Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Smith, a prisoner at HMP Durham, on 13 July 2020

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

OGL

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Michael Smith, a prisoner at HMP Durham, died in hospital from a hypoxic brain injury (a lack of oxygen to the brain) on 13 July 2020, after being found hanging in his cell two days earlier. He was 31 years old. I offer my condolences to his family and friends.

This is a disturbing case.

Mr Smith was recalled to Durham on 10 July. When arrived, he was suspected of concealing illicit items internally and was sent to the prison's segregation unit. He was restrained by staff on the way to the segregation unit and again when he arrived there. He hanged himself within 24 hours of arriving at Durham.

I am concerned that despite several risk factors for suicide and self-harm, staff did not identify Mr Smith's increased risk and failed to monitor him under suicide and self-harm prevention procedures (known as ACCT).

There were significant and unacceptable failings in the procedures designed to assess the risks of newly arrived prisoners: Mr Smith's vulnerabilities assessment was inaccurate and incomplete; he did not have a healthcare reception review or a first night interview; a nurse completed the segregation health screen assessment without seeing him; and he was not referred to the mental health team as he should have been.

This is the seventh time since January 2019 time that I have identified concerns about Durham's failure to identify risk factors for suicide and self-harm. The Governor and the Prison Group Director must ensure that improvements are made as a matter of urgency.

I also have serious concerns about the two restraints Mr Smith was subjected to shortly after his arrival at Durham. Mr Smith was extremely abusive to staff. However, I do not consider that he posed a risk of harm that justified the use of force. I am concerned that staff did not use de-escalation techniques before and after they used force, and I am troubled by the level of force used, particularly the use of pain compliance which I do not consider to have been justified.

Although the restraints did not cause Mr Smith's death directly, they may have contributed to his state of mind at the time he hanged himself. I have recommended that the Governor considers whether disciplinary action should be taken against some of the staff involved.

There were several other worrying failings, including poor record keeping in the segregation unit, failures by healthcare staff, and a delay in calling an ambulance (which may have affected Mr Smith's chance of survival).

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 **December 2021**

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Summary

Events

1. On 10 July 2020, Mr Smith was recalled to HMP Durham. A member of his family raised concerns about his welfare with the Probation Service the previous day. Mr Smith had a history of substance misuse and self-harm and had previously been monitored in prison under suicide and self-harm prevention procedures, known as ACCT.

2. Mr Smith was upset that he had been recalled to prison. The reception officer did not consider that he was at risk of suicide or self-harm. A body scan indicated that he was concealing illicit items internally and he was taken to the prison's segregation unit in line with local policy. Healthcare staff did not assess him in reception due to his abusive behaviour.

3. On his way to the segregation unit, Mr Smith was extremely abusive and argued with staff and they used force to restrain him. He was restrained for a second time in the segregation unit before being searched.

4. A nurse checked Mr Smith once that night. Staff raised no concerns about Mr Smith's welfare during his first night at Durham.

5. On 11 July, prison staff said they suspected that Mr Smith was under the influence of drugs. Mr Smith was seen three times by a nurse. She said officers did not tell her of their suspicions. Prison officers checked Mr Smith roughly every half hour. He was last checked at around 5.18pm.

6. At around 5.45pm, an officer found Mr Smith unresponsive in his cell, with a ligature tied around his neck. Nurses and officers tried to resuscitate him, and paramedics later assisted. A pulse was found, and Mr Smith was stabilised. He was taken to hospital but died on 13 July.

7. Post-mortem toxicology results showed that Mr Smith had used a large quantity of etizolam, a powerful tranquiliser, before his death.

Findings

8. Staff underestimated Mr Smith's risk of suicide and self-harm. The vulnerabilities assessment was not completed in full. The other first night assessments designed to identify prisoners' needs and risks – the reception health screen and the first night officer's interview - did not take place on 10 July or the following day, and a nurse assessed that Mr Smith was fit to be segregated without seeing him in person.

9. Mr Smith was extremely abusive to staff when he arrived at Durham. However, we consider that an officer and a Custodial Manager (CM) responded in ways more likely to inflame than to defuse the situation.

10. We do not consider that the first use of force was necessary or justified.

11. We are concerned that no attempt was made to de-escalate the situation after force had been used.

12. We do not consider that the second use of force was necessary or justified. We also consider that the use of pain compliance during the use of force was not necessary or justified.

13. Mr Smith was not seen by a nurse after force had been used.

14. The segregation unit records were inadequate and there is no record of significant interactions with Mr Smith.

15. There is no evidence that officers told healthcare staff that they suspected Mr Smith was under the influence of drugs.

16. The clinical reviewer concluded that the healthcare that Mr Smith received at Durham was of a mixed standard and not wholly equivalent to that which would have been received in the wider community.

Recommendations

Reception and risk assessment

- The Governor and Head of Healthcare should ensure that all reception staff:
    - know the risk factors and triggers for suicide and self-harm as set out in PSI 64/2011;
    - consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm;
    - understand that they must take risk factors into account when assessing risk and not rely solely on what a prisoner says or how he presents;
    - start ACCT procedures where appropriate; and
    - record the information considered and the reasons for the decision about whether to start ACCT procedures.

- The Governor and Head of Healthcare should ensure that all staff, including healthcare staff, are aware of their responsibility to complete the vulnerabilities assessment fully, including when a prisoner is in the segregation unit.

- The Governor and Head of Healthcare should ensure that:
    - a reception health screen takes place on a prisoner's first day in custody and that healthcare staff have access to all relevant information; and
    - if, exceptionally, the screen does not take place:
        - the reason is clearly documented in a prisoner's medical record; and
        - healthcare and prison staff should work together to ensure the screen takes place as soon as possible after the prisoner's arrival.

- The Governor and Head of Healthcare should ensure that the segregation health screen is completed in the segregation unit within two hours of a prisoner's arrival.

Secreted items policy

- The Governor and the Head of Healthcare should review Durham's secreted items policy to ensure that:
    - prisoners' risks and needs are properly assessed on arrival by both prison and healthcare staff; and
    - staff in the segregation unit understand and comply with the policy's requirements.

Use of force

- The Governor should initiate investigations into the conduct of CM A, Officer A and Officer B on 11 July 2020 with a view to considering whether disciplinary action is appropriate and inform the Ombudsman of the outcomes.

- The Governor should ensure that local use of force training emphasises the law on the use of force and de-escalation techniques.

- The Governor and Head of Healthcare should ensure that after a use of force:
    - a member of healthcare staff is always asked to examine a prisoner; and
    - Form F213 is completed accurately by prison and healthcare staff and is stored safely.

Segregation

- The Governor and Head of Healthcare should ensure that:
    - segregated prisoners are managed appropriately in line with PSO 1700;
    - segregation paperwork is appropriately completed, and records made of any significant interactions; and
    - staff are reminded to be particularly alert to signs of drug taking in prisoners who have been segregated under the secreted items policy.

- The Head of Healthcare should ensure that prisoners at risk in the segregation unit receive appropriate DART monitoring and that healthcare staff complete regular rounds in the segregation unit.

Emergency response

- The Governor should ensure that:
    - officers understand the importance of communicating the details of a medical emergency as quickly as possible; and

- control room staff call an ambulance as soon as they receive a medical emergency code.

Learning lessons

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Durham informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

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

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

20. The investigator interviewed 11 members of staff at Durham, some jointly with the clinical reviewer, and spoke to a prisoner at the prison. All the interviews were conducted remotely, either by video or by telephone, because of the restrictions imposed as a result of the COVID-19 pandemic.

21. We informed HM Coroner for County Durham and Darlington of the investigation. He provided us with a copy of the post-mortem report. We have sent him a copy of this report.

22. We contacted Mr Smith's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They asked:

    - if issues about his welfare had been passed to the prison;
    - why he was in the prison's segregation unit if he was being monitored under suicide and self-harm procedures;
    - if he had been assessed by the prison's mental health team; and
    - when and how he was found by staff.

    We have addressed these questions in this report.

23. Mr Smith's family received a copy of the initial report. They did not make any comments.

Background Information

HMP Durham

24. HMP Durham is a local prison. It holds around 990 prisoners. Spectrum Healthcare provides GP and pharmacy services and Tees, Esk and Wear Valley NHS Trust provide mental health services.

HM Inspectorate of Prisons

25. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Durham in September and October 2018. They noted that the number of self-harm incidents was very high, and that Durham did not focus sufficiently on implementing recommendations from the Prisons and Probation Ombudsman.

26. Inspectors reported that the use of force had trebled since their last inspection and there was a lack of clear evidence that de-escalation techniques were used consistently and effectively. They were not convinced that force was always used as a last resort and concluded that the increase may have been due to new staff who were not yet confident in using de-escalation techniques.

27. Inspectors noted that initial risk assessments were inadequate and did not focus sufficiently on identifying prisoners' vulnerabilities, needs or risks during the reception and first night process. Inspectors reported that the segregation unit was managed reasonably well and that relationships between staff and prisoners were good.

28. Inspectors reported that joint working between the prison and the drug and alcohol recovery team (DART) was reasonable, but more needed to be done to ensure staff made prompt referrals for prisoners considered to be under the influence of illicit substances. They noted that the team was not always aware of all drug-related incidents on the wings, and it was difficult to provide timely support.

29. 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 that reasonable progress had been made in assessing newly arrived prisoners on arrival, but that staff were working under considerable pressure due to the volume of prisoners, which meant that the process was often rushed.

30. Inspectors noted that although staff generally engaged courteously and constructively with prisoners, they occasionally spoke to them abruptly or even rudely.

Independent Monitoring Board

31. 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 ending October 2019, the IMB reported their concern about the increase in self-harm incidents and a deterioration in the delivery of induction. They noted instances where prisoners located in the

segregation unit did not receive their first night screen due to having secreted items. The IMB reported that the governance of use of force incidents had improved and that they were generally satisfied with how prisoners were managed in the segregation unit and the level of professionalism staff showed.

Previous deaths at HMP Durham

32. Mr Smith was the seventh prisoner to take his life at Durham since January 2019. Since his death, there has been a further self-inflicted death at the prison. There were a number of similarities between our findings in this investigation and in previous investigations. In five of the previous self-inflicted deaths, we made recommendations about the need for staff to assess prisoners' risk factors holistically and to record their reasons for not starting ACCT procedures.

33. A prisoner who died in February 2019 was also in the segregation unit due the prison's drug secretion policy. In our investigation, we found that healthcare staff failed to complete a segregation safety screen within two hours. Similarly, in our report into the death of a man in September 2019, we found that the segregation health screen was not adequately completed, and we were concerned about the lack of a coordinated healthcare approach and poor record keeping.

34. In our report into the self-inflicted death of another prisoner in July 2020, we again found that staff failed to assess his risk appropriately, and we also made a recommendation about the delay in calling an ambulance and communicating the nature of an incident

Assessment, Care in Custody and Teamwork

35. 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. As part of the process, a risk reduction plan, also known as a caremap (a plan of care, support and intervention) should be put in place. The ACCT plan should not be closed until all the actions of the risk reduction plan have been completed. After closure, a follow-up interview should take place within seven days.

36. 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. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Durham's secreted items policy

37. Prisoners may hide drugs internally by wrapping them in packages and then either placing them in their rectum or swallowing them. This will not be obvious during a visual search by officers but should be identified by the body scanning equipment now used in some prisons.

38. Durham's secreted items policy, dated March 2019, sets out several requirements for segregation and healthcare staff when a prisoner is identified as having concealed items internally. It says:

- prisoners will be given the opportunity to surrender any secreted items;
- prisoners will receive a reception healthcare screen in reception;
- a first night officer will give prisoners an induction;
- prisoners will be observed twice an hour on the first night (although the form on which officers records their observations says the checks should be carried out twice hourly for the whole period that a prisoner is subject to the secreted items policy);
- staff will initiate the prison's concealed items booklet;
- healthcare staff will be contacted each morning to assess the prisoner;
- the custodial manager or orderly officer responsible for the secreted items policy will see prisoners each morning to encourage compliance, offer support and consider if a further body scan is needed; and
- prisoners will be subject to a Challenge, Support and Intervention Plan (CSIP, a multi-disciplinary approach which focuses on those who pose a raised risk of violence and works to change their behaviour).

39. Staff told us that, where possible, a prisoner who is suspected of having secreted drugs will be placed in one of the special cells in the segregation unit that have traps in the toilet to catch any items that are flushed away.

Control and Restraint

40. Prison Service Order 1600, Use of Force, says that force must only be used as a last resort after all other means of de-escalating (e.g., persuasion or negotiation) the incident, not involving the use of force, have been repeatedly tried and failed. It goes on to say that, when the use of force has become necessary Control and Restraint (C&R) techniques are always the preferred option.

41. C&R techniques are set out in a Training Manual. They are used by a team of three officers (with the option of having another person involved to control the legs). They only use the force that is necessary to enable staff to cope competently and effectively with violent prisoners and potentially disruptive situations, with the minimum risk of injury to staff or prisoners. Staff must continue to attempt to de-escalate the situation throughout the incident with the aim of releasing holds and locks. Staff must not employ C&R techniques when it is unnecessary to do so or in a manner which entails the use of more force than is necessary. The application of C&R holds may cause pain to a prisoner and if the prisoner is compliant, the holds must be relaxed.

42. All new prison officers receive training in C&R techniques as part of their initial training, including training in the law on the use of force. All operational officers must attend refresher training every 12 months.

43. Following any use of force, all staff involved must complete a statement setting out what happened (known as an Annex A).

Key Events

Background

44. On 17 January 2018, Mr Michael Smith was remanded to HMP Durham, charged with robbery and the assault of a close family member. He was sentenced to four years in prison. He had a history of depression and significant substance misuse.

45. On 28 October 2019, Mr Smith was transferred to HMP Risley. On 11 January 2020, Mr Smith harmed himself and was monitored under ACCT procedures for two days. On 14 May, he was released on licence, but an emergency recall was instigated by the probation service on 3 July.

Thursday 9 July 2020

46. At around 10.55am on 9 July, a member of Mr Smith's family told a probation officer that Mr Smith appeared to be under the influence of drugs and had tried to hand himself in to police the previous evening but had been turned away as they did not have his recall paperwork. At 11.19am, she contacted Cleveland Police to ask for Mr Smith's recall to be actioned as soon as possible following the concerns raised by his family. (She had taken over as Mr Smith's probation officer on 8 July as his risk of harm to others had been reclassified as a result of the recall. Previously he had been managed as a medium risk of harm to others, but due to the change in risk to high Mr Smith had to be managed by a probation officer.)

47. At around midday, the member of Mr Smith's family told the probation officer that Mr Smith had been arrested and asked for him to receive help when he arrived at prison as he felt low and very emotional. She reassured them that she would ensure that the receiving prison were made aware of their concerns. (She told the investigator that the member of Mr Smith's family did not specifically say that Mr Smith had expressed thoughts of suicide or self-harm but had been worried about his state of mind and was concerned that he was using drugs and not coping very well.)

Friday 10 July 2020

48. At around 11.00am, the probation officer shared Mr Smith's family member's concerns with the police. She noted in probation records that Mr Smith remained in police custody as he had used drugs, but that her concerns would be passed to the police custody sergeant and that Mr Smith would be monitored closely. She flagged the concerns about Mr Smith's mental health and emotional wellbeing in his probation records to ensure that the receiving prison would be aware of his increased risk.

49. At 12.43pm the probation officer sent an urgent email to the offender management unit (OMU) at Durham, confirming that Mr Smith had been recalled to prison on 3 July and, her belief, that he had been returned to custody on 8 July. She asked for confirmation of if Mr Smith was at HMP Durham, as there were concerns about his emotional well-being and that he would need to be assessed by safer custody and mental health as a precautionary measure.

50. Durham OMU responded immediately and, having received further identifying information about Mr Smith, confirmed at 12.58pm that Mr Smith was not at Durham.

51. That afternoon, Mr Smith was transferred to HMP Durham he arrived at 3.50pm. The person escort record (PER, a document that accompanies prisoners between police custody, courts and prisons and which sets out risks) noted Mr Smith's volatility the previous day, and that he had previously been identified as at risk of suicide or self-harm but had denied any thoughts of doing so and had stated that he had bi-polar disorder.

52. During the reception process at Durham, Mr Smith was given a body scan which indicated that he had probably secreted illicit items internally. In line with the prison's secreted items policy, Mr Smith was told that he would be monitored in the segregation unit.

53. A nurse who was working in reception completed an initial segregation health screen. She noted that there was no reason why Mr Smith should not be held in the segregation unit.

54. A cell-sharing risk assessment was also completed which concluded that Mr Smith posed a high risk to staff and prisoners due to historic violence.

55. At around 6.15pm, a Supervising Officer (SO) partially completed the vulnerabilities assessment form (which is used to identify a prisoner's risk to himself during reception, first night and the early days in custody). She noted that Mr Smith was in a "particularly irate mood" due to his recall to Durham, that he had not recently harmed himself, and that he did not have a history of attempted suicide or self-harm and denied any thoughts of doing so. She also noted that Mr Smith had been recalled to custody but that his offence had not been against a family member and he did not display signs of withdrawal from drugs or alcohol. The remainder of the vulnerabilities assessment was not completed.

56. The investigator pieced together the following account of subsequent events on 10 July from CCTV and body-worn video camera (BWVC) footage.

57. Mr Smith was repeatedly abusive to reception staff and demanded to speak to a manager. At around 6.16pm, an officer took Mr Smith to collect some food before putting him in a holding room. Despite Mr Smith's verbally abusive behaviour, the officer spoke calmly to him to de-escalate the situation. (The officer normally worked in the segregation unit but had been deployed to reception that day.)

58. Prison staff said that Mr Smith tried to damage the holding room, although they did not record their concerns at the time, and we have seen no footage to confirm this. Custodial Manager (CM) A, who was the orderly officer that day, said that she happened to be in reception at the time and saw Mr Smith jumping on the benches in the holding room, trying to damage them. There is no record of this.

59. At around 6.30pm, Mr Smith was taken from the holding room so that healthcare staff could complete his initial reception health screen. Mr Smith told the officers escorting him that he was "pissed off" and that he should not be there as he should have been recalled to Risley. He said he wanted to see the mental health team and

to speak to a CM. A CM (who had just started work at Durham and was shadowing CM A for the day) told him calmly that he could speak to a CM in the segregation unit. When Mr Smith asked CM A if she was a CM, she said "I'm just a girl". Mr Smith continued to complain and swear at staff. His behaviour was consistently extremely abusive and insulting but he was not physically aggressive towards them and he kept his hands by his sides and followed the instructions he was given.

60. CM A asked a nurse in reception if she wanted to assess him given his abusive behaviour and the nurse declined. Mr Smith, who had been facing the officers, not the nurse, turned to the nurse and told her he was "alright" but before she could reply, Officer A, a segregation unit officer who was working in reception that afternoon, told him that the nurse did not want to see him, and he should come with him.

61. At 6.33pm, two officers and two CMs left reception to escort Mr Smith to the prison's segregation unit. Mr Smith followed instructions and walked down an internal flight of stairs. He continued to be very abusive and argumentative with the officers, telling them that that they were "nothing without their uniform" and would not dare to look him in the eye if they were outside the prison. They left the reception building and emerged into an outside area known as Hospital Bank

62. As Mr Smith left the building, Officer A said, "Carry on and fucking walk. I've fucking had enough of you". Mr Smith told him to "shut your fucking mouth" and the officer replied, "Why? What are you going to do?" As Mr Smith walked independently along Hospital Bank, the officer told him that he needed to be "compliant" while he was walking to the segregation unit and he replied that he was "being fucking compliant".

The first use of force

63. Mr Smith continued to swear and be very abusive and Officer A can be heard arguing back loudly. About a minute after they had left reception, CM A, who was behind Mr Smith, told Mr Smith to stop. She told him to "listen" and said all they were asking him to do was to walk and keep his mouth shut. Mr Smith turned back towards the CM and said again that he wanted to speak to a manager. She told Mr Smith that she was a manager and to continue walking. Mr Smith continued to argue with her, and she came close to him, raised her voice and told him to "keep his mouth shut" and pointed her finger at him, almost touching his chest, as he continued to answer back. Mr Smith told her to "watch her language" and said he had not raised his voice. She said he had now, and he said she had done so first. Their faces were fairly close together as they argued.

64. CM A then said, "Listen. Be quiet. Right", and immediately took hold of Mr Smith's arm. Officer A then immediately took Mr Smith to the floor where he took control of Mr Smith's head. (In doing so, he became the lead officer responsible for directing the restraint in line with C&R procedures.)

65. CM A and an officer handcuffed Mr Smith's wrists behind his back while he lay face down on the floor with Officer A holding his head. Mr Smith continued to use very abusive language while this was being done but he did not struggle, and he asked the officers to hurry up. The officers brought Mr Smith to his feet and they immediately walked him to the top of a flight of stone steps using the under-link

technique (crooking their arms under his and holding his arms up, and so forcing him to walk with his head bent down, with his hands handcuffed behind his back).

66. Mr Smith was taken down the flight of steps in this position, with an officer and CM A holding his arms and Officer A walking in front. It is not possible to see clearly what happened from the BWVC footage. The officer said he momentarily lost his footing on the stairs when Mr Smith appeared to push or lean into him, and the CM said she slipped because Mr Smith was struggling and seemed to be trying to pull them down the stairs. Mr Smith can be heard asking the officers to be careful of his arms, to "push his arms down a little bit, please" and then shouting at them urgently, apparently in pain, to "push my fucking arms down". Officer A put his face close to Mr Smith's and shouted, "Walk, right, walk, be fucking quiet and walk" and took control of Mr Smith's head again, telling him to keep his "fucking head down". Mr Smith told the officers they were "fucking bullies" and said they were dragging him down the stairs.

67. At the foot of the steps, Officer A released Mr Smith's head. Mr Smith said several times that he was "alright" and that he would walk. The officer told him to keep quiet while he was walked to the segregation unit. The officers continued to walk Mr Smith along the path under restraint using the under-link method. Mr Smith was bent double with his head almost at the level of his knees. He continued to shout obscenities at the officers, while also telling them that he could not walk and asking them several times to "please" watch his arms, to let go of his arms, to slow down and to help him as he was "going to fall" and pleading for them to let him stand up.

68. At around 6.37pm, Mr Smith arrived at the segregation unit. At the entrance, he again told staff that he had difficulty walking. He said that the officers would "get done" for dragging him down the stairs and that he would "recognise" them. He was taken into the segregation unit where he asked again to see a CM. He continued to be abusive, calling CM A "a fucking squat …", and asked to be allowed to stand up. She said this would not happen while he was shouting abuse.

69. Staff continued to restrain him using the under-link technique and he was put in a gated cell on the ground floor of the segregation unit. (Gated cells have two lockable cell doors, an inner gate with bars and an outer door. They are used for potentially violent prisoners as staff can open the outer door and see where the prisoner is before opening the gate.)

70. After Mr Smith was placed in the cell, Officer B, a segregation unit officer, told Mr Smith he was going to be given a full search and put into sterile clothes. He asked, "Are you going to comply with staff and keep your mouth shut?" Mr Smith said, "I'm alright man" and was allowed to stand up.

71. In total, from the time he was raised to his feet after the initial restraint until he was allowed to stand up in the gated cell, Mr Smith had been held in a bent position for around five and a half minutes. The BWVC footage shows he had sustained a noticeable cut or bruise under his eye between leaving reception and arriving at the segregation unit.

The second use of force

72. Once he stood up, Mr Smith continued to complain about the way he had been treated and Officer B told him that being "compliant" meant he should only speak when he was spoken to and that if he kept talking and shouting, he would "go back down". Officer A said something to him, and Mr Smith said he did not want to speak to him. He then asked why he had to wear "jail clothes". Officer B immediately initiated a further use of force on Mr Smith by taking control of his head. The other officers present helped to restrain Mr Smith and he was taken to the floor.

73. At 6.40pm, officers removed the handcuffs as Mr Smith was restrained face downwards on the floor, and applied wrist locks as Mr Smith's clothes were removed and he was searched under restraint. During the search, Mr Smith accused Officer A of twisting his wrist, and said that he was going to break it. At 6.43pm, the officers withdrew from the cell and locked the door.

74. Mr Smith's segregation records noted that he had last been monitored under ACCT procedures on 14 January, and that his cell could only be unlocked with two officers present.

75. At 10.37pm, a nurse checked on Mr Smith. This was his first contact with healthcare staff since arriving at Durham. She noted that Mr Smith expressed no anxieties but that officers were monitoring him every 30 minutes and would inform healthcare staff of any concerns.

Saturday 11 July 2020

76. Overnight a nurse spoke to the segregation unit night officer and noted that Mr Smith had settled. At 5.45am, she checked on Mr Smith through the cell door observation panel and again noted that he appeared settled. Records show that officers checked Mr Smith twice an hour that night in line with Durham's secreted items policy.

77. An officer checked on Mr Smith at 6.11am, 7.05am, 7.20am and at 8.07am. At 8.19am, Officer A spoke briefly to Mr Smith through his cell door. He told the investigator that he could not remember what they spoke about, but he recalled that Mr Smith's behaviour was threatening as he recognised him from the previous day.

78. At 8.37am, Officer A opened Mr Smith's cell door. Officer C and another officer were also present and talked to Mr Smith for a short time. There is no record of this discussion. Mr Smith was then moved from the gated cell to an adjacent standard cell. There is no record of the move or reason for it. (Officer A said Mr Smith was moved as his behaviour had improved. CM A, who was the orderly officer again, said Mr Smith was moved so that another prisoner could be put in the gated cell.)

79. CCTV footage shows that when Mr Smith moved cells, he was unsteady on his feet. Officer A told the investigator that he could not recall if Mr Smith was under the influence at this time. Officer C said she could not recall if staff had discussed whether Mr Smith was under the influence when he moved cells. There is no record that Mr Smith's behaviour was reported to healthcare staff.

80. At 8.40am, Officer C spoke to Mr Smith in his new cell. At around 9.00am, a prison GP and a healthcare assistant (HCA) arrived in the segregation unit, but neither saw Mr Smith. They returned to the unit at around 10.00am and spoke briefly to two officers before leaving again.

81. At 10.11am, a senior manager and Officer A spoke to Mr Smith for several minutes. There is no record of the visit or the conversation and they told the investigator they could not remember what was discussed.

82. At 10.41am, Mr Smith rang his cell bell and asked to speak to a manager. Two CMs and Officer A spoke to Mr Smith. CM A said Mr Smith shouted abuse at her when he recognised her and said something like, "Not you, you fucking slut". Officer A said Mr Smith told the officers he would attack them if he got the opportunity to leave his cell.

83. At 10.56am, officers moved Mr Smith back to the gated cell. There is no record of the move or the reason for it. CCTV footage shows that Mr Smith again appeared unsteady on his feet. At interview, Officer A said that this was when he became suspicious that Mr Smith might have been under the influence of drugs. CM A said that none of the officers raised this issue with her.

84. Mr Smith's segregation history record noted that he had rung his cell bell all morning, demanding food, and that he had "bad mouthed staff" and declined wing activities (a shower, exercise and a telephone call).

85. At 11.12am, a prison GP noted that he had tried to see Mr Smith but had been told that he was on a three-officer unlock, and his cell door could not be opened because there were not enough staff available. He asked the substance misuse team to monitor Mr Smith and to complete a urine drug test that afternoon, if possible, and that he would review Mr Smith two days later. He prescribed Mr Smith medication for the symptoms of drug withdrawal (known as a "rattle kit").

86. At around 11.21am, a nurse gave Mr Smith the medication that the prison GP had prescribed. Officers B and C and another officer accompanied her. The nurse said that Mr Smith was extremely angry with the officers. She said that Mr Smith did not appear to be under the influence of drugs and that officers had not told her anything about him being so.

87. Prison staff checked on Mr Smith at midday, 12.07pm and 1.05pm. At 2.23pm, Officer B talked to Mr Smith for around a minute, as did Officer A at 2.54pm. There is no record of these conversations.

88. At around 3.00pm, Mr Smith flooded his cell. Officer C and Officers A spoke to him but said that he did not explain why he had done so. They said that he threatened them and said, "Just you watch" and "Look what I can do". Officer A turned the water off in the cell. Officer C said that she and Officer A again suspected that Mr Smith was under the influence of drugs and asked healthcare staff to assess him. Several minutes later, Officer A talked to Mr Smith through the cell door and appeared to be amused. At 3.20pm, Officer C noted that Mr Smith had demanded more food and had flooded his cell in response to being told that he would have to wait until dinner.

89. A segregation unit cleaner spoke to Mr Smith briefly several times after the officers had left. He said that Mr Smith had not really answered when he asked why he had flooded his cell.

90. Officer A said that he asked the nurse to check on Mr Smith. At around 3.26pm, she gave Mr Smith his medication and she and a CM talked to him for several minutes. She said that Mr Smith was angrier than he had been in the morning, refused medical intervention or to take his medication. She said that she saw no evidence that he was under the influence of drugs and the officers did not mention anything about it to her.

91. Officer C said that the nurse agreed with her that Mr Smith appeared under the influence of drugs and told her to continue checking him every half hour.

92. Officer A said that Mr Smith continued to be abusive towards staff. At 3.29pm, he locked Mr Smith's cell door and the officers left. The officer appeared to be laughing at the situation. Soon afterwards, Mr Smith was given his evening meal. At around 3.57pm, Officer C checked on Mr Smith.

93. At around 4.00pm, a nurse said she spoke to Officer B by telephone about carrying out Mr Smith's initial health screen. She recorded that she could not assess Mr Smith as there were not enough staff available to unlock him. She noted that Mr Smith would be assessed by a nurse the following day and checked three times by officers overnight.

94. At 4.15pm, Officer C noted that Mr Smith had displayed a "disgusting" attitude to staff, called her a "slag" and had threatened Officer A when he was given his evening meal. Officer C also noted that the nurse had seen Mr Smith, as he was suspected of being under the influence of drugs.

95. At around 4.26pm, Officer A checked on Mr Smith and talked to him briefly. The officer checked on him again at 4.32pm.

96. Officer C, Officer A and CM A said that during their contact with Mr Smith that day, he expressed no thoughts of suicide or self-harm.

97. At around 5.00pm, Officer C was left alone on the unit as the prison went into patrol state. She briefly checked on Mr Smith at around 5.03pm and again at 5.18pm.

98. At around 5.45pm, Officer C checked on Mr Smith and saw that he had tied a ligature around his neck, using prison bedding, and was suspended from the cell's central light fitting. She immediately called a medical emergency code blue (used when a prisoner is unresponsive or has breathing difficulties). She said she felt sick at what she had seen and walked away from the cell as she needed a moment to herself and to fetch some protective gloves. She returned to the cell 30 seconds later and kicked the outer cell door to get a reaction from Mr Smith. A minute after finding Mr Smith, she opened the outer door to the gated cell and removed her anti-ligature knife from her belt and stood looking into the cell.

99. The orderly officer was in the command suite dealing with a significant incident on one of the prison's wings when the code blue was called. She said that she immediately left the command suite and made her way to the segregation unit. She said that staff who would normally have been available to respond to the code blue

were involved in the other incident. At 5.47pm, while en-route to the segregation unit, she radioed to ask if Mr Smith was breathing. Officer C replied, "It's hard to see at the moment, he is hanging from the light fitting and has assaulted staff, so I am not entering alone".

100. At 5.49pm, an officer arrived at the segregation unit. As he approached Mr Smith's cell, Officer C unlocked the gated door, and the officers went in. He took Mr Smith's weight and Officer C cut the ligature. They moved Mr Smith onto the landing outside the cell. The officer could not find a pulse so started cardiopulmonary resuscitation (CPR), while Officer C and another officer collected emergency equipment. The orderly officer and a nurse arrived soon afterwards and assisted the officer with the CPR efforts. A defibrillator advised no shock.

101. Paramedics arrived at around 5.59pm and found a pulse. Mr Smith was stabilised and taken to hospital at around 6.25pm.

102. The police recorded that after Mr Smith's arrival at hospital, a package of white powder was removed from under his foreskin. Hospital staff reported the find to the police and were told to dispose of the substance, which they did. This meant that the substance was not tested and identified.

103. Mr Smith died in hospital at 11.40pm on 13 July.

Contact with Mr Smith's family

104. A prison chaplain was appointed as the family liaison officer. Although Mr Smith had provided details of his next of kin, he had not provided a contact number for them. The prison asked the police to identify a telephone number. The chaplain tried to contact the next of kin in the early hours of 12 July, but not did make contact until 6.00am, when he told them that Mr Smith had been admitted to hospital. Mr Smith's family went to the hospital and were with him when he died. The prison contributed to the funeral expenses in line with national instructions.

Support for prisoners and staff

105. Durham told the investigator that a debrief for staff took place on the evening of 11 July to discuss Mr Smith's hanging and the incident that had taken place elsewhere in the prison at the time that Mr Smith was found. Although it is not clear who led the debrief, staff involved in the emergency response had the opportunity to discuss any issues arising and were offered support. The Head of Residence and Services held another debrief after Mr Smith's death.

106. The prison posted notices informing other prisoners of Mr Smith's death and offered them support. On 14 July, staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Smith's death.

Intelligence report

107. An intelligence report completed on 12 July (after Mr Smith had been found hanging and taken to hospital) noted that a wing cleaner had heard Mr Smith shouting out of his cell window that afternoon, bragging that he had a "stash" of illicit drugs,

including “blues” (etizolam, a strong tranquiliser), Subutex (an opioid substitute) and Xanax (a tranquiliser), and was going to “have a ball”. Officers working on the segregation unit who had contact with Mr Smith on 11 July, including those interviewed by the investigator, did not report that they had heard Mr Smith shouting this out, or that he had told them he had drugs in his possession.

Post-mortem report

108. A post-mortem examination found that Mr Smith died from a hypoxic brain injury (a lack of oxygen to the brain), following a cardiorespiratory arrest, due to hanging.

109. The pathologist noted that there was a purple/green bruise under Mr Smith’s right eye measuring 40 x 14 mm with an 8 mm long scratch at one end, and that there were several minor bruises and abrasions on Mr Smith’s body. However, the pathologist concluded that there were no injuries to suggest he had suffered an assault.

110. The toxicological examination found that Mr Smith had consumed a large dose of etizolam before he hanged himself. (Etizolam is a benzodiazepine tranquiliser, not licenced for use in the UK. It is around ten times more potent than diazepam (Valium) and is sometimes sold illegally as “blues”. It can cause significant intoxication, drowsiness, reduced inhibitions and reduced judgement.)

111. The toxicological examination also found low levels of methadone, pregabalin and cannabis, which were unlikely to have caused intoxication before Mr Smith was found hanging.

Findings

Assessment of Mr Smith's risk of suicide and self-harm at Durham

112. Prison Service Instruction (PSI) 64/2011 on safer custody requires staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm, and to manage those at risk under ACCT procedures.

113. A number of processes are in place to ensure that a prisoner's risk to himself and his healthcare needs are assessed when he arrives in prison. There were significant failings in all these processes in Mr Smith's case.

Vulnerabilities assessment

114. When Mr Smith arrived at Durham, the task of assessing his risk to himself would have been more straightforward if prison staff had been aware of his family member's concerns about his low mood and the possibility of self-harm. However, Mr Smith did have a number of clear risk factors: he had been recalled to prison and was in "a particularly irate mood" as a result; he had a history of self-harm; he had been monitored under ACCT procedures six months earlier; he had asked to see the mental health team; he was probably concealing drugs internally; and he was going to be segregated.

115. The SO who saw him in reception, did not consider that he needed to be monitored under ACCT procedures, although she did not record her reasons as she should have done. She did not accurately record Mr Smith's risk factors in his first night vulnerabilities assessment, an important tool used to communicate identified risk to staff responsible for a prisoner's care. Although she knew that Mr Smith had harmed himself in January 2020, she did not record this. At interview, she said that she did not do so because he told her it was "nothing" and said that he had no thoughts of self-harm.

116. The SO also said that although Mr Smith said he had bipolar disorder, she did not record this as she assumed this would be picked up by the nurse in his reception health screen. Although we accept that she might reasonably have assumed that a nurse would refer Mr Smith to the mental health team after his reception health screen, we consider that she should still have listed his bipolar disorder as a risk factor on the vulnerabilities assessment.

117. This was the only assessment undertaken when Mr Smith arrived at Durham and was a missed opportunity to identify Mr Smith's risks.

118. Two important sections of the vulnerabilities assessment were not completed: there was no initial health screen in reception and there was no first night interview. These failings are discussed below.

119. Mr Smith's risk increased after he was moved to the segregation unit as segregation is a known risk factor for suicide and self-harm. The SO said she did not know he was going to be segregated when she considered his risk.

120. In addition, although the vulnerabilities assessment form clearly states that it should move with the prisoner, there is no evidence that Mr Smith's form was forwarded to the segregation unit, and we are concerned that none of the prison staff with whom Mr Smith had contact in the segregation unit considered whether he might be at risk of suicide or self-harm.

121. We consider that, even without knowing about his family member's concerns, staff under-estimated Mr Smith's risk to himself. If they had started ACCT procedures, they would have evaluated his risk in more detail. This was a missed opportunity for staff to provide more appropriate support - although we cannot know whether this would have changed the outcome for Mr Smith.

122. We are very concerned that we have repeatedly identified that staff at Durham have failed to assess prisoners' risk appropriately. We identified similar deficiencies twice in February 2019, and again in January and May 2020, and Durham agreed to implement our recommendations each time.

123. In our recent reports into the death of prisoners at Durham in May and July 2020, we made a recommendation that the Prison Group Director (PGD) for Tees and Wear should write to the Ombudsman, setting out what he is doing to ensure that staff at Durham better understand the principles of risk assessment for suicide and self-harm. The PGD replied setting out a large number of actions he had taken in response to our reports. However, we repeat the following recommendation:

The Governor and Head of Healthcare should ensure that all reception staff:

- **know the risk factors and triggers for suicide and self-harm as set out in PSI 64/2011;**
- **consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm;**
- **understand that they must take risk factors into account when assessing risk and not rely solely on what a prisoner says or how he presents;**
- **start ACCT procedures where appropriate: and**
- **record the information considered and the reasons for the decision about whether to start ACCT procedures.**

The Governor and Head of Healthcare should ensure that all staff, including healthcare staff, are aware of their responsibility to complete the vulnerabilities assessment fully, including when a prisoner is in the segregation unit.

Initial reception health screen

124. Prison Service Instruction (PSI) 07/2015 on early days in custody requires newly arrived prisoners to have a detailed medical examination to assess their physical and mental health, including any safer custody or substance misuse concerns.

125. Healthcare staff did not complete Mr Smith's reception health screen in reception on 10 July because of his behaviour (although this appears to have been a decision

made more by CM A than by a nurse). There is no evidence that they tried to assess him in the segregation unit that evening.

126. Although a nurse contacted the segregation unit to arrange to conduct the initial health screen at 4.20pm the following day, this did not happen because there were insufficient staff available to unlock him.

127. The clinical reviewer noted that healthcare and prison staff did not appear to have made many attempts to work jointly to facilitate access to complete Mr Smith's reception screen. He considered that if a face-to-face assessment was not possible, an initial assessment should have taken place "through the door", including a review of relevant documentation such as the PER form, which identified possible mental health issues. As it was, Mr Smith did not have a health screen before he hanged himself. As a result, he was not referred to the mental health team as he should have been. This was another missed opportunity to identify his needs and risks.

128. We note that the IMB expressed concerns in 2019 that the operation of Durham's local secreted items policy meant that not all prisoners had an initial reception health screen. This should not, therefore, have still been happening at the time of Mr Smith's death.

129. We recommend:

The Governor and Head of Healthcare should ensure that:

- **a reception health screen takes place on a prisoner's first day in custody and that healthcare staff have access to all relevant information; and**
- **if, exceptionally, the screen does not take place:**
    - **the reason should be clearly documented in a prisoner's medical record; and**
    - **healthcare and prison staff should work together to ensure the screen takes place as soon as possible after the prisoner's arrival.**

First night officer's interview

130. New arrivals should also have an interview with the first night officer about welfare and wellbeing issues. This provides an opportunity to have a meaningful conversation about a prisoner's needs and risks before he is locked in the cell on his first night.

131. We recognise that Mr Smith was in an agitated state when he first arrived in the segregation unit, but we are concerned that there is no evidence that anyone tried to hold a first night interview with him later that evening or the following morning.

Segregation health screen

132. Segregation is stressful for prisoners and can increase their risk of suicide or self-harm. PSO 1700, the management of segregation units therefore requires a member of healthcare staff to complete a segregation safety health screen for all segregated prisoners to assess the prisoner's physical, emotional and mental wellbeing when deciding whether it is safe to segregate them. The health screen must be completed within two hours of a prisoner being segregated, after a discussion with the prisoner.

133. In line with Durham's secreted items policy, Mr Smith's segregation health screen was completed in reception, and not in the segregation unit. The nurse who completed it did not see Mr Smith in person. She had access to his medical records and the PER (information that had travelled with him) but did not note that he had been prescribed an antidepressant or that he said he had bipolar disorder.

134. We are very concerned that Mr Smith was not assessed in the segregation unit, face-to-face. This was yet another missed opportunity for healthcare staff to have considered his needs and risks and to identify his possible mental health issues. It is of particular concern in this case as Mr Smith did not have a first night reception health screen either.

135. We consider that the local policy of completing the segregation health screen in reception when a prisoner is suspected of having secreted items does not meet the requirements of PSO 1700.

136. We recommend:

The Governor and Head of Healthcare should ensure that the segregation health screen is completed in the segregation unit within two hours of a prisoner's arrival.

Secreted items policy

137. Although the senior manager who authorised Mr Smith's segregation recorded that a member of healthcare staff had spoken to Mr Smith about the risks of secreting items, this was not the case as Mr Smith had not been seen by healthcare staff at the time. It appears the text had been copied and pasted.

138. In addition, a manager did not encourage him to surrender the items, offer support or consider whether a further scan was necessary, and there were occasions when staff did not check Mr Smith twice an hour in line with the secreted items policy. We also found at interview that staff were confused about how often they were required to check prisoners under the policy.

139. We consider that Mr Smith's behaviour in reception distracted staff from properly considering his risk. We recognise the difficulty of handling such situations, particularly at a busy local prison. However, staff should be mindful that aggressive behaviour can be a way of expressing emotional distress and can be an indication of increased risk.

140. We also note that an officer and a CM both spoke calmly and courteously to Mr Smith and were successful to some extent in defusing the situation as a result.

141. We also consider that the local secreted items policy meant that Mr Smith missed out on important safeguards before he was located in the segregation unit. We fully support Durham's efforts to reduce the supply of drugs entering the prison, but the policy needs to be applied in a way that recognises the potential vulnerabilities of prisoners who arrive with secreted items.

The Governor and the Head of Healthcare should review Durham's secreted items policy to ensure that:

- **prisoners' risks and needs are properly assessed on arrival by both prison and healthcare staff; and**
- **staff in the segregation unit understand and comply with the policy's requirements.**

Use of force

142. Mr Smith was subject to the use of force twice on the evening of 10 July. He did not sustain any serious injuries as a result, and it did not contribute directly to his death. However, the use of force, even when performed entirely legitimately and in line with C&R procedures, is likely to be a painful and humiliating experience for a prisoner. It is possible, therefore, that it played on Mr Smith's mind, particularly given his existing low mood, and that it may have contributed to his decision to hang himself. We have, therefore, considered whether the use of force on Mr Smith was justified in the circumstances.

143. Prison Service Order (PSO) 1600 on the use of force in prisons says that the use of force by one person on another without consent is unlawful unless it is justified, and that the use of force in prisons will be justified, and therefore lawful, only if:

- it is reasonable in the circumstances
- it is necessary
- no more force than is necessary is used; and
- it is proportionate to the seriousness of the circumstances.

144. The PSO also says that staff should always try to prevent a conflict whenever possible and defuse the situation through communication and de-escalation skills before using force, and that force "must only be used as a last resort after all other means of de-escalating the incident have been repeatedly tried and failed".

145. Annex C of the PSO gives guidance on how to defuse a situation where there is a potential for violence. It states that, among other things, staff should display calmness; speak slowly, gently and clearly; lower their voice; avoid arguing and confrontation; show they are listening; allow the prisoner adequate personal space; reduce direct eye contact (which may be taken as confrontation); and avoid sudden movements.

The first use of force

146. When Mr Smith arrived in reception, he was extremely verbally abusive to towards staff. We recognise that staff would have been conscious that there was the potential for him to become violent but, from viewing the BWVC footage, we do not consider his body language was threatening. However, Mr Smith calmed down a little when an officer spoke to him calmly and courteously and he accepted a meal, and we note that a female officer entered the holding room while Mr Smith was in it on her own twice, which does not suggest that she felt at risk. Although he questioned details (such as why he would not be allowed vapes), he accepted that he was being taken to the segregation unit and did not argue about it.

147. We consider that the accounts subsequently given by staff, after they had used force, exaggerated the risk Mr Smith presented. The nurse in reception did not look scared, stand up and move away from Mr Smith (as CM A said), but remained sitting at her computer, and the CM effectively told her that she did not want to see Mr Smith, rather than the nurse taking that decision.

148. We consider that CM A could and should have tried to de-escalate the situation in reception. When Mr Smith said he wanted to speak to a CM, a CM said calmly that he would speak to Mr Smith when they were in the segregation unit. However, CM A's strange comment that she was not a CM but "just a girl" gave the impression that she was not taking Mr Smith's concerns seriously and was instead making fun of him. We consider that this was inappropriate and was a missed opportunity to defuse the situation.

149. When Mr Smith left reception, he continued to be extremely abusive to staff, but he complied with the instructions to go down the internal stairs and he did not "square up" to anyone on the stairs (as CM A said). However, as Mr Smith and the prison escort left the reception building, Officer A swore at Mr Smith and he and the officer began to shout at each other. We consider that Officer A's behaviour and the language he used were completely unnecessary and unprofessional and showed very poor judgement. He should have attempted to defuse the situation and calm Mr Smith down, but instead he inflamed it and so increased the potential for the situation to turn violent.

150. CM A appropriately told everyone to stop, although we consider she might usefully have intervened earlier. She told us that it was her intention to try to defuse the situation. When she first spoke to Mr Smith, she did so in a calm tone that might have been successful if she had continued. However, when Mr Smith argued back, she appeared to lose her patience almost immediately. She began to argue with him, moving forwards and very close to Mr Smith, waving her finger at him and shouting directly into his face. We consider that she showed very poor judgement and that her behaviour in fact inflamed the situation and put herself and her colleagues at greater risk.

151. CM A then appeared to lose her temper and took hold of Mr Smith's arm aggressively. She said that she had not intended to use force and that she had put her hand on Mr Smith's arm in a 'guiding hold', but this is not how it appears on the BWVC footage or how Mr Smith was likely to perceive it. We consider that when she took hold of Mr Smith, she effectively initiated a use of force, whether she

intended to or not. Once she had taken hold of Mr Smith's arm, her colleagues had no option but to support her.

152. Officer A immediately took Mr Smith to the ground. He told the investigator that he initiated force to prevent harm because Mr Smith was non-compliant, there were no alternative options, and his actions were a last resort. He said Mr Smith's chest was puffed out, he had started to move his arms and his facial expressions were getting more aggressive. CM A told the investigator that the initiation of force was a last resort because Mr Smith had earlier damaged prison property, had threatened and abused staff, and was angry and aggressive.

153. We agree that Mr Smith's constant abuse of the officers was unacceptable. However, we are satisfied that, although he was being argumentative and verbally abusive, Mr Smith was complying with officers' orders by walking to the segregation unit. Up to and including when force was used, Mr Smith did not physically resist staff, and did not appear to make any movement or say anything which could reasonably be perceived as a physical threat or as posing a risk that he was about to attack CM A or Officer A. He did not move towards the officers, although they moved towards him, his hands remained by his side and he did not move his arms uncontrollably or puff his chest out (as Officer A said).

154. The BWVC footage shows that CM A placed herself within easy striking distance of Mr Smith before force was initiated. That does not suggest that she felt physically threatened by him.

155. We recognise that there are occasions when a prisoner is so verbally aggressive and threatening that officers might reasonably feel at imminent risk of assault, even if the prisoner has not been physically aggressive. In such situations, the pre-emptive use of force to prevent harm may be justifiable. However, we do not consider that was the case here.

156. It follows that we do not consider that it was necessary for staff to use force at this point to avoid harm to themselves. We are also concerned about the behaviour and poor judgement of CM A and Officer A. We consider that a CM should have been able to handle a potentially volatile situation better and should have set a better example to the officers, and we consider that an officer who has been selected to work in the segregation unit, as Officer A was, should have the skills to de-escalate rather than inflaming such situations.

157. We are also concerned that the three officers involved – CM A and Officer A and another officer – all appeared to consider that because Mr Smith continued to be abusive to staff after being told to keep quiet, this constituted 'non-compliance' which justified the use of force.

158. PSO 1600 is clear that disobeying an order is not enough by itself to justify a use of force. In addition, although Mr Smith's language to the officers was deeply unpleasant and unacceptable, we do not consider that it amounted to 'harm' that justified the use of force. There were other effective, less injurious, means of dealing with it, such as placing him on a disciplinary charge for breaching Prison Rule 51 (19) or (20) (being disrespectful to an officer, or using threatening, abusive or insulting words or behaviour).

159. We are also concerned that after force was initiated, Officer A (who was managing the restraint) did not try to de-escalate the situation. After the initial restraint, Mr Smith was brought to his feet and officers proceeded to walk him down a flight of steps, along the path and into the segregation unit using the under-link method which forced Mr Smith to walk bent double.

160. Mr Smith had walked independently before he was restrained and BWVC footage shows he had not struggled when he was restrained. He had his hands cuffed behind his back and was surrounded by four officers. We consider that when Mr Smith was brought to his feet, Officer A should have given him the opportunity to agree to walk upright to the segregation unit in a guided hold. If he had refused or failed to follow instructions, he could have been brought under control again quickly.

161. We consider that it would have been both proportionate and safer for Mr Smith and staff for Officer A to have tested his compliance before he was taken down the steps. Although the BWVC footage is unclear, we do not consider there is evidence to support staff accounts that Mr Smith tried to pull them down the steps. On the contrary, we consider it would have been difficult for Mr Smith to go down the steps safely given the position he was in, and that his comments on the BWVC footage make it clear that he was fearful for his own safety as he was being taken down the steps at speed.

162. At interview, Officer A said that he made "a split-second decision" not to de-escalate at the top of the steps. However, there was no need for him to make a split-second decision at this point and we consider this was another error of judgement by him that put his colleagues at increased risk.

163. At the bottom of the steps, Mr Smith said several times that he was 'alright' and that he would walk (apparently meaning that he would not struggle and would walk compliantly). We again consider that Officer A should have attempted to de-escalate the situation and given Mr Smith the opportunity to walk upright.

164. During the walk to the segregation unit, Mr Smith appealed several times to staff to stop as he said he was falling. At interview, Officer A said he did not attempt to de-escalate because his primary concern was to get to the segregation unit safely, and CM A said that they did not give Mr Smith the opportunity to stand upright because they took his abusive behaviour as non-compliance. We do not consider that the BWVC footage shows that staff were at risk of harm from Mr Smith at this point and we consider that requiring Mr Smith to stay bent double for around five and a half minutes in total was an excessive and disproportionate use of force which cannot be justified.

165. We also note that Officer A said in his Annex A statement that "de-escalation was used continuously", which was clearly untrue - as he accepted at interview.

Second use of force

166. In the segregation unit, Mr Smith was placed in a cell and Officer B told him he would be allowed to stand upright if he complied with staff and "kept his mouth shut". Mr Smith was then stood up. He appeared to be calmer and quieter than before, but he was still argumentative and abusive. After he asked why he had to

wear jail clothes, the officer immediately initiated force and he was taken to the ground.

167. Officer B said that he used force because Mr Smith "was shouting and swearing and generally being non-compliant". He also said that Mr Smith was making threats to harm officers outside of prison (although it is not clear if he was suggesting this was a reason for using force). Officer A said that Mr Smith had been asked to be quiet and only speak when spoken to and that despite two warnings to comply with instructions, he did not remain quiet and therefore staff used force for a second time.

168. At interview, Officer A said that although Mr Smith was not physically non-compliant, he was verbally non-compliant. He also said in his Annex A statement and at interview that Mr Smith was being aggressive before he was restrained in the segregation unit. When the investigator queried this and played the BWVC footage, he said that Mr Smith was "clenching his jaws, he's staring at the staff … he is being quite aggressive there".

169. The BWVC footage shows that Mr Smith did not struggle with staff and that he indicated he would comply with a full search. At the time Officer B initiated the use of force, Mr Smith was standing upright with his hands cuffed behind his back and closely surrounded by at least three officers. He was not shouting, and he did not make any aggressive movements or threaten to do so. We do not consider that the BWVC footage shows him "clenching his jaws" (as Officer A said).

170. The immediate cause for the use of force was that Mr Smith had turned his head and asked a question. It is clear from the BWVC footage and the officers' Annex A statements that he was restrained because he had not followed instructions to remain silent. We do not consider that he posed a risk of harm to staff at this point, and it follows that we do not consider that the use of force was necessary or justified.

171. As before, we are concerned that Officers A and B considered that force could be used on the grounds that a prisoner failed to follow an instruction not to say anything. PSO 1600 makes it clear that this is not a justifiable reason to use force.

172. In addition, we cannot hear Mr Smith making any threats to staff on the BWVC footage, apart from the comment he made earlier about 'recognising' staff (although it is not always possible to hear exactly what is being said). Moreover, even if Mr Smith had made threats to assault staff in the future, we do not consider that he posed a risk of harm to staff at the time force was used and such behaviour should have been dealt with as a disciplinary issue.

Pain compliance

173. BWVC footage shows that when Mr Smith was full searched under restraint, he was lying face down on the floor under the control of three officers who were using approved C&R techniques. Mr Smith was not struggling or physically resisting but complained about the restraint and shouted out to officers. The footage shows that Officer A responded to some of Mr Smith's comments by applying the wrist lock he had on Mr Smith with greater force. This caused Mr Smith to cry out in pain.

174. At interview, Officer A accepted that he had used pain compliance (although he had not mentioned it in his Annex A statement as he should have done). He said that he felt that his use of pain compliance was justified as Mr Smith was abusive and aggressive and was trying to release himself from his hold. He said, "So, it would have been a reminder that, yes, I have got control, stop trying to resist". He said that that he could use pain compliance to gain control if he felt he was going to lose it, and that, although Mr Smith does not appear to be struggling on the BWVC footage, at the time he could "feel" him doing so. He said that looking back at the use of force, he would not, with hindsight, have done anything differently.

175. PSO 1600 states that staff must not employ C&R techniques when it is unnecessary to do so or in a manner which entails the use of more force than is necessary. It says that C&R holds, such as wrist locks, can cause pain and if the prisoner is compliant, the hold must be relaxed. We consider that Mr Smith was clearly compliant while under restraint and that there was no justifiable reason for Officer A to use pain compliance. It was not reasonable, necessary or proportionate to the circumstances. We note that another officer (who had control of Mr Smith's other arm) did not feel that pain compliance was necessary.

Use of inappropriate language

176. Before and during the two restraints and escort of Mr Smith to the segregation unit, Officer A used language on several occasions that we do not consider appropriate and which we consider inflamed the situation.

177. We recognise that an unplanned use of force on a prisoner, where the safety of officers and others might be at risk, is a stressful situation and that inappropriate language may sometimes be used in the heat of the moment. However, Officer A had started to swear at Mr Smith before he was restrained, which we do not consider was excusable.

178. We are concerned that Officer A said at interview that he felt it was "normal" and "necessary" to use such language on occasions and that he did not believe it would have inflamed the situation. One of the grounds officers gave for using force on Mr Smith was that he was using abusive language, which they, understandably, found offensive and which they described as aggressive. Prison staff are expected to model pro-social behaviour to set prisoners an example of how to behave and if an officer uses such language to prisoners, it is difficult to argue that it is unacceptable for prisoners to use it to officers.

179. CM A told us that she held a debrief with the staff involved after the two restraints. PSI 30/2015 (which makes some amendments to PSO 1600) says that the person who holds the debrief must follow up any concerns they have about the incident and the techniques and methods used by staff. At interview, she said that she did not think it was "helpful" for Officer A to have sworn at Mr Smith before force was used and that, with hindsight, she thought there should have been more attempts to de-escalate and communicate with Mr Smith. However, there is no evidence that she raised her concerns with Officer A or his line manager.

Completion of the F213 injury form after the use of force

180. PSO 1600 says that healthcare must be informed when force has been used so that a doctor or nurse can assess the prisoner. Form F213 should be completed to record any injuries sustained and any treatment given. The first page of the F213 should be completed by the officer responsible for the use of force and the second page should then be completed by the healthcare professional who sees the prisoner.

181. The BWVC footage in the segregation unit shows that Mr Smith had sustained a noticeable cut or bruise under his eye during the first use of force. The first page of the F213 was completed by Officer A, who recorded that Mr Smith had not sustained any injuries. Although the injury was not serious, it was still noticeable at the time of the post-mortem six days later. We are concerned that the injury was not recorded on the F213, particularly as it was a head injury.

182. We are also very concerned that there is no evidence that healthcare staff were asked to examine Mr Smith after the use of force, or that anyone did so. At interview, we found that staff were not clear whose responsibility it was to ask healthcare to come to see Mr Smith.

183. We are concerned about the way Officer A conducted himself throughout this incident. We are particularly concerned that he had been selected to work in the segregation unit. Segregation is an extreme and isolating form of custody and segregation units hold prisoners who may be both very challenging and very vulnerable. It is essential that staff working in segregation units fully understand their special responsibilities and have the skills to defuse difficult situations wherever possible and to recognise when prisoners are in distress.

184. We make the following recommendations:

The Governor should initiate investigations into the conduct of CM A, Officer A and Officer B on 11 July 2020, with a view to considering whether disciplinary action is appropriate, and inform the Ombudsman of the outcomes.

The Governor should ensure that local use of force training emphasises the law on the use of force and de-escalation techniques.

The Governor and Head of Healthcare should ensure that after a use of force:

- **a member of healthcare staff is always asked to examine a prisoner; and**
- **Form F213 is completed accurately by prison and healthcare staff and is stored safely.**

Segregation

185. We are concerned that there is no record that anyone made a meaningful attempt to engage with Mr Smith while he was in the segregation unit.

186. When Mr Smith arrived at Durham, he was upset at being recalled and asked to see someone from mental health and a CM. Neither happened. PSI 30/2015 also says that after a use of force, there should be a de-brief in which someone unconnected with the incident speaks to the prisoner about what happened. There is no evidence that this took place.

187. When a prisoner is taken to the segregation unit, the staff who have taken him there normally hand him over to the segregation staff, giving the prisoner the opportunity to start afresh with new staff. In this case, an officer and Officer A normally worked in the segregation unit and therefore continued to have contact with Mr Smith in the unit after they had restrained him. It is unlikely that Mr Smith would have wanted to expose his vulnerabilities to them in the circumstances, but he had no opportunities to talk privately to anyone else, particularly as he did not have a healthcare reception screen. Officer A accompanied the senior manager, for example, when he spoke to Mr Smith. We consider that a manager should have recognised this and should have tried to give Mr Smith the opportunity on 11 July to discuss his concerns with someone unconnected to the events of the previous day.

188. We are also concerned about the processes and record keeping in the segregation unit. Mr Smith's segregation records were of a poor standard, visitors had not signed in, and there were poor and too few entries about Mr Smith, given his difficult and challenging behaviour.

189. For example, staff gave the investigator different accounts of why Mr Smith moved cells on 11 July, and there was no entry about the move or the reason for it in segregation records. Although the senior manager and Officer A spoke to Mr Smith for several minutes a few hours before he hanged himself, there is no record of the conversation or even that it took place, and, although Officer A had two encounters with Mr Smith later that day that appeared to amuse him, there is no record of what he found funny.

190. We are particularly concerned that segregation unit staff failed to record that they suspected Mr Smith was under the influence of drugs on the afternoon he hanged himself. Although Officer A and Officer C said they had told a nurse, they did not record this, and the nurse says she was not told.

191. Mr Smith was believed to have secreted drugs internally and it could therefore be assumed that he would pass them at some point. The possibility that he might use drugs in the segregation unit was, therefore, a known risk. Staff should have been on the alert for signs that he had done so and should have taken appropriate action if they suspected it.

192. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **segregated prisoners are managed appropriately in line with PSO 1700;**
- **segregation paperwork is appropriately completed and records made of any significant interactions; and**
- **staff are reminded to be particularly alert to signs of drug taking in prisoners who have been segregated under the secreted items policy.**

Clinical care

193. The clinical reviewer concluded that the clinical care Mr Smith received was of a mixed standard and not wholly equivalent to that which he could have expected to receive in the community. He found there were missed opportunities to monitor Mr Smith and establish his risk level, and there were missed opportunities to assess his mental state. He noted that Mr Smith had stated that he had a history of bipolar disorder which should have generated a mental health referral. He also noted omissions in completing electronic medical records. He has made a number of recommendations which the Head of Healthcare will need to address.

Substance misuse care

194. The clinical reviewer noted that Mr Smith had limited opportunity to engage with substance misuse services at Durham. He reported that although attempts were made to monitor Mr Smith's condition and medication was prescribed for symptomatic drug withdrawal relief, he chose not to accept this.

195. The clinical reviewer also considered that there was a missed opportunity for a prison GP to review Mr Smith on 11 July. He said that if healthcare staff are denied access to assess a prisoner, healthcare and prison staff should record their consideration of the decision.

196. The clinical reviewer was also concerned that, although the prison GP said that that DART should monitor Mr Smith's condition and a urine drug screen should be completed, there is no evidence that these actions were taken. We make the following recommendations:

    The Head of Healthcare should ensure that prisoners at risk in the segregation unit receive appropriate DART monitoring and that healthcare staff complete regular rounds in the segregation unit.

Emergency response

197. Although Officer C called a medical emergency code as soon as she saw Mr Smith hanging, she did not communicate the details of the emergency for another three minutes, when she said he was hanging. It is important that the details are communicated as quickly as possible so they can be passed to the ambulance service.

198. After Officer C called the code blue, it took four minutes before an officer arrived to support her. This was not his fault – indeed, he showed initiative in arranging for a colleague to cover for him so he could respond. We appreciate that Durham was short staffed as a result of the COVID-19 pandemic and that a security incident was taking place in the prison at the time of the code blue, but we are concerned about the length of time it took other officers to attend. We make no formal recommendation, but we would expect the Governor to review the incident to see whether things could have been done differently.

Delay in calling ambulance

199. PSI 03/2013 on medical emergency response codes requires staff to radio a code blue in a medical emergency and for the control room to call an ambulance immediately when an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

200. Although Officer C called an emergency code blue on finding Mr Smith, there was a delay of around three minutes before control room staff called an ambulance. Any delay can have a significant impact on a person's chance of survival. Given that staff and paramedics were able to establish Mr Smith's pulse, we cannot know whether earlier intervention might have affected the outcome for him. It is important that prison staff understand their roles in a medical emergency, and we make the following recommendation:

The Governor should ensure that:

- **officers understand the importance of communicating the details of a medical emergency as quickly as possible; and**
- **control room staff call an ambulance as soon as they receive a medical emergency code.**

Learning lessons

201. We have identified a significant number of concerns in this report. We consider it is important that staff learn from our findings. We make the following recommendation:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

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