Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Andrew Price, a prisoner at HMP Durham, on 20 September 2020

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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 Joseph Price died in his cell at HMP Durham on 20 September 2020, 10 days after arriving there on remand. He was 28 years old. Post-mortem toxicology tests showed that he had used methadone, cannabis, diazepam and pregabalin before his death, but the pathologist was unable to establish the cause of death. I offer my condolences to Mr Price's family.

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

Although there is no evidence that Mr Price took his own life, he had a number of risk factors for suicide and I am concerned that staff did not monitor him under suicide and self-harm procedures, known as ACCT, when he arrived at Durham. When ACCT procedures were started, monitoring only lasted for one day and ended the day before his death. I consider that ACCT procedures ended prematurely.

I am also concerned about waiting times for medical appointments and health screens, and about the poor quality of CCTV images at night which meant that we could not determine whether the roll check was properly conducted on the morning that Mr Price was discovered dead in his cell.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. On 10 September 2020, Mr Joseph Price was remanded to HMP Durham. This was not his first time in custody.

2. Mr Price arrived at Durham with a suicide and self-harm warning form after telling the police that he would set fire to and hang himself in prison. He had a history of self-harm, attempted suicide, mental health issues, attention deficit hyperactivity disorder (ADHD), emotionally unstable personality disorder (EUPD) and substance misuse. During his short time at Durham, he was prescribed medication to relieve his drug withdrawal symptoms and methadone (an opiate substitute medication).

3. On 18 September, staff raised concerns about Mr Price's wellbeing and mental health and began monitoring him under suicide and self-harm procedures, known as ACCT. Staff stopped ACCT monitoring the next day when staff assessed that Mr Price felt better.

4. On 20 September, an officer found Mr Price unresponsive in his cell during a routine roll check. The officer radioed a medical emergency code blue and staff responded quickly. Staff did not try to resuscitate Mr Price as rigor mortis was present. When the paramedics arrived, they pronounced that Mr Price had died.

Findings

Illicit substances

5. Although post-mortem toxicology tests indicated that Mr Price had used methadone, cannabis and various prescription drugs, which had not been prescribed to him, before he died, the post-mortem was unable to establish the cause of his death.

6. Although Mr Price had a history of substance misuse, staff saw no evidence that he was using drugs at Durham.

7. The availability of illicit drugs has been an ongoing problem at Durham. Although we are concerned that Mr Price was apparently able to access drugs, we recognise that Durham, a busy local prison, faces considerable challenges in tackling drug supply. We note that it has a comprehensive drug strategy and that measures introduced to tackle drug supply appear to be having an impact.

Clinical care

8. The clinical reviewer found that the healthcare Mr Price received was equivalent to that which he could have expected to receive in the community. However, he considered that Mr Price should have been offered a secondary health screen and he was concerned about the waiting time for a routine ECG appointment.

Assessment of risk

9. There is no evidence that Mr Price took his own life. However, he had a number of risk factors for suicide and self-harm when he arrived at Durham: he had been

recalled to prison, he had a history of substance misuse, self-harm and mental health issues, and he had arrived with a suicide and self-harm warning form after threatening to kill himself.

10. We are concerned that staff placed too much emphasis on Mr Price's comment that his risks would significantly be reduced if he received his methadone medication and did not give sufficient weight to his other risk factors.

11. When ACCT procedures were started on 18 September, they were stopped after only 24 hours. We consider that this was premature and meant that staff could not assess Mr Price's risk adequately.

Roll checks

12. The CCTV footage at night on Mr Price's wing is very poor quality. This meant that we could not determine whether a roll check had been completed correctly about an hour before Mr Price was found dead in his cell.

Recommendations

- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:
  - Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.
  - Staff have a clear understanding of their responsibilities and the need to record and share relevant information about recognised risk.
  - Staff address all known risk factors adequately before ending ACCT procedures, and record the action taken.
- The Governor should ensure that all CCTV cameras work effectively, and that footage is clear, even at night.
- The Head of Healthcare should ensure that a secondary health screen is carried out for all prisoners in line with NICE guidance.
- The Head of Healthcare should ensure that ECGs are delivered in a timely manner.

The Investigation Process

13. 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.

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

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

16. The investigator and clinical reviewer interviewed eight members of staff at HMP Durham in October and November 2020. All the interviews were conducted by telephone or video-link due to the COVID-19 restrictions in place.

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

18. One of the Ombudsman's family liaison officers contacted Mr Price's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Price's mother wanted to know if Mr Price lived in a single cell, whether he was monitored under suicide and self-harm procedures and when healthcare staff saw him. We have covered these issues in this report.

19. Mr Price's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies in the report and accepted all recommendations.

Background Information

HMP Durham

21. HMP Durham, which holds up to 996 prisoners, is a local prison serving the courts of Durham, Tyneside and Cumbria. Spectrum Community Health CIC provides primary nursing, GP, clinical substance misuse, pharmacy and sexual health services. Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons (HMIP)

22. The most recent inspection of HMP Durham was in September and October 2018. Inspectors were concerned that Durham was unsafe. They reported the high prevalence of illicit drugs and noted that there had been five deaths in the space of eight months where it was suspected that illicit drugs might have played a role. They also noted that there had been seven self-inflicted deaths since their last inspection in October 2016. They were disappointed that Durham had not addressed the PPO's recommendations with sufficient vigour and urgency.

23. 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.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 October 2019, the IMB reported that overcrowding in the prison continued to be a major problem. They noted that there had been a significant decrease in the number of use of force incidents, assaults, deaths in custody and illegal use of drugs. However, they noted that incidents of self-harm had increased.

Previous deaths at HMP Durham

25. Mr Price was the fifteenth prisoner to die at Durham since September 2018. Four of the previous deaths were from natural causes, eight were self-inflicted and two were drug related. In our investigations into previous deaths, we made recommendations about the assessment of prisoners' risk, availability of drugs, and emergency response.

Key Events

26. Mr Joseph Price had served a number of custodial sentences for burglary and the possession of offensive weapons. He had a history of attempted suicide and self-harm, mental health issues, attention deficit hyperactivity disorder (ADHD), emotionally unstable personality disorder (EUPD) and substance misuse.

27. On 28 May 2016, Mr Price was charged with burglary, possession of a controlled drug and theft. On 24 January 2017, he was sentenced to five years and three months in prison. Mr Price was released from prison on licence on 30 May 2019. At the time of his release, Mr Price was being monitored under suicide and self-harm procedures, known as ACCT, after he harmed himself.

HMP Durham

28. On 10 September 2020, Mr Price was recalled to prison for breaching his licence conditions and remanded to HMP Durham, charged with intent to steal, possession of cannabis, assaulting a police officer and damaging a police cell.

29. Mr Price arrived at Durham with a suicide and self-harm warning form after telling the police that he would set fire to, and hang, himself in prison. His Person Escort Record (PER) also noted that he had a history of substance misuse (cannabis, pregabalin and morphine) and had tried to swallow a pen lid and bite staff the previous day. He had also threatened to kill prison escort staff.

30. An officer saw Mr Price when he arrived. She reviewed the PER and suicide and self-harm warning form and assessed that it was not necessary to start ACCT procedures, based on the available information and an assessment of Mr Price's presentation. She noted that he interacted well, and that he wanted to see the substance misuse nurse so that he could be prescribed methadone (an opiate substitute medication). When she asked Mr Price about the suicide and self-harm warning form, Mr Price said that he had no thoughts of suicide or self-harm. He said that he was 'okay' and had not harmed himself for years. He said that he was autistic and used cannabis and buprenorphine. She referred him to see a nurse and the mental health team. She noted that he showed signs of drug withdrawal.

31. Durham's revised reception screen process gives prisoners immediate access to physical healthcare, mental health and substance misuse staff in reception. A mental health nurse completed Mr Price's reception health screen. She told us that Mr Price was irritable and withdrawing from the effects of drugs and was concerned that he would not be offered methadone on his first night in prison. She noted that his physical observations were within normal limits. Mr Price tested positive for buprenorphine (also known as Subutex, an opiate substitute medication), opiates and cannabinoids. He was referred to the substance misuse nurse.

32. The mental health nurse noted Mr Price's history of mental health issues and reviewed the suicide and self-harm warning form. She told the investigator she did not recall seeing the PER. She said she questioned him about his threats of self-harm. Mr Price said that he had no intention of harming himself and had only threatened to do so because he was withdrawing from drugs. She noted that Mr

Price displayed no evidence of thoughts of self-harm, but she referred him to the mental health team.

33. An advanced nurse practitioner saw Mr Price and completed a substance misuse screen. He stated that Mr Price looked well, was coherent, had no signs of psychosis and did not appear intoxicated or sedated. He was unable to confirm Mr Price's buprenorphine dose with the community chemist (as it was closed). However, he agreed to prescribe Mr Price a low dose of methadone and drug withdrawal relief medication until the community chemist confirmed Mr Price's medication prescription.

34. The mental health nurse told the investigator that once Mr Price found out that he would receive methadone that evening, his mood improved considerably, and he appeared "overjoyed".

35. Afterwards, another mental health nurse saw Mr Price. She recorded Mr Price's mental health issues and self-harm attempts while previously in prison. She also discussed with him his more recent threats to harm himself. Mr Price said that he was happy that he had his medication and had threatened to harm himself because he was withdrawing from drugs. He said that he had no thoughts of suicide or self-harm and did not need further support from the mental health team. She noted that Mr Price had no symptoms of poor mental health and generally appeared okay. She noted that she would check whether Mr Price had engaged with community mental health services.

36. After his initial health screen in Reception, Mr Price was moved to the First Night Centre on E Wing. An officer completed his first night interview and told him about the available support.

37. A nurse checked on Mr Price throughout the night to ensure that he did not have significant withdrawal effects.

38. On 11 September, Mr Price attended a routine appointment at the substance misuse clinic. He said that he had stomach pain, cramps and constipation. Over the next five days, healthcare and substance misuse staff monitored Mr Price's withdrawal symptoms and assessed that he had no significant symptoms.

39. A prison GP reviewed Mr Price's medication in line with his community prescriptions after receiving his community summary care record. It was noted that Mr Price had only been prescribed folic acid in the community. He was subsequently prescribed a daily supplement of folic acid tablets.

40. A substance misuse GP reviewed Mr Price's substance care remotely. Mr Price's community chemist had confirmed that he was taking buprenorphine. He prescribed Mr Price methadone for opioid maintenance therapy.

41. A non-clinical substance misuse worker saw Mr Price. Due to the COVID-19 restrictions, she spoke to him through his cell door. She explained how the substance misuse service worked and discussed the risks associated with illicit substance use. Mr Price said he had no intention of misusing drugs in custody.

42. On 14 September, Mr Price complained of ongoing drug withdrawal symptoms, including stomach pain, cramps and restlessness. A nurse examined him and

noted his pulse was slow. Mr Price asked for an increase in his methadone. The substance misuse GP reviewed Mr Price remotely again and at Mr Price's request, agreed to increase his methadone dose to 40mg daily. He asked for Mr Price to have an electrocardiogram (ECG) due to his slow pulse, and one was booked for 22 September. He told us that that due to COVID-19, waiting times for such tests had been extended but an urgent ECG could be requested, if needed.

43. On 15 September, healthcare staff saw Mr Price in his cell after he complained of breathing problems. The nurses examined Mr Price and recorded that his physical observations were within normal limits, he was able to speak clearly and in full sentences and was not struggling to breathe. Mr Price thought that he had withdrawal symptoms. It was noted that his methadone dose was due to be increased that day and that the substance misuse team would review him.

44. Mr Price phoned his mother on the mornings of 16 and 17 September. He told her that he needed to get the "tablets" out of his system.

45. On 17 September, prison staff referred Mr Price to the mental health team after concerns were raised. A nurse saw Mr Price in his cell. He said that he was scared to leave his cell. The nurse noted that he had an appointment with the mental health team the next day.

46. On 18 September, a mental health nurse and a primary care mental health provider from Rethink, saw Mr Price and completed an initial assessment. The nurse told the investigator that Mr Price appeared distressed, distracted and anxious during the assessment. He felt that he was at risk of being murdered. He said that his brother had been murdered several years earlier and the same fate awaited him. He said that he heard the voices of his deceased brother and father. He was also unhappy that he had to share a cell and was paranoid that his cellmate may harm him. Mr Price asked to be moved to a single cell.

47. The nurse was concerned about Mr Price and wanted to discuss him with the wing Supervising Officer (SO). She tried to return Mr Price to his cell, but he was reluctant and instead climbed onto the railing in what looked like an attempt to throw himself onto the netting fixed between the landings on the wing. Prison staff quickly intervened and stopped him. She started ACCT procedures, and initially considered that Mr Price may need to be under constant supervision.

48. The nurse spoke to a wing SO and to the Head of Safer Prisons, who agreed to review Mr Price immediately. The Head reviewed Mr Price's prison records and risk history before he returned to interview Mr Price. The nurse accompanied him.

49. She noted that Mr Price engaged "really well" with the Head of Safer Prisons and appeared a lot more relaxed. Mr Price said that he found it hard dealing with his brother's death and that his autism contributed to his irrational behaviour. He said he was concerned that he might become violent towards his cellmate. The Head explored Mr Price's risk of self-harm. Mr Price stressed that his mother was a very important part of his life and he would not want her to lose two sons. Based on this information and Mr Price's presentation, the Head asked for Mr Price's cell sharing risk to be immediately increased to high to ensure that Mr Price was allocated a single cell. It was agreed that constant observation was not needed, and it was agreed that Mr Price should be monitored under ACCT procedures and observed

every 30 minutes. An ACCT assessment and first review were also arranged for that day. Mr Price was happy with the actions taken to support him and pleased that he would be allocated a single cell.

50. Shortly afterwards, a nurse recorded in Mr Price's medical record that another nurse had discussed Mr Price at a multidisciplinary team (MDT) meeting. The other nurse had reported her concerns which had resulted in ACCT monitoring. (The nurse confirmed that her entry in the SystmOne record was an account of the MDT discussion and that she had not seen Mr Price.)

51. That afternoon, an officer saw Mr Price and completed an ACCT assessment. He noted that Mr Price's main issues were the death of his brother, that he was struggling in custody and that he had drug withdrawal symptoms. Mr Price said that he had PTSD and was autistic. It was agreed that the mental health team should review him to consider the need for medication as he was hearing voices. Mr Price was moved to a single cell on A Wing in line with his request. He said that a single cell helped him feel relaxed and less anxious. Mr Price said that he did not want to die, and that his mother and nieces were his protective factors.

52. Shortly after this, an officer completed Mr Price's basic custody screen by telephone due to the COVID-19 restrictions. She noted that Mr Price engaged well, was polite and upbeat. Mr Price said that the substance misuse team was supporting him, and he had no thoughts of self-harm.

53. That evening and night, wing staff reported no concerns about Mr Price.

54. At 10.00am on 19 September, a SO and a mental health nurse conducted Mr Price's first ACCT review. An officer provided a verbal handover of his ACCT assessment. The SO noted that Mr Price was in good spirits and had settled in his new single cell. He noted that the substance misuse team was supporting Mr Price while he had drug withdrawal symptoms. Mr Price said that he had no thoughts of self-harm. The SO judged that Mr Price's risk level was low and decided to stop ACCT monitoring. The SO told the investigator that he did not recall much about his contact with Mr Price but confirmed that he had read his ACCT assessment notes.

55. The mental health nurse recorded her account of the ACCT review in Mr Price's medical record (although she did so retrospectively on 20 September 2020 after Mr Price's death). She noted that Mr Price stated that he felt much better than he had the previous day, and that his issues related to his ongoing drug withdrawal. She noted that he had asked for his methadone dosage to be increased, had no thoughts of suicide or self-harm, was no longer hearing voices and said that he was happy in his single cell. She told the investigator that Mr Price had implied that he had used the situation the previous day to ensure that he was allocated a single cell. While Mr Price said he did not need any support from the mental health team, he was happy to have a full mental health assessment. She said that the ACCT review panel agreed to end ACCT monitoring. She told the investigator that Mr Price was adamant that his concerns from the previous day were no longer an issue and that his ongoing drug withdrawal did not fall within the remit of ACCT procedures.

56. At 7.30pm that evening, Officer A started his night shift duty on A Wing. CCTV footage shows that he was on the wing landing at 7.47pm. (The CCTV footage ran three minutes ahead of real time.) He told us that he completed a roll check which included checking the welfare of all prisoners and that all cell doors were locked. The investigator viewed the CCTV footage. It was unclear and of poor quality and he was unable to determine if the roll check was completed as it was too dark.

57. Officer A said that he had no concerns about Mr Price. He recalled that he had been subject to ACCT monitoring the previous night and when he had checked him, he had had to use a torch as his cell night light (which was operated from outside the cell) was not working. He said that it was standard practice for him to use his torch when checking prisoners. CCTV footage shows that he was carrying a torch. Other staff had told him that there was a problem with the electrics and that this had already been reported to the maintenance department.

20 September 2020

58. At around 5.15am, Officer A started the morning roll check on the wing and should have completed it by 5.45am. He told us that he completed the roll check. The investigator viewed the CCTV footage. Again, it was unclear and of poor quality.

59. When his duty came to an end at around 6.00am, Officer A gave an oral handover to Officer B, who started his morning roll check on A Wing at around 6.30am. CCTV footage shows that he arrived at Mr Price's cell at 6.37am and he looked through the cell door observation panel. Officer B said that he switched on the cell night light, but it did not illuminate the cell brightly enough for him to get a clear view. From what he could make out, he saw Mr Price lying across the bottom bunk, with his head against the wall and his legs hanging off the bed. He thought that Mr Price did not look quite right and so tried to obtain a response from him by rattling the cell door. As Mr Price did not respond, he radioed Officer C, who was on an adjacent wing, to attend A Wing.

60. Officer C arrived quickly. He looked through Mr Price's cell observation panel and thought that Mr Price appeared to be in an unnatural position. Officer B radioed a Custodial Manager (CM), the officer in charge, raised his concerns about Mr Price and said that the two officers intended to enter his cell. The CM radioed for other staff to assist them.

61. The two officers entered the cell. Officer C turned on the cell light from inside, which turned the full light on. Officer B said that at this point, he could see Mr Price and that his eyes and mouth were wide open. Officer B radioed a medical emergency code blue, indicating a life-threatening situation. The control room log recorded this at 6.37am and an ambulance was called at 6.38am.

62. Officer C tried to get a response from Mr Price. He told us that Mr Price was cold to touch, had no pulse, no colour and when he pushed his arms, they were stiff, an indication that rigor mortis (a stiffening of the body) had set in. As it was clear that Mr Price had died, they did not perform cardiopulmonary resuscitation (CPR).

63. Officer B had a quick look around Mr Price's cell for anything unusual. He saw a strip of bedding hanging from just above the window, but it was clear that this had

not been used as a ligature. There was no drug paraphernalia and only a vape pen located near Mr Price.

64. By 6.43am, additional staff arrived at Mr Price's cell in response to the code blue. A nurse arrived at 6.44am and examined Mr Price. He was slumped across his bed, had mottled and discoloured skin, he was cold to touch, his pupils remained fixed throughout, he had no pulse and rigor mortis was present. The nurse agreed that CPR was not appropriate as Mr Price showed no signs of life.

65. The ambulance paramedics arrived at 6.55am and confirmed Mr Price's death.

Contact with Mr Price's family

66. The prison appointed two officers as the prison's family liaison officers. At 9.15am, one officer telephoned Mr Price's mother (due to the COVID-19 restrictions) to inform her of Mr Price's death and offered condolences and support. He also spoke to Mr Price's sister. He and the other officer continued to support Mr Price's family by telephone before and after his funeral, which was held on 30 September. The prison contributed towards the costs of the funeral in line with national instructions.

Support for prisoners and staff

67. After Mr Price's death, the Head of Security 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.

68. The prison posted notices informing other prisoners of Mr Price's death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Price's death.

Post-mortem report

69. The post-mortem examination was not able to establish the cause of Mr Price's death.

70. Post-mortem toxicology tests detected methadone, cannabis, diazepam and pregabalin in Mr Price's system, meaning he had used these drugs before he died. Only methadone had been prescribed to him. (Diazepam is a tranquiliser and pregabalin is prescribed for epilepsy, anxiety and nerve pain but is widely abused in prisons for its euphoric effects.)

71. The post-mortem examination found no natural disease and no injuries that might account for or have contributed to Mr Price's death. The pathologist said that the methadone was not present at a level that would normally have been expected to have caused Mr Price's death. She commented that it was possible that the combined effects of methadone and diazepam could have caused the death as both have the effect of depressing respiration, but that there was no evidence that this was the case. The toxicology results indicated that Mr Price had been a frequent user of cannabis and the toxicologist noted that although deaths as a direct result of cannabis use are rare, there is some evidence that the drug may have an adverse effect on the heart.

Findings

Illicit substances

72. Although the cause of Mr Price's death is unascertained, post-mortem toxicology tests showed that Mr Price had used methadone, cannabis, diazepam and pregabalin some time before he died. Mr Price was not prescribed pregabalin, diazepam or cannabis and so he must have obtained these illicitly.

73. Mr Price had a long history of substance misuse. After he arrived at Durham, he was placed on a methadone maintenance programme, he was monitored for withdrawal symptoms and he was appropriately referred to the substance misuse team, although he declined their support. Staff saw no evidence that Mr Price was using drugs in the 10 days he spent at Durham, although it appears from the post-mortem results that he was doing so. It is troubling that Mr Price was apparently able to access pregabalin, diazepam and cannabis in the prison, particularly during the COVID-19 lockdown when severe restrictions were in place on prisoner and visitor movement.

74. The ready availability of illicit drugs has been an ongoing issue at Durham for some time. In its last full inspection of Durham in September and October 2018, HMIP highlighted that illicit drug use was very high. There were five drug-related deaths at Durham in 2018. However, HMIP's Independent Review of Progress in July 2019 found that Durham had made good progress in stemming the supply of drugs, and mandatory drug test results showed that the use of PS had declined.

75. Durham has a comprehensive drug strategy, but it is apparent that drugs continue to be available in the prison. The deputy governor told us that Durham receives 80-100 new prisoners a week, and this number did not reduce significantly during the national COVID-19 lockdown. It is therefore a challenge to tackle drug supply, given Durham's high turnover of prisoners.

76. The deputy governor said that Durham had a range of measures in place to tackle drug supply, including a body scanner in reception, photocopying normal mail and checking that legal mail has come from a legitimate source, netting over the exercise yards to prevent throw-overs, a dedicated search team, access to a drug dog search team, additional cameras at the perimeter and mandatory drug testing (though testing was suspended during the lockdown).

77. Although we are concerned that Mr Price was apparently able to access drugs in prison, we are satisfied that Durham has an appropriate drug strategy in place and that measures introduced to tackle drug supply appear to be having an impact. We make no recommendation, though Durham will need to keep its drug strategy under regular review to ensure it is tackling the key issues.

Managing Mr Price's risk of self-harm

78. Prison Service Instruction (PSI) 64/2011 on safer custody and PSI 07/2015 on early days in custody list risk factors and potential triggers for suicide and self-harm. Mr Price arrived at Durham with a number of these risk factors: he had been recalled to

prison, he had a history of substance misuse, self-harm and mental health issues, and he had arrived with a suicide and self-harm warning form.

79. We would generally expect staff to consider or start ACCT procedures for a prisoner who arrived with a suicide and self-harm warning form. We note that prison, healthcare and mental healthcare staff assessed him in reception and in the first night centre and determined that his risk of suicide and self-harm was low and that he did not need ACCT monitoring at that time. We appreciate that staff had to weigh up Mr Price's history of attempted suicide and self-harm, substance misuse and risk information against the new information that he appeared happy to receive methadone. However, a number of significant risk factors remained. He was still suffering from withdrawal symptoms and earlier that day, he had threatened to hang and set fire to himself in prison, which is why escort staff had completed a suicide and self-harm warning form for him. We consider that staff should therefore have started ACCT monitoring when Mr Price arrived at Durham.

80. ACCT procedures were appropriately started on 18 September 2020 when Mr Price said that he wanted to take his own life, was distressed, paranoid, agitated and tearful, and tried to jump onto the netting between the wing landings.

81. However, when staff reviewed him the following day, he did not present with thoughts of suicide or self-harm. Given Mr Price's history, his recent threats of suicide and self-harm, and that he had been allocated a single cell, we consider that staff ended ACCT monitoring prematurely after just 24 hours. It would have been prudent to continue ACCT monitoring to assess whether Mr Price had ongoing thoughts of self-harm, and until staff could review him the following week. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including that:

- **Staff consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, person escort records and medical records.**
- **Staff have a clear understanding of their responsibilities and the need to record and share relevant information about recognised risk.**
- **Staff address all known risk factors adequately before ending ACCT procedures, and record the action taken.**

Roll checks

82. The primary purpose of a roll check is to confirm that all prisoners are present and correctly accounted for. However, roll checks are also an opportunity to check on prisoners' well-being and to identify any obvious signs that a prisoner may be ill or dead.

83. Officer A said that he had completed the roll checks on the evening of 19 September and the morning (5.15 to 5.45am) of 20 September. The quality of the

CCTV footage on the wing at night was extremely poor and neither the investigator nor the prison could identify any detail from it. This meant that it was not possible to see whether the officer conducted the roll checks appropriately. Durham also told the investigator that "the Group Safety Lead checked the CCTV footage for both dates, the wing is very dark, and you can make out the officer moving along the landings during roll checks but unfortunately cannot make out whether or not he looks through observation panels".

84. Mr Price was discovered at 6.37am, around an hour after Officer A said that he had completed a roll check. By this time, rigor mortis was present. The time for the onset of rigor mortis is variable but on average it usually appears between two to four hours after death. It is therefore likely that Mr Price was already dead at the time of the early morning roll check.

85. When Officer B carried out the next roll check, he switched on the light in Mr Price's cell and thought that he could see Mr Price lying in an unnatural position. The light was not bright enough for him to be sure, so he and a colleague entered the cell when they could not obtain a response from Mr Price. We commend him for carrying out a thorough roll check.

86. It is likely to have been darker at the time of the earlier roll check and we cannot therefore say if Mr Price's unnatural position would have been as visible to Officer A. We are, however, concerned that the absence of clear CCTV footage prevented us determining whether the roll check was completed correctly or not. It is critical for security and safety purposes that CCTV footage is clear, even at night. We therefore make the following recommendation:

The Governor should ensure that all CCTV cameras work effectively, and that footage is clear, even at night.

Clinical care

87. The clinical reviewer concluded that, overall, the healthcare that Mr Price received was of a good standard and was equivalent to that which he could have expected to receive in the wider community. However, the clinical reviewer identified some concerns which the Head of Healthcare will need to address, although they are not directly related to Mr Price's death.

88. First, there is no evidence in Mr Price's medical records that he received a secondary health screen after his arrival. NICE guidelines on the physical health of prisoners states that a secondary health screen to review potential long-term health conditions should be offered within seven days of arriving at prison. The cause of Mr Price's death is unknown. While it may not have changed the outcome for him, a secondary health screen might have identified additional health needs.

89. The other concern is that, although a prison GP referred Mr Price for an ECG, it was not scheduled until eight days later, by which time Mr Price had died. While we cannot know whether the ECG would have identified any concerns, the clinical reviewer was concerned that there was a waiting time of eight days for a routine ECG.

90. We make the following recommendations:

The Head of Healthcare should ensure that a secondary health screen is carried out for all prisoners in line with NICE guidance.

The Head of Healthcare should ensure that ECGs are delivered in a timely manner.

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