Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Smyth, a prisoner at HMP Altcourse, on 12 October 2024

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Paul Smyth was found hanging in his cell at HMP Altcourse on 12 October 2024. Staff tried to resuscitate him but were unsuccessful. He was 60 years old. I offer my condolences to Mr Smyth's family and friends.

Mr Smyth was the fourth prisoner to take his own life at Altcourse in 2024.

Mr Smyth had been at Altcourse for less than five days when he died. I am satisfied that Mr Smyth gave no indication to prison staff that he was at imminent risk of suicide and that they could not have foreseen his actions.

The clinical reviewer found that Mr Smyth, who was withdrawing from drugs, was not properly monitored by healthcare staff, and was not offered relief for his diarrhoea and stomach pains. She concluded that the care he received was only partially equivalent to that which he could have expected to receive in the community.

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

Adrian Usher
Prisons and Probation Ombudsman **August 2025**

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Summary

Events

1. On 7 October 2024, Mr Paul Smyth was sentenced to five months in prison for possessing a bladed article in a public place. He was sent to HMP Altcourse. It was not his first time in prison.

2. Mr Smyth had a history of substance misuse and tested positive for benzodiazepines and amphetamines when he arrived at Altcourse. He said he had no thoughts of suicide or self-harm. He was put on a benzodiazepine detoxification programme and monitored by healthcare staff for drug withdrawal symptoms.

3. On 8 October, Mr Smyth told an officer he was not feeling well due to going through 'detox' but would feel better in a few days.

4. A mental health nurse conducted a routine mental health assessment the same day. The nurse noted that Mr Smyth presented as low in mood due to his withdrawal, but he engaged well and she found no evidence of significant anxiety or depression. Mr Smyth said he had no thoughts of suicide or self-harm. The nurse assessed that Mr Smyth did not need mental health support at that time and discharged him from the mental health team.

5. On 10 October, Mr Smyth soiled himself while in bed. He complained of stomach pains and said he felt awful. A nurse saw him but there is no record Mr Smyth was offered any medication for his pain or diarrhoea.

6. On 11 October, a healthcare assistant noted that Mr Smyth appeared very low in mood. She sent a task (on Mr Smyth's electronic medical record) to the mental health team asking them to assess him.

7. At 8.10am on 12 October, a prisoner found Mr Smyth with a belt around his neck, tied to the ladder of his bed. The prisoner shouted to staff. Staff immediately ran to Mr Smyth's cell and at 8.11am, entered the cell, removed the belt, and started CPR. Healthcare staff arrived and CPR continued.

8. At 8.26am, ambulance paramedics arrived. They assessed that Mr Smyth was dead and at 8.28am, pronounced life extinct.

9. The toxicology report showed that Mr Smyth had amphetamines in his blood, which indicated that he had taken amphetamines shortly before he died.

10. After Mr Smyth's death, a prisoner told us that Mr Smyth was being bullied for his canteen (items bought from the prison shop). Another prisoner said that they had seen other prisoners taking items from Mr Smyth's cell on 10 October.

Findings

11. Mr Smyth had no significant risk factors for suicide and self-harm when he arrived at Altcourse. Although he felt down due to his drug withdrawal over the next few days, he did not give any indication to staff that he was at risk of suicide. We are satisfied that staff could not have foreseen his actions.

12. The clinical reviewer concluded that the care Mr Smyth received for his physical health and for his substance misuse was only partially equivalent to that which he could have expected to receive in the community. She found that there was insufficient physical health monitoring during his withdrawal and that some healthcare staff mistakenly thought that Mr Smyth was detoxing from alcohol rather than benzodiazepines.

13. The clinical reviewer found that Mr Smyth received good mental health care, equivalent to that which he could have expected to receive in the community. However, she considered that further guidance was needed for healthcare assistants on how to escalate concerns around prisoners with very low mood.

14. Evidence obtained from two prisoners suggests that Mr Smyth was being bullied (cell theft is a form of bullying). Following a previous death at Altcourse, we made a recommendation to the Director that he should review the prison's Violence Strategy so that it provides clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence. While a revised strategy was issued in November 2024, we consider it inadequate as it still provides little guidance to staff on how to identify and support victims of bullying and intimidation.

Recommendations

- The Head of Healthcare and the Merseycare Mental Health Lead should review the process for healthcare assistants to escalate concerns about prisoners with very low mood to a nurse.

- The Head of Healthcare should ensure that for prisoners withdrawing from drugs, staff:

    - follow a clinical detoxification care plan;

    - complete physical observations, including NEWS2, to ensure timely assessment and monitoring of patients at risk of deterioration;

    - provide documented symptomatic relief (e.g., for stomach cramps and diarrhoea), in line with NICE NG57 guidelines; and

    - audit detoxification cases regularly to ensure care plans are in place.

- The Head of Healthcare should review and update the Standard Operating Policy for managing benzodiazepine dependence within three months.

- The Director should update the prison's Violence Strategy so that it provides clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence.

The Investigation Process

15. HMPPS notified us of Mr Smyth's death on 12 October 2024.

16. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

17. The investigator visited Altcourse on 31 October. He obtained copies of relevant extracts from Mr Smyth's prison and medical records. He also obtained CCTV and Ambulance Service records.

18. The investigator interviewed two prisoners at Altcourse on 31 October. In March 2025, he interviewed a member of prison staff over video call.

19. NHS England commissioned an independent clinical reviewer to review Mr Smyth's clinical care at the prison. In December, the clinical reviewer and investigator conducted joint interviews with six members of healthcare staff by video call.

20. A second clinical reviewer subsequently took over and completed the clinical review.

21. We informed HM Senior Coroner for Liverpool of the investigation. We have sent the Coroner a copy of this report.

22. The Ombudsman's office contacted Mr Smyth's brother to explain the investigation and to ask if he had any matters he wanted us to consider. Mr Smyth's brother raised two issues which have been answered in separate correspondence.

23. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies. HMPPS and Practice Plus Group provided an action plan which is annexed to this report.

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

Background Information

HMP Altcourse

25. HMP Altcourse is a local prison in Liverpool that houses adult male prisoners and young offenders who are either sentenced or on remand from the Cheshire and Merseyside courts. About half of the prisoners are on remand or serving very short sentences. Sodexo took over management of the prison from G4S in June 2023.

26. Practice Plus Group provides primary healthcare and clinical substance misuse services seven days a week. Mersey Care offers mental health services from Monday to Friday, 8.00am to 8.00pm. Phoenix Futures provides non-clinical substance misuse services from Monday to Friday, 8.00am to 4.00pm.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Altcourse was in November 2021. At the time of inspection Altcourse was run by G4S.

28. Inspectors noted that prisoners' safety was not sufficiently good and had deteriorated since the last inspection in 2017. Eight prisoners had taken their own lives; four in the previous 12 months. Levels of self-harm remained high and Early Learning Reviews had not been transferred into longer term safety plans. Staffing numbers had a detrimental impact on the development of primary and mental health care.

29. Staff-prisoner relationships remained a real strength. Inspectors observed supportive and caring interactions between staff and prisoners across all units. Key work took place more frequently than in similar prisons and was of a better standard.

Independent Monitoring Board

30. 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 30 June 2024, The IMB reported that the increased prison population had made it more difficult to safely house vulnerable prisoners. They were concerned that many prisoners who died at Altcourse had only been there for a few days. Substance misuse had been a recurring factor in most deaths, underscoring the crucial role of the substance misuse team in supporting prisoners. There had been ongoing challenges in engaging short-term prisoners in managing substance misuse.

Previous deaths at HMP Altcourse

31. Mr Smyth was the nineteenth prisoner to die at Altcourse since October 2021. Of the previous deaths, six were self-inflicted, ten were from natural causes and two were drug related.

32. Following a self-inflicted death in February 2024, we recommended that the prison should review its Violence Strategy so that it provided clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence. The prison accepted this recommendation, with a target date of November 2024 for implementation.

Key Events

33. On 7 October 2024, Mr Paul Smyth was sentenced to five months in prison for possessing a bladed article in public. He was sent to HMP Altcourse. It was not his first time in prison.

34. At reception, Mr Smyth told staff he had no mental health issues, had never self-harmed, and did not have thoughts of suicide or self-harm. (Mr Smyth had a history of anxiety and paranoid schizophrenia. In July 2024, he threatened neighbours and jumped out of a window, leading to concerns about the risk he posed to himself and others. He was taken to A&E for assessment. He had also taken an overdose 20 years earlier.)

35. Reception staff noted that Mr Smyth appeared to be under the influence of drugs and had tested positive for benzodiazepines (used to treat anxiety and depression but also widely abused) and amphetamines (stimulant drugs used in ADHD treatment but also widely abused).

36. Mr Smyth told the GP at Altcourse that he used heroin daily and asked for methadone (used to reduce heroin withdrawal symptoms but can also be abused). Mr Smyth did not test positive for heroin, so the GP refused to prescribe methadone. The GP prescribed diazepam (a benzodiazepine, detoxification medication).

37. Mr Smyth was moved into a shared cell on Furlong Red, an induction and detoxification unit.

38. On 8 October, a prison custody officer (PCO) saw Mr Smyth for a key worker session. The PCO noted that they discussed Mr Smyth's drug and alcohol dependency. Mr Smyth told the PCO that he was detoxing and felt low due to drugs. He said he had no debts. Mr Smyth said he was aware he could seek mental health support if needed.

39. Later that morning, a nurse from the Integrated Mental Health Care Team (IMHCT) saw Mr Smyth for a routine mental health assessment. He noted Mr Smyth appeared low in mood. Mr Smyth told the nurse he did not have any current mental health problems but had paranoid schizophrenia 20 years earlier and was prescribed antipsychotic medication. The nurse noted that Mr Smyth had been under the care of a psychiatrist in 2011 according to his medical records. The nurse assessed Mr Smyth and found no evidence of significant anxiety or depression. He discharged him from the IMHCT.

40. A member of Phoenix Futures, who provide psychosocial support for prisoners with substance misuse issues, also saw Mr Smyth that day. Mr Smyth told them he wanted to work with them for help and support with his drug misuse. They gave him leaflets about harm minimisation and advised him to contact the team if he required any further support.

41. At 11.16am, Mr Smyth telephoned his brother. The investigator listened to the recording of Mr Smyth's call. During the call, Mr Smyth sounded upbeat, and his cellmate, could be heard in the background. Mr Smyth and his brother discussed

his offence, arrest, and sentence. Mr Smyth said he had two months left in prison (his release date was 4 December) and his flat was secured for his release.

42. Mr Smyth told his brother he missed taking drugs. Mr Smyth's brother asked about mental health support. Mr Smyth told his brother he was too tired from coming down off amphetamines to engage with the support offered. Mr Smyth declined his brother's offer to send money to him, saying he did not need it for his remaining eight weeks in prison.

43. At 4.15pm, Mr Smyth telephoned his brother again, asking him to send £60 to a prisoner's prison account for a Trespass jacket and some other items of clothing. (The prisoner received the £60 in his prison account the next day.)

44. Throughout the night, healthcare staff conducted four welfare checks on Mr Smyth, with no concerns raised.

45. On the morning of 9 October, healthcare staff took Mr Smyth's clinical observations, which raised no concerns.

46. On 10 October, Mr Smyth defecated in his bed and staff noted that his cell was covered in faeces. A healthcare staff member recorded in Mr Smyth's medical record that he was not assessed for withdrawal symptoms that day due to a "dirty protest". (A "dirty protest" is when a prisoner deliberately defecates or urinates in their cell without using the toilet as an act of non-compliance.)

47. A nurse saw Mr Smyth in his cell. He told her he was detoxing from drugs, had stomach pains, and felt awful. The nurse recorded that Mr Smyth was on alcohol detoxification (which was incorrect). There was no record that she offered any relief for Mr Smyth's pain or diarrhoea.

48. Staff subsequently reassessed Mr Smyth as high risk for cell sharing on medical grounds, meaning he was not suitable to share a cell. The cellmate moved out, leaving Mr Smyth alone in the cell.

49. A prisoner and wing cleaner told us he helped clean Mr Smyth's room and delivered new bedding. He said Mr Smyth seemed alright but did not want to discuss what had happened.

50. On 11 October, the cellmate told us that he saw other prisoners taking noodles and vape capsules from Mr Smyth's cell. He said that he told wing staff. No information related to this was recorded in Mr Smyth's record and staff did not recall being told about it.

51. That afternoon, a healthcare assistant, conducted Mr Smyth's secondary health screening. She noted that Mr Smyth appeared very low in mood and was hard to understand. She sent a task (on Mr Smyth's electronic medical record) to the mental health team asking them to assess him.

Events of 12 October

52. A PCO carried out the early morning roll check on 12 October. She said at interview that at around 5.05am, she shone her torch into Mr Smyth's cell and saw him sitting on the side of his bed. She said Mr Smyth turned his head to look at her.

53. At around 8.10am, a prisoner was delivering breakfast packs to cell doors. He told us that Mr Smyth's cell flap was open, and he could see Mr Smyth with a belt around his neck, tied to the third rung on the bunk bed ladder. He said Mr Smyth was leaning forward into the belt. The prisoner said he banged on Mr Smyth's door to try and get a response, and when no response came, he shouted for staff.

54. The investigator watched the body-worn video camera (BWVC) footage, which showed staff responding to the prisoner's shouting. Staff arrived at Mr Smyth's cell door at 8.11am and immediately entered. A PCO entered the cell first, followed by three other prison staff. Staff removed the belt from Mr Smyth's neck, laid him on the floor, and started CPR. BWVC footage shows Mr Smyth was very pale with no colour in his face.

55. Staff radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) and at 8.12am, control room staff called an ambulance.

56. A nurse arrived. She noted Mr Smyth's airway was clear, but he was unresponsive, with no signs of life, no pulse, and was not breathing. The nurse took over chest compressions. At 8.14am, more healthcare staff arrived.

57. According to the communications log, the ambulance arrived at the gate at 8.15am.

58. At around 8.16am, the nurse applied a defibrillator (a machine that can detect electrical activity in the heart and deliver a shock to restart the heart) to Mr Smyth (no shock was advised at any point), while another member of healthcare managed Mr Smyth's airways.

59. At 8.26am, ambulance paramedics arrived at Mr Smyth's cell. They assessed Mr Smyth and concluded that he was dead. They asked staff to stop CPR. At 8.28am, a paramedic pronounced life extinct.

Contact with Mr Smyth's family

60. On 12 October, the prison appointed a member of staff as the family liaison officer (FLO).

61. Mr Smyth had not provided an address for his next of kin, his brother. At 12.00 pm, The FLO telephoned Mr Smyth's brother to inform him of Mr Smyth's death and apologised for breaking the news over the phone (Mr Smyth's brother lived in Northern Ireland).

62. The FLO maintained contact with Mr Smyth's brother over the following weeks, offering support and advice.

63. The prison contributed to the costs of Mr Smyth's funeral in line with national policy.

Support for prisoners and staff

64. After Mr Smyth'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.

65. The prison posted notices informing other prisoners of Mr Smyth'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 Smyth's death, and prison carers were deployed on the wing to support prisoners if needed.

Post-mortem report

66. We have not received the post-mortem report. However, the toxicology report found evidence of amphetamines in Mr Smyth's blood.

Findings

Assessment of Mr Smyth's risk of suicide and self-harm

67. Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), which was in force at the time of Mr Smyth's death, set out the procedures (known as ACCT) that staff should follow when they identified that a prisoner was at risk of suicide or self-harm. It set out the risk factors and triggers that could indicate increased risk. (The policy has since been superseded by the Prison Safety Policy Framework though ACCT procedures remain broadly the same.)

68. Mr Smyth did not have any significant risk factors for suicide and self-harm when he arrived at Altcourse. A mental health diagnosis, such as schizophrenia, is a risk factor, but Mr Smyth was not open about this. Even if had told the reception nurse about his diagnosis, we do not consider that this in itself would have merited ACCT procedures being started for Mr Smyth. Likewise, his suicide attempt happened a long time ago, and so would not have been a significant risk factor when he arrived at Altcourse.

69. A few days after arriving at Altcourse, a nurse noted that Mr Smyth appeared low and he told her that he was withdrawing from drugs and felt awful. He gave no indication that he was at risk of suicide or self-harm and so there was no reason to start ACCT monitoring. We are satisfied that staff could not have foreseen Mr Smyth's actions.

Illicit drug use

70. The toxicology report noted that Mr Smyth had amphetamines and diazepam in his blood. Mr Smyth had been prescribed diazepam but not amphetamines. Amphetamines can typically be detected in the blood for about 12 to 24 hours after use. The exact duration can vary depending on factors such as the individual's metabolism, the dosage taken, and their overall health. Mr Smyth was at Altcourse for over four days, so this suggests that he took amphetamines while in prison. This could also explain why Mr Smyth's condition worsened and he soiled himself on 10 October (a nurse told us that taking illicit substances while on detoxification medication could have this effect).

71. We presume that Mr Smyth obtained amphetamines while at Altcourse, rather than that he brought any in secreted on his person.

72. The Acting Head of Safety told us that prisoners on Furlong Red are more likely to seek illicit substances, and that while illicit substances were available on Furlong Red, they were not a huge problem. She outlined current strategies such as searches and drug screenings but noted challenges posed by prisoners who know the system.

73. In their most recent inspection, HMIP noted that prison managers at Altcourse had identified drugs as a key threat. Random mandatory drug testing (MDT) had been reintroduced, with 19% of prisoners testing positive for drugs. Measures to disrupt drug supply included body scanners, enhanced searches of staff and visitors, and

scanning incoming mail. However, suspicion-led drug testing had not resumed, and frequent staff redeployment reduced the security team's capacity for intelligence-led cell searches.

74. We recognise that illicit substances are endemic across the prison estate. As Altcourse appears to be appropriately tackling this issue, we make no recommendation.

Clinical care

75. The clinical reviewer found that Mr Smyth's physical health care was only partially equivalent to that which he could have expected to receive in the community. She found that clinical welfare checks were not consistently completed daily as part of monitoring Mr Smyth's withdrawal. There were four checks on the night of 8/9 but this was not repeated on other nights and there were none on the first night. Staff recorded that they did not complete a welfare check on 10 October due to Mr Smyth's "dirty protest". The clinical reviewer said that this was an inappropriate term as it was more likely the effect of loose bowels and a symptom of Mr Smyth's withdrawal. Although a nurse saw Mr Smyth later that afternoon, she did not assess his withdrawal status or clinical deterioration, nor offer relief for his diarrhoea and stomach pains.

76. The clinical reviewer found Mr Smyth received good mental health care, equivalent to that which he could have expected to receive in the community. However, the clinical reviewer considered that rather than submitting a task to the mental health team when Mr Smyth appeared to have very low mood, the healthcare assistant should have consulted with a nurse who could have decided on the best course of action. The lack of escalation to a nurse meant that there was no senior clinical oversight to consider Mr Smyth's thoughts in relation to low mood, including his risk of suicide and self-harm and whether ACCT procedures were needed.

77. The clinical reviewer found that Mr Smyth's substance misuse care was partially equivalent to that which he could have expected to receive in the community. He was appropriately assessed, and a treatment plan was put in place on 7 October. However, she found that the rationale for Mr Smyth's detoxification was not clearly documented and there were some clinical entries that indicated some staff thought Mr Smyth was on alcohol detoxification rather than benzodiazepine detoxification. She found that Mr Smyth did not have a detoxification care plan in place and that the Standard Operating Policy for managing benzodiazepine dependence needed updating as it did not specify the frequency of monitoring.

78. We recommend:

The Head of Healthcare and the Merseycare Mental Health Lead should review the process for healthcare assistants to escalate concerns about prisoners with very low mood to a nurse.

The Head of Healthcare should ensure that for prisoners withdrawing from drugs, staff:

- **follow a clinical detoxification care plan;**
- **complete physical observations, including NEWS2, to ensure timely assessment and monitoring of patients at risk of deterioration;**
- **provide documented symptomatic relief (e.g. for stomach cramps and diarrhoea) in line with NICE NG57 guidelines; and**
- **audit detoxification cases regularly to ensure care plans are in place.**

The Head of Healthcare should review and update the Standard Operating Policy for managing benzodiazepine dependence within three months.

Emergency response

79. Ambulance service records show that the ambulance was held at the prison gate for two minutes. It then took around nine minutes for paramedics to get to Mr Smyth's cell. The prison has told us that there was no delay and that the time taken was due to the distance and the fact that the ambulance had to pass through three gates, which had to be opened and closed in turn before the ambulance could pass through each one.

80. The time taken made no difference to Mr Smyth who was dead when found. However, it could make a crucial difference in future cases if ambulances are taking over ten minutes to get from gate to cell. We bring this to the Director's attention.

Allegations of bullying

81. A nurse told us that when Mr Smyth had soiled himself, his cellmate, was unkind to him about it, and she challenged this behaviour. The cellmate said Mr Smyth was embarrassed about soiling himself.

82. After Mr Smyth had died, a prisoner said that other prisoners had been taking items from Mr Smyth's cell. He said he reported this to staff, though there is nothing in Mr Smyth's prison record to corroborate this. Another prisoner said he had heard that Mr Smyth was being bullied for his canteen (items bought from the prison shop).

83. There was nothing in Mr Smyth's prison record about the events of 10 October when he soiled himself. We would have expected a record to have been made about this, but it was not. It is therefore possible that reports of potential bullying (cell theft is a form of bullying) from his cellmate, were also not recorded by prison staff. However, we cannot say for sure whether staff were made aware. We also cannot say what impact, if any, this had on Mr Smyth.

84. Following an investigation into a self-inflicted death at Altcourse in February 2024, we recommended that the prison should review its Violence Strategy so it provided clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence. The prison accepted this recommendation, with a target date of November 2024 for implementation.

85. An updated Violence Strategy, dated November 2024, was shared with us. However, it still has very little guidance on identifying and supporting victims. We recommend:

The Director should update the prison's Violence Strategy so that it provides clear guidance to staff on how to identify and support prisoners at risk of bullying, intimidation, or violence.

Inquest

86. At the inquest held from 6 to 8 July 2026, the jury concluded that Mr Smyth died by suicide.

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