

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Smith a prisoner at HMP Exeter on 30 December 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

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

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 Jamie Smith was found hanged in his cell at HMP Exeter on 30 December 2015. He was 46 years old. I offer my condolences to Mr Smith's family and friends.

The clinical reviewer noted that Mr Smith suffered from depression and insomnia but staff did not check his medication was in line with that he had been prescribed in the community. He also identified areas for improvement in detoxification arrangements.

Staff at Exeter appropriately identified that Mr Smith was at risk of suicide when he first arrived at the prison on 22 December and began monitoring procedures. While I recognise that there was little to indicate that Mr Smith was at imminent and high risk of suicide immediately before his death, I am concerned that staff did not take into account all his risk factors, as a newly arrived prisoner withdrawing from alcohol. I am also concerned that security procedures regarding covered observation panels were not properly followed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2016

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings 13

Summary

Events

1. On 22 December 2015, Mr Jamie Smith was sentenced to 12 months in prison for burglary and was taken to HMP Exeter. He had been in prison before. He suffered from epilepsy, depression, anxiety and insomnia, for which he was prescribed medication. He had a history of prescribed drug and alcohol misuse.
2. Escort staff had completed a suicide and self-harm warning form to alert prison staff to Mr Smith's risks. He had recent self-harm marks on his arms, was withdrawing from alcohol and his mood was low. A reception officer began suicide and self-harm prevention procedures known as ACCT. Staff were expected to check him hourly until a first case review, the next day.
3. At an initial health screen, Mr Smith reported a history of drug and alcohol misuse. He was withdrawing from alcohol and began an alcohol detoxification programme to manage the symptoms. He was not allowed to keep the medication he had brought with him, and no one contacted Mr Smith's community GP to check what medication he was prescribed.
4. At the first ACCT review on 23 December, Mr Smith was assessed as a low risk of suicide and self-harm and staff were required to have two conversations during the day and check him three times during the night. Mr Smith said that he was concerned he had not received his usual medication. No member of healthcare staff was present.
5. On 24 December, Mr Smith told a substance misuse worker that he was worried he had not received his correct medication since he arrived at Exeter. This caused him sleepless nights and increased his stress levels. He was concerned that he would have a seizure as he was withdrawing from alcohol. He said he was depressed and anxious, and thought he might self-harm. Not long after, he had a seizure. Nurses did not refer him for a GP review.
6. At 4.49am on 30 December, a night patrol officer checked Mr Smith and found he had obscured the observation panel of his cell door. However, he believed he could see, through a small gap, the outline of Mr Smith's body asleep in bed, and did not check further. At 5.22am, the night patrol officer said that Mr Smith's observation panel was completely covered. He alerted the night manager and they found Mr Smith hanged from a ligature made from torn sheets and an electrical cable. The night manager radioed a medical emergency code and the control room called an ambulance immediately. Staff tried to resuscitate Mr Smith but without success. Paramedics arrived very quickly and assessed him. At 5.30am, they recorded that Mr Smith had died.

Findings

7. When Mr Smith arrived at Exeter, staff appropriately assessed him as at risk of suicide and self-harm and monitored him under ACCT procedures. Mr Smith had complex substance and alcohol misuse, mental health, and physical health needs, but a member of healthcare staff was not involved in his ACCT case

review. We are not satisfied that staff at the review fully took into account all his risks factors and we consider they incorrectly assessed his risk as low.

8. We had some concerns about the standard of Mr Smith's healthcare at Exeter. He was prescribed a much lower dose of antidepressant medication than in the community. Healthcare staff were unaware of this, as no one had contacted his community GP to check his medication and get a summary of his conditions, as should have happened. A GP did not review Mr Smith after he had a seizure and there was no clear clinical policy for managing alcohol detoxification.
9. Contrary to prison procedures, the night patrol officer did not inform the night manager when he first found Mr Smith's cell observation panel covered, so that staff could assure themselves of his safety.

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 guidance, including that:
 - First case reviews are multidisciplinary and always include a member of healthcare staff.
 - Staff consider and record all known risk factors when determining the level of risk of suicide and self-harm and set levels of observations that reflect that risk.
- The Governor should ensure that staff satisfy themselves of a prisoner's safety if they cannot see them properly at checks and alert the relevant manager if there are any concerns or the observation panel is covered.
- The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested and considered for newly arrived prisoners to ensure appropriate prescribing decisions and continuity of care.
- The Head of Healthcare should ensure there is a local clinical policy for assessing and treating prisoners withdrawing from alcohol and drugs, which incorporates current national clinical guidance and includes a clear process to follow up patients with complex and co-existing needs.

The Investigation Process

10. The investigator issued notices to staff and prisoners at Exeter informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Exeter on 8 January 2016. He obtained copies of relevant extracts from Mr Smith's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison
13. The investigator interviewed 13 members of staff at Exeter in February 2016. The clinical reviewer joined him for some interviews. The investigator interviewed one ex-prisoner by telephone.
14. We informed HM Coroner for Exeter of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Smith's mother, to explain the investigation. She did not have any specific matters for the investigation to consider.
16. Mr Smith's mother received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP Exeter

17. HMP Exeter is a local prison holding about 560 men. The prison primarily serves the courts of the South West. Dorset NHS University Foundation Trust provides health services. Healthcare staff are on duty 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Exeter was in July and August 2013. Inspectors reported a positive culture at the prison. They considered that reception arrangements were generally satisfactory. Staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was regarded as very good. Inspectors noted that the dedicated first night unit was too small to hold all new receptions and its capacity was often further reduced as it was used as an overflow for the vulnerable prisoners unit. There was little support for newly arrived prisoners and night staff on all wings had no understanding of the increased vulnerability of new prisoners. Inspectors were concerned that there were shortfalls in ACCT case management procedures, including poor care planning and a lack of multidisciplinary reviews. Substance misuse services were good.

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 December 2015, the IMB reported that healthcare resources were inadequate to provide a service equivalent to the community. The IMB noted that incidents of self-harm at the prison remained high and there had been an increase in self-inflicted deaths in 2015. There were concerns that low staff numbers prevent staff from engaging as they would like with prisoners in difficulty.

Previous deaths at HMP Exeter

20. We have investigated 16 deaths at Exeter, since 2014, six of which were apparently self-inflicted. We have previously made recommendations about the assessment and management of prisoners receiving treatment for substance misuse. This was an issue again in this investigation.

Assessment, Care in Custody and Teamwork

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been

completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22 December 2015

22. On 22 December 2015, Mr Jamie Smith was sentenced to 12 months in prison for burglary and arrived at HMP Exeter that evening. His escort record noted that he was epileptic, had a history of alcohol misuse, mental health problems, and took antidepressants and sleeping tablets. He had previously self-harmed in prison. He arrived with medication for insomnia (nitrazepam), anxiety (sertraline) and epilepsy (levetiracetam) and a suicide and self-harm warning form completed at court.
23. An officer interviewed Mr Smith in reception, noted the suicide and self-harm warning form and that Mr Smith had last been in prison six years earlier. He noted that Mr Smith was withdrawing from alcohol and his mood was low. Mr Smith said he had previously attempted suicide and had last self-harmed six months earlier. The officer told the investigator that he saw what appeared to be more recent scratch marks on Mr Smith's arms. He began ACCT suicide and self-harm prevention procedures.
24. A Supervising Officer (SO) recorded that staff should observe Mr Smith once an hour until his first ACCT case review, he should share a cell, be referred to the substance misuse service and have access to Listeners and the Samaritans. (Listeners are prisoners trained by the Samaritans to support other prisoners.) He identified Mr Smith's depression and withdrawal from alcohol as potential triggers for suicide and self-harm.
25. At an initial health screen, a nurse noted that Mr Smith was homeless. He had intermittent Raynaud's syndrome (that made his right hand blue and numb in cold weather) and complained of pain to the left of his ribs. He said he drank 245 units of alcohol each week, reported using heroin intermittently, the last time two weeks earlier, and said he had used crack cocaine three days before. She noted that Mr Smith's speech was slurred and he showed signs of withdrawal. A urine test was positive for cocaine, opiates and benzodiazepines.
26. Mr Smith told the nurse that he had no current thoughts of suicide or self-harm. He said he had taken an overdose of prescribed medication a year earlier and currently self-harmed by scratching his arms. Mr Smith said he had been admitted to a psychiatric hospital around ten years before and had recently seen a doctor for mental health problems. Mr Smith was not allowed to keep his medication in his cell because of his history of overdose. She referred him to the prison GP because of his excessive use of alcohol and drug misuse.
27. Mr Smith gave the nurse the details of his community GP. There is no record that she or any of the healthcare team contacted the GP for Mr Smith's community medical records.
28. A prison GP assessed Mr Smith and noted he had epilepsy. Mr Smith said he needed codeine for his cold hands. He said he smoked cannabis at night, had smoked heroin the previous night, and had used it intravenously two weeks earlier. He said he drank eight cans of Special Brew a day (40 units of alcohol) and had last had a drink earlier that day. The GP noted that Mr Smith had

symptoms of withdrawal; his hands shook, he was agitated and slightly sweating. He diagnosed alcohol dependence syndrome and prescribed chlordiazepoxide on a reducing dose for eight days to help manage his alcohol withdrawal symptoms. He also prescribed sertraline and thiamine. He noted that Mr Smith did not need support for withdrawal from benzodiazepines but did not record whether he needed help for potential withdrawal from cocaine and opiates.

29. Mr Smith shared a cell on C Wing with another prisoner. That night, a mental health nurse referred Mr Smith to the mental health team because his mood was low and because of his recent self-harm. She noted that Mr Smith had no current thoughts of harming himself.
30. Mr Smith began an eight day alcohol detoxification programme and was given a 40mg dose of chlordiazepoxide that night. His dosage would reduce to 30mg three times a day on 23 December, and then would be reduced every day until 29 December when Mr Smith would receive a last single dose of 5mg and complete the detoxification programme.

23 December 2015

31. An officer checked Mr Smith hourly throughout the night in line with his ACCT plan. A healthcare assistant checked Mr Smith three times during the night to make sure he was not suffering any ill-effects from alcohol withdrawal.
32. That morning, a SO assessed Mr Smith's resettlement and offending behaviour needs. Mr Smith said he was homeless and willing to address his alcohol addiction. She noted that Mr Smith was being monitored under ACCT procedures. He told her that he had last self-harmed on 22 December by cutting his forearms because he had felt stressed about appearing in court. She referred Mr Smith to the housing team, the substance misuse team, the prison employment team and the mental health team.
33. A substance misuse nurse took Mr Smith's pulse and blood pressure readings which were normal. The nurse noted that Mr Smith's hands tremored when they were outstretched. Mr Smith told her that he only used cocaine occasionally and had used heroin just twice. The nurse noted that the substance misuse team would assess how he was coping as part of his alcohol detoxification programme and would check him for the first five days.
34. Later on 23 December, an officer assessed Mr Smith, as part of ACCT procedures. Mr Smith told her it was his first time back in prison for six years and he felt depressed. He said that he had a history of attempted suicide (by hanging) and self-harmed by cutting and stabbing himself. He said he had taken an overdose of heroin two weeks before, as a spontaneous response, as he had felt he had had enough. Mr Smith said he had no current thoughts of suicide or self-harm, and had no contact with his family. He was concerned that he would be homeless on release from prison. Mr Smith said he was withdrawing from alcohol. He told the officer that he had had an epileptic seizure eight weeks earlier but had not received medication for epilepsy or depression in prison. He said he had previously been prescribed nitrazepam for insomnia.

35. Afterwards, a custodial manager chaired Mr Smith's first ACCT case review with two officers. There was no healthcare representation, although this is a mandatory requirement for first ACCT case reviews. (She told the investigator that she had not asked a nurse to attend as she believed the nurse who assessed Mr Smith in reception would have addressed his health matters.) Mr Smith told her that he had depression, was on an alcohol detoxification programme, and was waiting to be prescribed his other medication. He said he used cannabis recreationally and accepted that he would have to serve about 12 months in prison. He wanted to get a prison job and take some educational courses.
36. The custodial manager recorded that the case review had assessed that Mr Smith's risk of suicide and self-harm was low, and noted that he needed to be prescribed medication. Based on Mr Smith's presentation, she was not concerned about him and set checks at two staff conversations with him during the day and three observations at night. She scheduled the next case review for 30 December.
37. The custodial manager noted in Mr Smith's ACCT caremap that he had four issues to address. He was waiting for medication for depression and insomnia medication, which he would collect once it was prescribed; he was withdrawing from alcohol and needed to complete the alcohol detoxification programme; he had to complete a housing application form to avoid being homeless when he was released; and that he could contact the Samaritans if he needed additional support. (Caremap actions should aim to reduce an individual's risk of suicide and self-harm by identifying and addressing the main issues and concerns.)
38. Also on 23 December, a member of the Choices Consultancy Service (a voluntary organisation that supports and advises offenders and their families through difficulties in prison) saw Mr Smith, who said that his mother knew he was in prison and was caring for his child. He said he expected to be homeless when he was released. She noted that Mr Smith's mood was low and he was tearful.
39. Mr Smith collected his evening meal and mixed with other prisoners during the evening association period. He then received his first dose of levetiracetam for epilepsy.

24 December 2015

40. On the morning of 24 December, when an officer unlocked Mr Smith, he said he was feeling a bit low. A substance misuse support worker checked Mr Smith and recorded that his blood pressure and pulse were normal. Mr Smith said he had no current thoughts of suicide or self-harm but was anxious and depressed and believed he might self-harm. He was concerned that he had not received any medication for insomnia and said that lack of adequate sleep could lead him to have nightmares. He believed he was at risk of having a seizure because of his alcohol withdrawal symptoms, particularly as he was epileptic. The support worker said that he had passed on Mr Smith's concerns to a nurse, but he could not recall which one.

41. That morning, Mr Smith had a seizure in his cell. Two nurses witnessed it and said it lasted two minutes. One nurse examined Mr Smith and checked his vital signs. She recorded that Mr Smith had a red mark on his left temple and jaw but appeared to have no injuries. He said he had a pain on his left side. Mr Smith's cellmate agreed that they would swap beds so that Mr Smith could have the bottom bunk.
42. That day, Mr Smith was given his first dose of sertraline, which a prison GP had prescribed on 22 December. He received it daily from then.

25 December 2015

43. On Christmas Day, an officer noted in the ACCT record that she had spoken to Mr Smith, who told her he was concerned that some of his medication had been reduced. He did not say which, although he was on a reducing dose of chlordiazepoxide. He said his appetite was good. Although he had not contacted any of his friends or family, he said this was normal for him. She said she would let the alcohol detoxification team know about his concerns. Later that day, she told Mr Smith that she had not been able to speak to anyone from the team and he should try to speak to someone about his medication the next day.

26 December 2015

44. On Boxing Day, an officer noted in Mr Smith's ACCT record that he had had a quiet morning and had collected his lunch. Mr Smith said he had no thoughts of suicide or self-harm. That evening, an officer noted in Mr Smith's ACCT record that he had said he was okay. He had been pinching scabs on his arms but said that he was not trying to self-harm.

27 December 2015

45. On 27 December, an officer recorded in Mr Smith's ACCT record that he had observed him throughout the morning. Mr Smith had been cleaning his room and sorting out his belongings. He appeared in a good mood. Mr Smith said he had settled in the prison and was content. He said he was worried about how he would feel when he stopped taking chlordiazepoxide at the end of the detoxification programme. The officer advised him to speak to healthcare staff about this.
46. Later that afternoon, Mr Smith told an officer that he had spoken to someone from the healthcare team who had explained that he needed to complete the detoxification programme before they could consider prescribing more medication. Mr Smith said he understood this but was concerned that when his mood was low, he was more likely to cut himself. The officer told the investigator that he reminded Mr Smith that he could speak to him or any other member of staff if he was feeling down and that he spoke to Mr Smith whenever he could during the day, so that he felt supported.

28 December 2015

47. On 28 December, an officer noted in the ACCT record that he had spoken to Mr Smith twice during the day, and said that they were positive interactions. He said that Mr Smith mixed well with other prisoners on the wing during the association period.

29 December 2015

48. On the morning of 29 December, Mr Smith's cellmate was released from prison. He told the investigator that he had got on well with Mr Smith, who was generally happy, despite his depression and stress. He said that they both sometimes had sleepless nights and would watch television together and talk. He said that he had not seen any indication that Mr Smith intended to kill himself. On the morning of his release, he said they had spoken about possibly meeting up sometime in the future.
49. At 11.50am, an officer noted in the ACCT record that he had spoken to Mr Smith, who said he was settled and was coping with his medication. Mr Smith said he had no thoughts of suicide or self-harm.
50. At 2.15pm, when an officer checked Mr Smith, he said that he was okay but wanted the prison doctor to prescribe him medication to help him sleep.
51. At 8.45pm, day staff handed over to the night manager. No one mentioned or identified any concerns about Mr Smith. An operational support grade (OSG) was the night patrol officer on C Wing that night. At 10.00pm, he checked Mr Smith, who appeared to be asleep in bed.

30 December 2015

52. At 1.00am, when the OSG made a further ACCT check, he noted that Mr Smith was awake and making a cup of tea. He asked Mr Smith if he was okay and Mr Smith said he was at the time, but he had had a bad couple of hours. He told the investigator that he told Mr Smith to ring his cell bell at anytime if he wanted to talk.
53. At 4.49am, the OSG shone his torch through the door observation panel to check Mr Smith, but his view was obstructed because Mr Smith had covered the panel with some material. He said that there was a small gap at the left of the panel, which allowed him to see into the cell a little. He said that he was satisfied that he saw what he believed was the shape of Mr Smith's body, sleeping in the bed. He did not turn the cell light on because he did not want to disturb Mr Smith any further because he knew he had been awake in the early hours of the morning.
54. At 5.16am, the OSG went to Mr Smith's cell, as part of a routine morning count of prisoners. He said he could not see into the cell, as the observation panel was completely covered and the small gap that he had previously looked through was no longer there. He banged on the door several times and called Mr Smith's name but got no response. He radioed the night manger, who said he would come immediately and that he should unlock and go into Mr Smith's cell if he could not get a response from him. (At night, prison staff on wings do not carry

standard prison keys but have a cell key in a sealed pouch for use in emergencies.)

55. The night patrol officer on the wing next to C Wing heard the OSG banging on the cell door and went to see if he needed help. She arrived at the cell at 5.19am. He broke the seal on his key pouch and unlocked the cell. As he did, the night manager arrived on the landing. CCTV shows this was 5.20am. The night manager and the OSG discovered that Mr Smith was hanging behind the cell door from torn sheets woven through an air vent above the door, which was then tied to a radio cable.
56. The night manager radioed an emergency medical code blue. This was recorded in the control room log at 5.22am and staff called an ambulance at 5.23am. He cut the ligature while the OSG supported Mr Smith's weight and they lowered him to the floor.
57. The night manager assessed Mr Smith and found no signs of life. He started chest compressions to try to resuscitate Mr Smith. Within two minutes of the code blue, a nurse arrived with an emergency response bag and oxygen. She checked Mr Smith but found no signs of life. His neck was stiff and his lips were blue. She took over chest compressions.
58. Two more staff had arrived at the cell a minute after the nurse. The nurse asked a healthcare colleague to bring a defibrillator, which she collected from the centre office and returned about a minute later. The nurses attached the defibrillator, which found no shockable heart rhythm and they continued with chest compressions. At 5.28am paramedics arrived, assessed Mr Smith and shortly afterwards recorded that he had died.
59. Mr Smith had left three short notes in his cell indicating his intention to kill himself.

Support for prisoners and staff

60. Around 7.10am on 30 December, a prison manager debriefed the staff involved in the emergency response to offer support and ensure they had the opportunity to discuss any issues arising. The staff care team also offered support. Most of the staff we interviewed said they had received very good support.
61. Later that day, staff reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by Mr Smith's actions. The prison posted notices informing other prisoners of Mr Smith's death, and offering support.

Contact with Mr Smith's family

62. Mr Smith had named a friend as his next of kin. The prison and police were unable to trace him from the information Mr Smith had given. They then found contact details for Mr Smith's mother. At 11.30am on 30 December, the prison's family liaison officer and the deputy governor visited Mr Smith's mother, informed her that he had died, and offered condolences and support.
63. On 31 December, the deputy governor spoke to Mr Smith's mother by telephone to discuss funeral arrangements. The family liaison officer telephoned her on Monday 4 January 2016 and subsequently made arrangements for Mr Smith's

funeral, which took place on Monday 25 January 2016. Exeter paid funeral costs in line with Prison Service policy.

Post-mortem report

64. The post-mortem findings confirmed that Mr Smith had died from hanging. Toxicology results found the presence of sertraline, levetiracetam and chlordiazepoxide at levels that would have been expected, but also showed the presence of citalopram and mirtazapine, which he had not been prescribed.

Findings

ACCT procedures and assessing risk

65. Prison Service Instruction (PSI) 64/2011 (Safer Custody) and PSI 07/2015 (Early Days in Custody) list a number of risk factors and potential triggers for suicide and self-harm. Mr Smith had a number of these risks when he arrived at Exeter:
- A history of self-harm and attempted suicide.
 - He had recently taken an overdose of illicit drugs.
 - He had depression.
 - He was withdrawing from alcohol and had a history of drug misuse.
 - He had a chronic physical condition (epilepsy).
66. Mr Smith had arrived with a suicide warning form completed at court. Prison staff considered Mr Smith's risks and appropriately began monitoring him under ACCT procedures when he arrived. However, we are concerned that the ACCT process did not operate fully effectively to support and protect Mr Smith.
67. PSI 64/2011 requires case reviews to be multidisciplinary where possible and, for the first case review, among others, the assessor, the person who raised the initial concern, and a healthcare representative must attend. While the assessor attended, there was no member of healthcare staff at the first ACCT case review on 23 December.
68. The SO who chaired the case review said she believed that Mr Smith's health needs would have been identified at his initial health screens, so there was no need to invite a nurse. This shows a misunderstanding of purpose of the ACCT case review and the value of input from staff from a range of disciplines, who can help bring different perspectives about how to manage the care of prisoners at risk. In addition, as there was no member of healthcare staff present, the staff were unaware that the reception nurse had identified current self-harm and this issue was not discussed at the case review.
69. The staff at the first case review assessed Mr Smith's risk of suicide and self-harm as low, apparently because of his presentation. They required staff to monitor Mr Smith by having two conversations with him during the day and observe him three times at night, a low level of observations.
70. PSI 07/2015 requires staff to be alert to prisoners' increased risk of suicide or self-harm during their early days in custody, and to act appropriately to address any concerns. In February 2016, we issued a Learning Lessons Bulletin about early days and weeks in custody based on a review of self-inflicted deaths of prisoners in their first weeks at a prison. The most common theme we identified was the failure of staff to identify and act on factors known to increase prisoners' risk of suicide. Too often the staff made judgments based on the prisoner's presentation, rather than identifiable risk factors.
71. Mr Smith had just arrived in prison. He had not yet received his medication for epilepsy, depression or insomnia. He had a history of attempted suicide and self-harm, had recently overdosed on drugs and had said he was currently self-

harming by scratching his arms. He misused drugs and alcohol, was suffering from alcohol withdrawal symptoms and had just started a detoxification programme. Mr Smith had no family contact, said he was depressed about being back in prison after six years in the community and was worried about being homeless. There is little evidence that staff took all of these factors into account when assessing his risk.

72. We recognise that in the immediate period before his death, Mr Smith gave little indication that he was at very high and imminent risk of suicide and it would have been difficult for staff to anticipate his actions. However, we are concerned that staff did not fully consider all his risk factors and ACCT procedures did not operate effectively to protect him. We 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 guidance, including that:

- **ACCT case reviews are multidisciplinary and first case reviews always include a member of healthcare staff.**
- **Staff consider and record all known risk factors when determining the level of risk of suicide and self-harm and set levels of observations that reflect that risk.**

Cell observation panel

73. When the OSG found Mr Smith's door observation panel covered at 4.49am on 30 December, he could not properly see into the cell to assure himself of Mr Smith's safety. We consider he should have radioed the night manager for help immediately. Even though he believed that Mr Smith was asleep, he was unable to be sure of this.
74. Prison Service Instruction (PSI) 24/2011, about the management and security of prisons at night, requires staff who find observation panels covered to inform the night manager, who should send additional staff to the cell to deal with the incident. Exeter's local procedure on 'Accounting for Prisoners' says that staff must physically see every prisoner when checking them. When observation panels are covered, they must obtain a response from the prisoner and report the matter immediately so that the panel can be uncovered.
75. The OSG did not follow these procedures and it is possible that Mr Smith was hanging behind the cell door when he looked through the observation panel at 4.49am. We make the following recommendation:

The Governor should ensure that staff satisfy themselves of a prisoner's safety if they cannot see them properly at checks and alert the relevant manager if there are any concerns or the observation panel is covered.

Clinical care

76. The clinical reviewer concluded that the general standard of care that Mr Smith received was not equivalent to the care he would have received in the community.

He had a number of concerns that were likely to have contributed to a deterioration in Mr Smith's mental health and his decision to take his life.

Continuity of healthcare

77. PSO 3050 requires that healthcare staff should make efforts to obtain any information required from the prisoner's GP or other relevant service he or she has recently been in contact with, to inform his clinical care in prison. Mr Smith gave the reception nurse his GP's details and details of his recently prescribed medication. However, there is no evidence that healthcare staff requested Mr Smith's community GP records or details of the medication he had been prescribed. We found no clear process for checking newly arrived prisoners' medication with community sources or for recording when community records have been requested.
78. As part of the investigation, the clinical reviewer contacted Mr Smith's community GP and established that he had been prescribed the following medication before he went to prison: levetiracetam (500mg), nitrazepam (25mg), thiamine (200mg) and sertraline (200mg). Mr Smith arrived at Exeter with sertraline 200mg daily (100mg twice daily) and a nurse correctly noted this. A prison GP said that he had prescribed medication based on the medications Mr Smith had with him when he arrived. However, he prescribed only 100mg of sertraline daily rather than 200mg. The nurse and GP had noted that Mr Smith had arrived with 5mg of nitrazepam. The GP considered that the chlordiazepoxide would replace the nitrazepam. However, Mr Smith had been prescribed 25mg in the community not 5mg.
79. The clinical reviewer considered that the effect of healthcare staff not checking Mr Smith's previous medication was serious and meant he received a significantly smaller dose of antidepressants than he had been used to taking. He considered that the reduced dose was likely to have had an adverse effect on Mr Smith's mental health.
80. The clinical reviewer considered it was also significant that the healthcare team did not establish the correct dose of nitrazepam that Mr Smith had been prescribed in the community. Although the chlordiazepoxide Mr Smith was taking for alcohol withdrawal treatment would have had an initial effect of replacing the nitrazepam, this would have become significantly less effective as the dose of chlordiazepoxide reduced each day. Nitrazepam is a benzodiazepine and he noted that Mr Smith was likely to have experienced increasing symptoms of benzodiazepine withdrawal as the week progressed, as his chlordiazepoxide dose reduced. We make the following recommendations:

The Head of Healthcare should ensure that community GP records and other relevant records are routinely requested and considered for newly arrived prisoners to ensure appropriate prescribing decisions and continuity of care.

Alcohol and substance misuse treatment

81. A reception nurse recorded that Mr Smith had recently used heroin before coming to prison. He tested positive for cocaine, opiates and benzodiazepines.

However, Mr Smith said his use of heroin was occasional and the prison doctor did not consider there was a need to address Mr Smith's drug use and potential opiate dependence.

82. Healthcare staff appropriately referred Mr Smith for alcohol detoxification treatment. However, during his first night assessment, no one recorded his pulse and blood pressure, which are important baseline measurements to assess an individual's physical health.
83. Mr Smith had epilepsy and had a seizure on his second day at Exeter. The clinical reviewer considered that this indicated that Mr Smith's medication for alcohol withdrawal was inadequate. However, nurses did not refer Mr Smith to a GP after the seizure and no one considered whether his medication needed adjusting to help prevent further seizures or whether he needed anti-epileptic medication.
84. Exeter did not have a clinical policy for assessing and determining the suitability of alcohol detoxification treatment prescribed to prisoners, and the general nursing staff were not trained in substance misuse. A prison GP said that there was no routine planned review of patients who had completed alcohol detoxification at Exeter and it was not clear from the clinical record how the healthcare team planned to monitor Mr Smith's progress. We make the following recommendation:

The Head of Healthcare should ensure there is a local clinical policy for assessing and treating prisoners withdrawing from alcohol and drugs, which incorporates current national clinical guidance and includes a clear process to follow up patients with complex and co-existing needs.

**Prisons &
Probation**

Ombudsman
Independent Investigations