Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dale Samm, a prisoner at HMP The Mount, on 25 September 2022

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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 Dale Samm was found hanged in his cell on 25 September 2022 at HMP The Mount. He was 28 years old. I offer my condolences to Mr Samm's family and friends.

Mr Samm had been at The Mount for less than four weeks when he died. I am satisfied that he gave staff no indication that he was at risk of suicide and self-harm during that time and that staff could not have foreseen his death.

My investigation found some delays with the emergency response when Mr Samm was found unresponsive. There was a delay in staff calling the medical emergency code and in entering the cell. Although it made no difference to the outcome for Mr Samm as he was dead when found, it is important that staff respond quickly to future medical emergencies as any delays could be critical.

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 **June 2023**

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Summary

Events

1. On 23 August 2022, Mr Dale Samm was sentenced to two months and 23 days in prison for property damage and carrying a bladed weapon. He was moved to HMP The Mount on 30 August.

2. Mr Samm had a history of depression and substance misuse. He was referred to the mental health team and to the substance misuse team.

3. On 12 September, a nurse conducted a mental health triage assessment for Mr Samm. Mr Samm said he was fine and had no thoughts of suicide or self-harm. The nurse noted that Mr Samm was stable in mood and had no concerns about him. He concluded that Mr Samm did not need support from the mental health team.

4. At around 5.30am on 25 September, during a routine check, an Operational Support Grade (OSG) saw that Mr Samm was slumped between his bed and his cell window. She knocked on the cell door, but Mr Samm did not respond. She thought he might be intoxicated, so she radioed for staff assistance. Then she noticed that Mr Samm was not breathing. Another OSG joined her and saw that Mr Samm had a ligature around his neck. She shouted to the first OSG to call a medical emergency code, which she did. Control room staff called for an ambulance. The two OSGs remained outside the cell until other staff arrived.

5. Around 90 seconds later, several officers arrived at Mr Samm's cell and entered. They assessed that Mr Samm was dead as he was cold and stiff. They did not start CPR.

6. The control room updated the ambulance service that Mr Samm had rigor mortis (stiffening of the body after death), which changed the urgency of the call. At around 7.00am, paramedics arrived at Mr Samm's cell, and at 7.15am, pronounced that he was dead.

Findings

7. Mr Samm did not give any indication to staff that he was at risk of suicide and self-harm during his few weeks at The Mount. We are satisfied that staff could not have foreseen his death.

8. There were delays with the emergency response when Mr Samm was found unresponsive. The OSG should have called a medical emergency code when she realised that Mr Samm was not breathing and once the second OSG joined her, they should have entered the cell rather than waiting for officers to arrive.

9. We found that despite Mr Samm having been at The Mount for almost four weeks, he had not been allocated a key worker. Key work sessions might have identified that Mr Samm was struggling.

Recommendations

- The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that they:
    - use the appropriate emergency code when they discover a medical emergency; and
    - enter cells as quickly as possible when it is safe to do so.
- The Governor should ensure that the key worker scheme provides meaningful and ongoing support to all prisoners in line with national policy.

The Investigation Process

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

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

12. The investigator interviewed seven members of staff between 18 October and 4 November 2022. These were carried out by video conferencing.

13. NHS England commissioned an independent clinical reviewer to review Mr Samm's clinical care at the prison. He jointly interviewed all staff with the investigator.

14. We informed HM Coroner for Hertfordshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The Ombudsman's family liaison officer contacted Mr Samm's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Samm's brother asked:

    - Whether a fight in the days leading up to his death contributed to Mr Samm's decision to end his life.

    - Whether there was any contact with an ex-girlfriend which might have contributed to his decision.

    These issues have been addressed in the report.

16. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

17. We sent a copy of our initial report to Mr Samm's brother. He did not notify us of any factual inaccuracies.

Background Information

HMP The Mount

18. HMP The Mount is a medium security prison holding approximately 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare and GP services. Hertfordshire Partnership University NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP The Mount was in March 2022. Inspectors found that the prison was dealing with significant weaknesses identified in previous inspections, but prisoners were more positive about many aspects of their care. Recorded levels of self-harm had slightly increased, with too little support for prisoners in crisis. Staff had struggled to implement the new case management support process, which sometimes ended without having addressed the prisoner's risks and needs. Not enough support was given to new arrivals.

Independent Monitoring Board

20. 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 28 February 2022, the IMB reported that on the whole, the prison was a clean and tidy environment. The new healthcare provider gave a satisfactory service.

Previous deaths at HMP The Mount

21. Mr Samm was the seventh prisoner to die at The Mount since September 2020. Of the previous deaths, one was self-inflicted, two were drug related and three were from natural causes.

22. We have previously made recommendations to The Mount about the use of medical emergency codes.

Key Events

23. On 23 August 2022, Mr Dale Samm was convicted of property damage and carrying a bladed weapon. He was sentenced to two months and 23 days in prison and was sent to HMP Bedford. Mr Samm had previously been in prison in 2021.

24. Mr Samm had no history of suicide attempts or self-harm in prison. Mr Samm's medical records show he had a period of treatment for low mood and anxiety from 2015 to 2018 and had a history of substance misuse.

25. On 23 August, a nurse conducted Mr Samm's reception health screen. He noted that Mr Samm was engaging well and did not have any thoughts or history of suicide attempts or self-harm. He referred Mr Samm to the mental health team for triage due to his past prescription for antidepressants.

26. On 24 August, a nurse conducted the secondary health screen and noted that Mr Samm told him that he previously suffered from depression and anxiety. However, he said he had no thoughts of suicide or self-harm. Another nurse then conducted a mental health triage assessment. She recorded that Mr Samm was not currently on medication for his mental health and appeared to be in a stable mood. She told Mr Samm to contact the prison GP if anything changed.

27. On 30 August, Mr Samm was moved to HMP The Mount. At his reception screening, he said he had no thoughts of suicide or self-harm.

28. A nurse conducted Mr Samm's health screen. He noted that Mr Samm was prescribed methadone (a heroin substitute) and referred him to the substance misuse team. He made a referral to the mental health team as Mr Samm had previously been prescribed antidepressants. Mr Samm said he had no thoughts of suicide and self-harm.

29. On 1 September, a nurse from the substance misuse team saw Mr Samm about his methadone treatment. Mr Samm asked for his dose of methadone to be reduced, so it was reduced by 5ml a week. Mr Samm did not express any problems or concerns during this appointment.

30. On 10 September, Mr Samm was moved off the induction wing. Mr Samm also engaged with the education team about enrolling in a course.

31. On 12 September, Mr Samm received a mental health triage assessment following the referral by the nurse. A nurse conducted the review. The nurse said Mr Samm engaged well in the assessment and talked about his previous treatments. Mr Samm told the nurse that he was having flashbacks to a past incident where he was stabbed but said he had no thoughts of suicide or self-harm. The nurse advised Mr Samm to self-refer to the Improving Access to Psychological Therapies (IAPT) team for support with his flashbacks and said he could contact the mental health team for any further support. He told Mr Samm he would not be on the mental health team caseload.

32. On 14 September, a nurse saw Mr Samm to discuss his substance misuse treatment, and he did not report any issues.

33. On 20 September, Mr Samm's probation practitioner completed a resettlement plan for Mr Samm as his sentence was due to end in October.

34. On 23 September, Mr Samm was moved to another cell on the same wing. Staff said this was due to Mr Samm and his cellmate not wanting to share together after moving from the induction wing. Mr Samm was allocated a single cell.

35. At around 8.00pm on 24 September, Operational Support Grade (OSG) A conducted a routine check of all prisoners on the wing, including Mr Samm. She said there was nothing out of the ordinary and she did not have any concerns about him at that time.

36. Mr Samm had one number on his prison phone account, which was his mother's. He did not make any calls while at The Mount.

Events of 25 September

37. At 5.32am on 25 September, during a roll check, OSG A saw that Mr Samm's light was on, and Mr Samm was at the far wall between the bed and the window, slumped over. She did not realise straightaway that he was hanging, so she knocked a few times to try and rouse him. When she got no response, she then requested assistance over the radio. She said at this point she thought Mr Samm could have been intoxicated.

38. A Custodial Manager (CM) said that he became aware of the situation when OSG A called for 'an assist'. The CM said he asked for clarification, and she responded that she wanted staff assistance. He went to the cell and was joined on the way by three members of staff.

39. OSG A said she knocked a few more times after calling for help and noticed that Mr Samm's chest was not moving, and she realised he was not breathing.

40. OSG B was the first member of staff to respond to the request for assistance. As she approached Mr Samm's cell, OSG A told her she saw Mr Samm slumped and he was not responding. OSG B said she went to the door, looked in and saw that Mr Samm had a ligature around his neck. She then shouted to OSG A to radio a code blue which she did.

41. OSG A said she considered the risk of entering Mr Samm's cell, but as she did not see him hanging initially, she did not believe it was safe. OSG B said that she did not enter the cell straightaway as other officers were at the cell very quickly and took over. CCTV shows there was around 90 seconds between OSG B getting to the cell and other officers arriving.

42. The CM said that while he was on the way to the cell the code blue was called. One of the OSGs met him at the gate and told him Mr Samm had a ligature around his neck. He went to the cell, looked through the flap and immediately went into the cell. He was followed in by an officer. Two other officers remained outside the cell.

43. The officer used his anti-ligature knife and cut the ligature. The CM said Mr Samm was cold and stiff, and he said to staff that CPR was probably not appropriate. The officer also said it was obvious that Mr Samm was deceased when they entered the

cell. He attached a defibrillator, which did not shock and advised CPR. He did one compression and stopped as it was clear Mr Samm was dead. He said he felt it would have been disrespectful to continue CPR.

44. The second officer said that she was communicating with the control room, providing information for the ambulance. She updated the control room that Mr Samm was deceased, and they passed this to the ambulance service. The control room noted that they told paramedics rigor mortis had set in. The ambulance service told the control room it could be up to six hours before someone attended. The third officer said it was approximately 5.46am when officers decided there was no more they could do.

45. At 7.03am paramedics arrived at Mr Samm's cell. They pronounced him dead at 7.16am.

Contact with Mr Samm's family

46. The prison's family liaison officer and a prison chaplain visited the home of Mr Samm's parents and told them that he had died and offered condolences. The prison paid toward to the cost of the funeral in line with national policy.

Support for prisoners and staff

47. After Mr Samm's death, a prison manager 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.

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

Post-mortem report

49. The post-mortem report established that Mr Samm died from hanging. Toxicology analysis found that Mr Samm had only methadone, which he was prescribed, in his system.

Findings

Assessment of risk

50. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), lists a number of risk factors and potential triggers for suicide and self-harm. It says all staff should be aware of the risk factors and should start suicide and self-harm procedures (known as ACCT) when they identify that a prisoner might be at risk.

51. Mr Samm did not have a history of suicide attempts or self-harm but did have some risk factors. He had substance misuse issues and a history of low mood and anxiety, all of which had been identified and recorded. However, we consider that these risk factors did not warrant ACCT monitoring.

52. Mr Samm gave no indication to staff that he was at risk of suicide and self-harm during his few weeks at The Mount. We are satisfied that staff could not have foreseen his death.

53. There is no record that Mr Samm was involved in any fights while at The Mount. The prison confirmed that he did not report anything to staff.

Emergency response

54. PSI 24/2011 on the management and security of nights says that under normal circumstances authority to unlock a cell at night must be given by the night orderly officer and no cell will be opened unless two/three (subject to local risk assessment procedures) members of staff are present one of whom should be the night orderly officer. However, it says that the preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff should do a dynamic risk assessment to decide whether it is safe to enter a cell.

55. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires prisons to have a two-code medical emergency response system: code blue for prisoners who are unconscious or having breathing difficulties; and code red for severe blood loss. Calling a medical emergency code should trigger the control room to call an ambulance immediately and for healthcare staff to attend with the appropriate medical equipment.

56. OSG A, who saw Mr Samm slumped by his window, did not notice that he was hanging and thought initially that he might be intoxicated. She called for assistance, which was justified in the circumstances. However, when she noticed that Mr Samm was not breathing, she should have called a code blue in line with national policy expectations.

57. We accept that the situation was unclear initially and that it was reasonable for OSG A to assess that it was not safe for her to enter Mr Samm's cell alone. However, once OSG B arrived and saw that Mr Samm was hanging, they should have entered the cell. It was another 90 seconds before other staff arrived and entered the cell. It made no difference to the outcome in this case as Mr Samm was dead when found, but a delay could be critical in a future medical emergency. We recommend.

The Governor should ensure that all prison staff understand their responsibilities during medical emergencies, including that they

- **use the appropriate emergency code when they discover a medical emergency; and**
- **enter cells as quickly as possible in life-threatening situations when it is safe to do so.**

Key worker support

58. The Prison Service's Manage the Custodial Sentence Policy Framework 2018 states that all prisoners within the male closed estate must be allocated to a prison officer who will have a key worker role. It also says that Governors must ensure that time is made available for an average of 45 minutes per prisoner per week for the delivery of key work, which should include time with each prisoner.

59. During the time Mr Samm was at The Mount he was not allocated a key worker and did not receive any sessions. While it is not possible to say whether staff would have picked up on anything in this case, key work sessions are a useful way to monitor the wellbeing of prisoners. We recommend:

The Governor should ensure that the key worker scheme provides meaningful and ongoing support to all prisoners in line with national policy.

Clinical care

60. The clinical reviewer found that the care Mr Samm received was of a good standard and was equivalent to that which he could have expected to receive in the community.

61. The clinical reviewer did not identify any issues with the mental or physical healthcare provided to Mr Samm while he was in prison.

Inquest

62. The inquest, held from 3 to 6 September 2024, concluded that Mr Samm died by suicide.

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