd told him he had been found with drugs in his possession, but that this was "normal" for Mr Todd and he did not seem worried about being taken to the segregation unit.

73. On 1 September, a conduct report for the disciplinary hearing noted that Mr Todd was an "immature" prisoner who was a "constant drain on staff resources". The author noted that he had a poor attitude to B Wing staff and towards tutors in his family programme class. They also noted that he was on the basic regime due to his behaviour and had multiple negative entries in his record.

74. His cellmate said that Mr Todd was his usual self over the weekend. He smoked PS frequently, but no more than normal. They spent quite a lot of time locked in their cell together. He had no concerns about Mr Todd or that he was a risk to himself.

75. A prisoner who spoke to Mr Todd during exercise on 1 September said that he was laughing with other prisoners.

Events of 2 September

76. At 6.45am, Mr Todd was taken to the segregation unit for his disciplinary hearing. The hearing was at 9.45am with the Head of Security, as adjudicating officer. Two officers were also present. Mr Todd pleaded guilty to the charge. He told the Head of Security that he was holding the drugs for another prisoner when he was searched. The Head of Security asked if he was under pressure and who he was holding the substance for. Mr Todd replied that he did not use "gear", he was holding it for a friend but would like to move to a different wing. Mr Todd said he was not under pressure. He was punished with 14 days loss of earnings and privileges and five days cellular confinement.

77. An officer locked Mr Todd in his allocated cell in the segregation unit at about 10.00am.

78. Another prisoner who lived in the segregation unit said that Mr Todd shouted to him from his cell that morning when he was walking past. He said that he opened his observation panel and asked Mr Todd why had returned to the segregation unit, and Mr Todd laughed. He checked that Mr Todd was "okay" and asked him to be quiet at night. He said that Mr Todd did not seem depressed.

79. CCTV footage shows two officers unlocked Mr Todd's cell at 11.44am for him to collect his lunch. The officers locked him back in his cell a minute later. At 11.54am, an officer checked Mr Todd by looking through the observation panel on his cell door.

80. At 12.00pm, a nurse completed the segregation safety algorithm. She recorded that Mr Todd was fit for segregation at that time and did not need any healthcare intervention. She told the investigator that she did not see Mr Todd in person, but completed the form based on her previous knowledge of him.

81. Officers were required to check prisoners subject to cellular confinement at least hourly. Prison records show that an officer signed the segregation unit record to confirm he had checked Mr Todd at 10.00am, an officer signed 11.00am, and another officer signed at 12.00pm. No further checks were signed for until 5.00pm.

82. At 12.13pm, an officer looked in Mr Todd's cell to complete the roll check. At 12.20pm, another officer checked Mr Todd. At 1.52pm, the officer unlocked Mr Todd's door with an officer present. An officer stayed at Mr Todd's door for a few seconds. At 2.22pm, an officer looked into Mr Todd's cell briefly to complete a roll check.

83. A prisoner said that Mr Todd was shouting to other prisoners out of his window during the afternoon, but he did not know about what. He said that Mr Todd did not seemed distressed or a risk to himself. Another prisoner heard Mr Todd ask another prisoner to ask their partner to message his partner to tell her that he was in "the block" and that he would call her the next day.

84. A prison GP was completing his daily round of the segregation unit, accompanied by two officers. An officer looked through Mr Todd's observation panel at 4.05pm. He saw that Mr Todd was hanging from the light fitting by a bed sheet. The officer immediately unlocked the door and shouted for staff assistance.

85. A Custodial Manager (CM) heard a shout for staff assistance, went directly to Mr Todd's cell (he was on the landing below) and pressed the general alarm on the way. As he got to the cell seconds later, he saw the officer supporting Mr Todd's weight as an officer cut him down using his anti-ligature knife. The CM radioed a code blue and assisted staff in laying Mr Todd on his bed.

86. The prison GP noted that he examined Mr Todd and his initial impression was that he was dead. He was not breathing, had no pulse and appeared to have vomited. The prison GP tried to clear the airway and administered breaths. Another CM had also responded and started chest compressions. They moved Mr Todd to the floor and staff took turns to continue chest compressions.

87. A nurse responded to the emergency code. She attached the defibrillator and administered oxygen while officers continued chest compressions. Paramedics arrived at 4.30pm. They moved Mr Todd to the landing, inserted an airway and took over resuscitation. At 4.56pm they pronounced that Mr Todd had died. Staff moved Mr Todd back into his cell and locked it.

Contact with Mr Todd's family

88. Mr Todd had not given a next of kin or nominated person to contact when he arrived at Durham. Two Reverends were appointed as family liaison officers (FLO). They contacted the police who gave them the details of Mr Todd's mother. They went to her address, but only Mr Todd's uncle was present. He said Mr Todd's mother was on holiday. Mr Todd's uncle telephoned her and broke the news. After publication of our initial report, Mr Todd's mother told us that she had already been told that Mr Todd had died by her brother who had been told by another prisoner. Mr Todd's uncle also agreed to inform Mr Todd's father.

89. A FLO stayed in contact with Mr Todd's mother and father over the following weeks and offered a contribution to funeral expenses, in line with Prison Service policy. Mr Todd's mother told the FLO that she thought her son had become involved in drug taking in prison. She had been telephoned and asked to transfer money to a specific account which she did and then changed her mobile number.

90. Mr Todd's brother, with whom he had shared a cell at Durham for a while, was at HMP/YOI Deerbolt and was informed of Mr Todd's death by the Chaplain there and offered ongoing support.

Information received after Mr Todd's death

91. After Mr Todd died, there were rumours that he had told prisoners that his baby son had died. He had not said anything about this to staff

Support for prisoners and staff

92. After Mr Todd's death, the Governor 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.

93. An officer said no one had spoken to him to ask if he was alright and that he would have appreciated it if someone had.

94. The prison posted notices informing other prisoners of Mr Todd'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 Todd's death.

Post-mortem report

95. A post-mortem examination found that the cause of Mr Todd's death was pressure on the neck caused by hanging. The toxicology report recorded that Mr Todd did not have any illicit substances in his system. This office requested further toxicological analysis for psychoactive substances, the results of which were also negative.

Findings

Assessment of risk

96. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm.

97. As we have noted many times in individual investigation reports, thematic reports and annual reports, too often staff make decisions about risk based on their perceptions of a prisoner's presentation and statements from the prisoner that they do not have any thoughts or intention of suicide or self-harm.

98. It is clear that Mr Todd had some risk factors, in particular, his history of self-harm, his significant history of illicit drug use, his mental health issues and his remand to custody facing a new custodial sentence, which could have been more fully explored with him. However, officers and healthcare staff knew him well and engaged with him often. Other prisoners, including his cellmate, did not consider that he was at risk of suicide.

99. An officer, his key worker, said that he thought he had a good rapport with Mr Todd. He described him as "cheeky" and "a little rogue", but said that he did not consider his behaviour was malicious, he just did not think before he acted. He said Mr Todd was "always happy", "a typical teenager, just energetic, always sort of … bopping around" and that he never saw him down or lethargic or low in mood, and he never saw him under the influence of drugs. He said he had been shocked when he heard that Mr Todd had hanged himself and wondered if it had been an attempt to get attention that went wrong.

100. We consider that Mr Todd gave no indication that he was thinking about killing himself in the days or weeks before his death. We think it was reasonable that staff considered that Mr Todd was not a risk to himself, although, with the benefit of hindsight, this judgement was proved wrong.

Segregation safety health screen

101. Segregation can increase a prisoner's risk of suicide or self-harm. PSO 1700 sets out 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 it is safe to segregate them. The health screen must be completed within two hours of the prisoner being segregated.

102. On 2 September, a nurse failed to conduct the required face to face assessment of Mr Todd's risk and suitability to be placed in cellular confinement, in line with national instructions. When interviewed, she confirmed that her assessment was solely based on her previous knowledge of Mr Todd. Furthermore, she made no entry in Mr Todd's medical record.

103. We are very concerned that the nurse assessed Mr Todd without seeing him face to face or making an entry in his medical record. This was very poor and unsafe practice. Although prison staff and other prisoners did not consider that Mr Todd was showing any signs of distress that day, this was a crucial missed opportunity to assess Mr Todd's state of mind in the hours before his death. We, therefore, recommend:

The Head of Healthcare should initiate an investigation into the nurse's failure to assess Mr Todd in person on 2 September, with a view to considering whether disciplinary action is appropriate.

Key Worker Scheme

104. The purpose of the key worker scheme is to give each prisoner a point of contact who will meet them regularly to help and support them. All prison officers who work on a residential unit will be allocated a maximum of six prisoners. They are expected to spend an average of 45 minutes per prisoner per week on the key worker role, which includes individual time and meaningful conversations with each prisoner. Governors must ensure that time is made available for this.

105. Mr Todd's records show that his key worker, an officer, had a weekly conversation with him from 2 May to 17 July. The officer said he had built up a good rapport with Mr Todd, but no time had been allocated for him to undertake any key worker sessions between the end of July and the middle of November.

106. We are very concerned that the officer had not met Mr Todd for the seven weeks before he died. There is evidence that they had previously had meaningful exchanges about Mr Todd's behaviour, his family, his anxiety about his court appearance and his drug use. The failure to see him in his last few weeks was therefore a missed opportunity to engage with Mr Todd to discuss how he felt about his drug use, his behaviour, the further charges he faced and a potential long sentence. We, therefore, recommend:

The Governor should ensure that key workers are allocated sufficient time for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.

Cellular Confinement Checks

107. National instructions state it is mandatory for a prisoner in cellular confinement to be checked hourly by staff. Segregation unit records show that staff on duty on 2 September, did not complete the required hourly checks between midday and 5.00pm. Although officers looked into his cell at 12.13pm, 1.52pm and 2.22pm that afternoon for other reasons, nearly two hours elapsed between the last time staff saw him and when Mr Todd was found hanging at 4.05pm. It is possible that Mr Todd's death might have been prevented if the checks had been done. We, therefore, recommend:

The Governor should ensure that segregated prisoners subject to cellular confinement are monitored every hour, in line with national guidance.

The Governor should commission an investigation into the segregation unit officers' failures to check Mr Todd hourly on the afternoon of 2

September, with a view to considering whether disciplinary action against named individuals is appropriate, and let the Ombudsman know the outcome.

Psychoactive Substances

108. Mr Todd had a significant history of illicit drug use while in the community and there is considerable evidence that he was using drugs, particularly PS, regularly in prison. Toxicology tests did not show that he had used PS or other drugs immediately before his death. However, it is possible the drug misuse contributed to his suicide, either by affecting his mental state or by causing him to build up drug-related debts which may have preyed on his mind and made him vulnerable to bullying.

109. We are satisfied that Mr Todd was offered support and advice for his illicit drug use. However, we are concerned that he was able to obtain PS while in Durham with apparent ease and able, by his own account, to use it daily. Both HM Inspectorate of Prisons and the Independent Monitoring Board have also expressed concern about the ready availability of drugs at Durham.

110. Durham has a strategy to address both the supply of, and demand for, PS and illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and the movement of drugs around the prison. Examples include photocopying mail to prevent sprayed PS entering the prison, and providing additional staff resources to carry out mandatory drugs tests and cell searches. There are also measures to educate prisoners about the dangers of PS and support those known to use the drugs, as well as additional disciplinary measures to deter drug use.

111. In its Independent Review of Progress in July 2019, HMIP found that the prison had made good progress in stemming the supply of illicit drugs. Inspectors noted that a body scanner was proving effective in deterring drug supply and finding illicit items and that many other steps had been taken or were in progress to reduce the supply of drugs.

112. We are satisfied that Durham is taking the drug problem seriously and we have not, therefore, made a recommendation about this.

Clinical care

113. The clinical reviewer judged that the care Mr Todd received was of a mixed standard and partially equivalent to that which would have been received in the wider community.

114. Mr Todd had a history of involvement with mental health services. The clinical reviewer concluded that the GP's management of Mr Todd's low mood was appropriate.

115. The clinical reviewer shared our concern that a nurse failed to assess Mr Todd's fitness for segregation in person on 2 September.

116. We are also concerned that the prison's substance misuse service did not fully record entries on SystmOne (the electronic system for prisoners 'medical

records). This meant that healthcare staff did not know about Mr Todd's significant ongoing substance misuse and therefore prevented a coordinated approach to his care by all health providers at Durham. Durham's record-keeping in this respect does not comply with General Medical Council and Nursing and Midwifery Council standards. We, therefore, recommend:

The Head of Healthcare should ensure all health care providers record all interventions in a prisoner's primary medical records (SystmOne) so all information is documented enabling appropriate holistic care for each prisoner.

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