

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Smith a prisoner at HMP Elmley on 2 October 2017

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*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Smith died of gabapentin and methadone poisoning on 2 October 2017 at HMP Elmley. He was 32 years old. We offer our condolences to his family and friends.

Mr Smith's friends said that he frequently used illicit prescription medication in prison, and toxicology tests showed that he had used some drugs that he was not prescribed. The ease with which he was seemingly able to obtain these drugs is concerning. Staff did not act on intelligence that Mr Smith might have used such drugs and they missed opportunities to review his prescription in the light of this.

There is no evidence that Mr Smith intended to take his life. It is, though, concerning that Prison Service suicide and self-harm prevention procedures were not started when Mr Smith arrived at Elmley, as he had recently been hospitalised after a deliberate overdose of medication.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2018

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Summary

Events

1. On 23 June 2017, Mr Paul Smith was recalled to HMP Elmley. He had been hospitalised after an overdose of medication three days earlier but no one began Prison Service suicide and self-harm prevention procedures (known as ACCT).
2. Mr Smith had taken illicit buprenorphine in the community, and he therefore began a methadone opiate detoxification programme at Elmley. Prisoners who knew him said that Mr Smith also frequently took illicit prescription drugs.
3. On 4 September, prison staff searched Mr Smith's cell and found what appeared to be drugs. On the same day, another member of staff suspected that he was under the influence of drugs. Prison staff opened disciplinary procedures due to the find in his cell but Mr Smith was not tested for drugs. Prescribers were not told of these events and did not therefore consider whether to make changes to his methadone prescription.
4. A prisoner told us that he saw Mr Smith buy tablets from another prisoner on the afternoon of 1 October. At around 9.30am on 2 October, an officer unlocked Mr Smith's cell and found that he had died.

Findings

Identifying and managing Mr Smith's substance misuse risks

5. We are concerned about the evident frequency and ease with which Mr Smith was able to obtain illicit medication at Elmley. The use of such drugs alongside methadone carries significant risks, and we are concerned that intelligence Mr Smith might have been using illicit medication was not properly followed up.

Staff-prisoner relationships

6. There was little evidence of any meaningful interaction between prison officers and Mr Smith. This meant that they had less opportunity to identify his illicit drug use or any other underlying issues he had.

Identifying risk of suicide and self-harm

7. Mr Smith presented with a range of risk factors, including a recent and significant drugs overdose. We are concerned therefore that no one began ACCT procedures when he arrived at Elmley.

Recommendations

- The Governor and Head of Healthcare should ensure that there is an effective and well-implemented substance misuse strategy, including that:
 - There is an effective strategy to identify and reduce trading of prescribed medication.

- When there is intelligence to suggest a prisoner is in possession of or has used illicit drugs, staff test the prisoner for drugs as quickly as possible in line with the requirements of PSO 3601.
- All prisoners who are prescribed methadone receive a 13-week review and have a methadone review when there is intelligence that they might have used illicit drugs.
- The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme which allows officers to get to know prisoners, identify their needs and make regular case history notes.
- The Governor should produce clear local guidance about procedures to identify prisoners at risk of suicide and self-harm and to manage and support them. In particular, this should ensure that reception and first night staff:
 - Have a clear understanding of their responsibilities and the need to share all relevant information about risk.
 - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide and self-harm, including information from suicide and self-harm warning forms, person escort records and other sources.
 - Start ACCT procedures whenever a prisoner has recently self-harmed or expressed suicidal intent.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
9. The investigator visited Elmley on 5 October. He obtained copies of relevant extracts from Mr Smith's prison and medical records, and interviewed two prisoners who knew Mr Smith.
10. The investigator interviewed four members of staff and four prisoners at Elmley on 20 November. He interviewed a further two members of staff on 8 December.
11. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. He joined the investigator for interviews with clinical staff on 20 November.
12. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted Mr Smith's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked:
 - what checks were completed after Mr Smith was locked in his cell on the night of 1 October;
 - whether there was an expectation for staff to obtain a response from him at these checks; and
 - whether Mr Smith had been assessed for mental health issues and received any medication?
14. Mr Smith's wife received a copy of the initial report. She raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Elmley

16. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Forward Trust provides substance misuse services. Houseblock 3 is the substance recovery unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that a greater number of prisoners than would be expected in similar prisons said it was easy to obtain illegal drugs, and slightly more prisoners than expected provided positive samples at mandatory drugs tests. Inspectors reported that drug and alcohol dependent prisoners could access prompt and flexible treatment, and there was a good range of substance misuse support programmes.
18. Inspectors also found that officers had little time to develop positive relationships with prisoners and there was no functioning personal officer scheme.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to October 2016, the IMB reported that violence had increased, much of which centred on illegal drug use. They highlighted ongoing work by the security team to target those suspected of being involved in organised crime and violence. The IMB also reported that Houseblock 3 continued to develop well as a substance misuse recovery unit.

Previous deaths at HMP Elmley

20. Mr Smith was the eighth of ten prisoners to die at Elmley in 2017. One prisoner had previously died as a result of methadone toxicity at the prison in 2014. In our report into his death, we found that he received good clinical care at Elmley but that it was too easy for prisoners to obtain illicit prescription medication.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be

written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

Background

22. Mr Paul Smith served several short prison sentences before he was sentenced to 17 years in prison in November 2011 for wounding with intent. Mr Smith spent most of his sentence in HMP Elmley and the neighbouring HMP Swaleside. During this period of imprisonment, Mr Smith reportedly used drugs, usually illicitly obtained prescription drugs, including buprenorphine (medication used to treat opiate addiction), tramadol (opiate based pain relief), gabapentin (anti-epileptic medication) and pregabalin (also used to treat epilepsy). He was prescribed methadone (medication used to treat opiate addiction) for much of his time in prison. In April 2014, Mr Smith was admitted to hospital following an apparent overdose of paracetamol.
23. There was significant intelligence that Mr Smith was involved in violence and bullying in prison but also that he was under threat and in considerable debt. He was released on licence on 2 March 2017.
24. On 20 June, following an incident at his home, Mr Smith was admitted to hospital having reportedly taken an overdose of 84 gabapentin tablets. Hospital staff discharged him to police custody on 21 June, and his offender manager authorised his recall to prison.

HMP Elmley

25. Mr Smith arrived at Elmley on 23 June. His person escort record (a form that accompanies prisoners on all journeys to communicate information, including about risk factors) highlighted his recent overdose. A police officer recorded on the form that there was no suicide and self-harm warning form available to complete. (The police and courts use these forms to warn prisons that prisoners might be at risk of harming themselves.) No one at Elmley began Prison Service suicide and self-harm prevention procedures, known as ACCT.
26. A nurse assessed Mr Smith and recorded that he said he had recently taken an overdose of 252 gabapentin and pregabalin tablets. Mr Smith said that he took the overdose because he did not want to come back to prison. He also said that he used illicit benzodiazepines (medication prescribed for a variety of reasons, often to treat anxiety or insomnia) and buprenorphine. Mr Smith said that he had been prescribed mirtazapine (anti-depressant medication) in the community but had stopped taking the medication. The nurse referred him to the mental health team and substance misuse team.
27. A prison GP then assessed Mr Smith. He recorded that Mr Smith's urine had tested positive for buprenorphine, benzodiazepines and cocaine. Mr Smith said that he used buprenorphine every day and drank a lot of alcohol. The GP prescribed a 20ml daily dose of methadone, plus a short course of chlordiazepoxide for alcohol withdrawal. Later in the evening, another GP prescribed mirtazapine.
28. On 24 June, a substance misuse nurse assessed Mr Smith. He recorded that Mr Smith said that he felt "rough" and was withdrawing from opiates. The nurse

- completed a clinical opiate withdrawal scale assessment, for which Mr Smith scored four, indicating mild symptoms of withdrawal. He referred Mr Smith to a substance misuse nurse prescriber to consider increasing his methadone prescription.
29. Later in the day, the substance misuse nurse prescriber increased Mr Smith's methadone prescription to 25ml per day. The nurse explained that the substance misuse nurse's assessment showed that Mr Smith was experiencing withdrawal symptoms some hours before he received his next dose of methadone. He therefore thought that it was appropriate to increase the dose.
 30. On the same day, an assistant psychologist completed a mental health triage assessment. Mr Smith told her that he had tried to end his life by taking an overdose before he was recalled to prison. He also said that he had previously lied about taking an overdose in prison as he wanted to manipulate a move within the prison due to trouble he had at the time. The assistant psychologist put Mr Smith on the waiting list for various mental health support groups.
 31. On 26 June, the substance misuse nurse prescriber assessed Mr Smith. He recorded that Mr Smith continued to complain of symptoms of opiate withdrawal. Mr Smith scored six on the clinical opiate withdrawal scale, again indicating mild symptoms of withdrawal. The nurse prescriber explained that the aim of the first five days of treatment was to ensure that the prisoner was stable on their prescription. He did not think Mr Smith's presentation indicated that his symptoms had stabilised. He therefore increased Mr Smith's methadone prescription to 35ml per day.
 32. On the same day, a drug and alcohol worker met Mr Smith for an induction to the Forward Trust substance misuse service. Mr Smith spoke of his history of illicit drug use and said that he had regularly used unprescribed buprenorphine before his recall to prison. They agreed a plan for Mr Smith to begin monthly one-to-one sessions with him.
 33. On 27 June, a nurse assessed Mr Smith. She recorded that Mr Smith reported some withdrawal symptoms and scored five on the clinical opiate withdrawal scale. Mr Smith said that he felt stable on his current dose of medication.
 34. On 28 June, the substance misuse nurse prescriber assessed Mr Smith. This was the last assessment in his initial five-day monitoring period. He recorded that Mr Smith said that his current dose of methadone was not sufficient for a 24-hour period. Mr Smith scored zero on the clinical opiate withdrawal scale, indicating that there were no signs of withdrawal at the time. The nurse prescriber increased Mr Smith's methadone prescription to 40ml per day. He explained that the assessment took place in the afternoon, a few hours after Mr Smith took his last dose of methadone. He said that this meant that it was not unusual that Mr Smith would have a low withdrawal scale score at this time but still experience symptoms later in the day.
 35. On 26 July, Mr Smith moved to Houseblock 3 (the substance recovery unit), where he shared a cell with another prisoner. The cellmate said that Mr Smith was a sociable man who was well liked on the unit. He said that Mr Smith had 'parties' around twice a week in which he took illicit drugs. He said that this was

usually prescription medication such as pregabalin and benzodiazepines. Mr Smith's uncle, who was at Elmley at the time, also said he had known Mr Smith to use drugs in prison. He said that these were what he considered 'soft' drugs, such as pregabalin and sleeping tablets, and he did not think Mr Smith took anything stronger. He added that Mr Smith was a regular user, but not dependent on drugs, and understood what he should and should not take.

36. On 31 July, Mr Smith had a one to one session with the drug and alcohol worker. They agreed that he would complete the 'Stepping Stones' drug and alcohol behaviours programme. Mr Smith subsequently began the programme on 31 August.
37. On 2 September, a prisoner passed a note to staff in which he stated that Mr Smith had bullied other prisoners for their medication and items from the prison shop. The prisoner also stated that Mr Smith had a bladed weapon. Prison staff searched Mr Smith's cell on 4 September. They found several weapons and five wraps of what appeared to be drugs. Officers charged Mr Smith with an offence against prison discipline.
38. On the same day, the leader of the Stepping Stones programme, recorded that Mr Smith appeared to be "under the influence" when he attended the course. She said that Mr Smith "seemed a bit all over the place" and not his normal self. When she challenged him, Mr Smith denied taking drugs and said that he had hurt his leg, which prevented him from walking straight. She said that she thought she spoke to a member of the healthcare team about her concerns, but could not remember who she spoke to and did not record the conversation.
39. On 5 September, a unit manager downgraded Mr Smith to the basic level of the Incentives and Earned Privileges scheme (IEP, which aims to encourage and reward responsible behaviour in prisons), due to the find in his cell. The following day, Mr Smith's disciplinary hearing was adjourned. On 9 September, the hearing was again adjourned for legal advice. It was not reconvened before Mr Smith's death. Mr Smith was also moved into a single cell as a result of the find in his cell.
40. On 11 September, a drug and alcohol worker spoke to Mr Smith about the suspicion that he had used illicit drugs. He recorded that he offered support and an additional care plan objective, but Mr Smith declined.
41. On 13 September, the leader of the Stepping Stones programme spoke to Mr Smith about his suspected illicit drug use. She said that she offered Mr Smith support but also warned him that he could be suspended from the Stepping Stones programme if there were further suspicions. She said that Mr Smith told her that he had not used illicit drugs.
42. Prisoners on methadone programmes should have a review 13 weeks after starting the programme. Mr Smith's review was due in the last week of September but did not happen. The substance misuse nurse prescriber said that prisoners in their first five days took priority for reviews and Mr Smith's 13-week review was, like many, deferred.

Events of 1-2 October 2017

43. On 1 October, Mr Smith moved back to the standard level of the IEP scheme. An officer said she played table tennis with Mr Smith that afternoon and that he appeared to be his normal self.
44. Several prisoners told us that they spent time with Mr Smith that afternoon. A prisoner said he saw Mr Smith buy several tablets from another prisoner. He said that Mr Smith did not appear well that afternoon, said his heart was aching and looked like he was struggling to breathe. Another prisoner said that Mr Smith appeared to have chest pain. Two prisoners said that they reported Mr Smith's poor health to an officer, who was identified by another prisoner as Officer A.
45. Closed circuit television footage shows Mr Smith and Officer A speak for around 30 seconds at 4.05pm. The officer told us that he did not remember what he spoke to Mr Smith about and could not remember any prisoners telling him that Mr Smith was unwell. He locked the prisoners on Mr Smith's spur in their cells for the night at around 4.45pm.
46. The night patrol officer completed a count of prisoners at around 8.45pm. She said that she could not remember what Mr Smith was doing at the time. She completed another count of prisoners at around 5.05am on 2 October. She said that she could not remember what Mr Smith was doing, but presumed he was in bed as she thought she would have noticed and remembered otherwise.
47. Prisoners on Houseblock 3 are unlocked at various times in the morning, depending on whether they work or have other activities to attend. Those who do not have an activity, such as Mr Smith, are unlocked at staggered times throughout the morning to collect their medication.
48. At around 9.30am, an officer unlocked cells on Mr Smith's spur for medication. She found Mr Smith with vomit in his mouth and his arm hanging off the bed. She said that Mr Smith appeared to have died, and called other staff to attend. An officer checked Mr Smith and found he had no pulse, and felt cold and hard to the touch. Another officer radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator recorded this call at 9.35am, and telephoned for an ambulance immediately.
49. A nurse and a healthcare assistant attended. They recorded that rigor mortis was present and they did not therefore attempt to resuscitate Mr Smith. At around 9.50am, a prison GP confirmed that Mr Smith had died.

Contact with Mr Smith's family

50. The Governor and a prison chaplain visited Mr Smith's wife on the morning of 2 October and told her of his death. Elmley contributed to the costs of Mr Smith's funeral in line with Prison Service instructions.

Support for prisoners and staff

51. After Mr Smith's death an operational manager debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
52. Mr Smith's uncle was away from his houseblock when Mr Smith died. When he returned, a supervising officer and two of his friends told him that Mr Smith had died, and gave him support.

Post-mortem report

53. Post-mortem and toxicology examinations established the cause of death as gabapentin and methadone poisoning. The toxicology examination also found evidence that Mr Smith had taken quetiapine (an antipsychotic medication). He was not prescribed either gabapentin or quetiapine.

Findings

Identifying and managing Mr Smith's substance misuse risks

54. Mr Smith was prescribed a course of methadone at Elmley to counter the effects of withdrawing from the buprenorphine which he had used illicitly in the community. The prescription was gradually increased to 40ml per day during his first five days in prison, and remained at this dose for the rest of his life. The clinical reviewer found that healthcare staff prescribed methadone appropriately and at a dose commonly used in maintenance regimes.
55. However, the clinical reviewer noted that using methadone alongside other medication can increase its effects and risks and that these risks can be life threatening. Gabapentin and quetiapine, which toxicology tests identified Mr Smith had used illicitly, are two such drugs.
56. Prisoners who knew Mr Smith said that he frequently used illicit prescription medication in prison, and one prisoner said he saw Mr Smith buy several tablets on the afternoon before his death. It is concerning that he was seemingly able to obtain illicit drugs so easily. HM Inspectorate of Prisons, in their most recent inspection, found that a greater number of prisoners than would be expected found it easy to obtain drugs at Elmley.
57. There was intelligence available to staff that Mr Smith was using illicit drugs. Officers found a quantity of drugs in his cell. He also appeared to be under the influence of drugs when attending the Stepping Stones course. Disciplinary action was taken against Mr Smith following the find in his cell, but neither of these events led to a mandatory drugs test. Prison Service Order (PSO) 3601 on mandatory drug testing, states that any prisoner reasonably suspected of misusing drugs, or in whose cell drugs are found, may be required to provide a sample for drug testing at any time.
58. There was also no medication review after these events – neither of which appear to have been communicated to nurse prescribers or prison doctors – and no 13-week review of Mr Smith's methadone programme. These constitute missed opportunities to consider, address and review Mr Smith's illicit drug use and methadone prescription. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is an effective and well-implemented substance misuse strategy, including that:

- **There is an effective strategy to identify and reduce trading of prescribed medication.**
- **When there is intelligence to suggest a prisoner is in possession of or has used illicit drugs, staff test the prisoner for drugs as quickly as possible in line with the requirements of PSO 3601.**
- **All prisoners who are prescribed methadone receive a 13-week review and have a medication review when there is intelligence that they might have used illicit drugs.**

Staff-prisoner relationships

59. Two prisoners told us that Mr Smith did not appear well on the afternoon of 1 October. Both said that they reported this to Officer A, who told us he could not remember anyone telling him that Mr Smith was unwell. Without independent corroboration, it is not possible to know exactly what happened.
60. Good communication in prison is important and positive relationships between staff and prisoners help to identify any risks and vulnerabilities. During his time at Elmley, there were very few entries in Mr Smith's case notes, none of which related to his welfare, and he did not have an assigned personal officer.
61. We appreciate the difficulties of running a successful personal officer scheme in a busy local prison such as Elmley, but it is of concern that so few entries were made for Mr Smith. While more meaningful contact would not necessarily have identified his illicit drug use, this was a missed opportunity to recognise this and any other underlying issues he might have had. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner through an effective personal officer scheme which allows officers to get to know prisoners, identify their needs and make regular case history notes.

Identifying risk of suicide and self-harm

62. Prison Service Instruction (PSI) 64/2011 on safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and recall to custody. Staff should interview new prisoners in reception to assess their risk of suicide and self-harm. All staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and should address any concerns, including starting Prison Service suicide and self-harm prevention procedures (known as ACCT), if necessary.
63. Mr Smith's person escort record recorded that he had very recently taken an overdose, and a police officer noted that they would have completed a suicide and self-harm warning form, had one been available.
64. We appreciate that there is no evidence that Mr Smith intended to take his own life. However, he presented with a range of risk factors when he arrived at Elmley which ACCT procedures might have helped address. Particularly in light of his recent and significant overdose, we consider that it would have been prudent for staff to have started ACCT procedures when he first arrived at Elmley and to have continued ACCT monitoring until staff were satisfied that he was stable and his risk factors had been addressed. Reception staff should have been aware of these risk factors but there is no evidence that they were properly considered. We make the following recommendation:

The Governor should produce clear local guidance about procedures to identify prisoners at risk of suicide and self-harm and to manage and support them. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of their responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the know risk factors of a newly arrived prisoner when determining their risk of suicide and self-harm, including information from suicide and self-harm warning forms, person escort records and other sources.**
- **Start ACCT procedures whenever a prisoner has recently self-harmed or expressed suicidal intent.**

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