Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Timothy Smith, a prisoner at HMP Risley, on 20 May 2020

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 Timothy Smith was found hanged in his cell at HMP Risley on 20 May 2020. He was 29 years old. I offer my condolences to his family and friends.

Mr Smith had only been at Risley for seven weeks when he died. He had a history of substance misuse, attempted suicide and self-harm, and while he denied any suicidal intent, he said he was struggling to cope with the restricted COVID-19 regime, and this had impacted on his mental health.

Staff faced significant challenges due to the restrictions imposed in response to the COVID-19 pandemic, with significantly less meaningful contact with prisoners. If staff had more opportunities to interact with Mr Smith, it is possible that they might have identified he needed additional support, was using drugs and may have been the victim of bullying.

I am concerned that when he told a mental health nurse that he was having thoughts of self-harm three weeks before his death, she did not open suicide and self-harm procedures (known as ACCT) and did not share this information with prison staff.

The post-mortem examination confirmed that Mr Smith had used psychoactive substances (PS) before his death. Although this was not found to have caused his death, PS is known to affect mental health adversely. I am concerned that Mr Smith was able to obtain PS with apparent ease at Risley, even though strict restrictions had been put in place during the current COVID-19 lockdown. Risley needs to continue in its efforts to reduce the supply of and demand for drugs.

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

Sue McAllister CB
Prisons and Probation Ombudsman **September 2021**

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Summary

Events

1. In October 2016, Mr Timothy Smith was sentenced to two and a half years in prison for actual bodily harm. He was released from prison on licence on 29 January 2020 but was recalled to HMP Forest Bank on 11 March. He was transferred to HMP Risley on 25 March.

2. Mr Smith had a long history of mental health issues, substance misuse and self-harm. The mental health team at Risley supported him and prescribed medication to treat his symptoms of depression and anxiety. He was compliant in taking his medication.

3. Mr Smith expressed some unhappiness at the very limited time that prisoners were permitted to spend out of their cells due to the COVID-19 pandemic. On 27 April, he told a mental health nurse during a telephone review that this resulted in him having thoughts of self-harm and in hearing voices. However, neither healthcare nor prison staff raised any concerns about him or considered starting suicide and self-harm procedures.

4. Although Mr Smith's mother raised her concerns with prison staff that he had accumulated drug debts, Mr Smith did not tell staff about this and there was no evidence that he had misused illicit substances, was in debt or had been bullied. Mr Smith did not express any thoughts of suicide or self-harm in the period before his death.

5. At around 3.19pm on 20 May 2020, an officer found Mr Smith hanged at the back of his cell. Staff were unable to resuscitate him and at 3.27pm, the prison GP pronounced that he had died. Post-mortem toxicology results identified that he had taken psychoactive substances (PS) before he died.

Findings

Assessment of risk

6. Mr Smith had a number of risk factors when he was recalled to Risley: he had a long history of mental health issues and was taking antipsychotic medication, he had substance misuse issues and a history of suicide attempts and self-harm.

7. We are concerned that staff placed too much emphasis on Mr Smith's assertions that he was 'fine' and did not give sufficient weight to his risk factors.

8. When Mr Smith told a mental health nurse that he had thoughts of self-harm and was hearing voices, she should have started suicide and self-harm prevention procedures, known as ACCT. At the very least, she should have shared this information with prison staff.

COVID -19 restrictions

9. The very restricted COVID-19 regime meant that prison staff had fewer opportunities to engage with Mr Smith and this would have reduced their ability to identify possible signs of distress, drug taking, bullying or a deterioration in his mental health.

10. The COVID-19 restrictions also meant that Mr Smith's only contact with mental health staff was conducted over the telephone by a nurse who had never met him in person.

11. Despite his risk factors, Mr Smith was not considered a priority prisoner who needed extra support in the form of more frequent contact with staff. This meant that he was not allocated a key worker at Risley during the pandemic. This resulted in fewer opportunities for prison staff to have meaningful contact with him and potentially identify his risks and address his needs.

Drug strategy at HMP Risley

12. Although Risley has a comprehensive drug strategy, Mr Smith was still able to obtain drugs in the prison. The prison revised its drug strategy following Mr Smith's death but must continue to work towards reducing supply and demand.

Clinical care

13. The clinical reviewer concluded that that the care that Mr Smith received was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor and Head of Healthcare should ensure that staff take into account all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.

- The Head of Healthcare should ensure that healthcare staff share important information about a prisoner's risk to himself with prison staff.

- The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

The Investigation Process

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

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

16. The investigator interviewed five members of staff at Risley. The interviews were completed by telephone due to the restrictions imposed in response to the COVID-19 pandemic.

17. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

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

19. We contacted Mr Smith's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Smith's family wanted to know if he had used drugs in prison.

20. Mr Smith's family received a copy of the draft report. They did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified three factual inaccuracies in the report which have been amended and the report updated accordingly. All recommendations were accepted.

Background Information

HMP

22. HMP Risley is a resettlement prison. Greater Manchester Mental Health NHS Foundation Trust provides healthcare services in the prison. Change Grow Live provides substance misuse services. There is 24-hour healthcare cover.

HM Inspectorate of Prisons

23. The most recent full inspection of HMP Risley was in June 2016. Inspectors reported that support for prisoners at risk of suicide and self-harm was adequate, but the quality of ACCT documentation varied, and some did not demonstrate sufficient interaction between staff and prisoners. Inspectors found that the mental health team was enthusiastic and well led. They noted that a weekly meeting identified prisoners who needed immediate attention and that those who needed routine assessment were usually seen within two weeks.

24. In November 2020, inspectors completed a scrutiny visit to Risley on the conditions and treatment of prisoners during the COVID-19 pandemic. They noted that for most prisoners, the regime was severely limited to around one hour a day unlocked, which was a serious concern. A lack of in-cell telephony placed pressure on prisoners to make their calls during the short time available out of their cell.

25. Inspectors noted that the amount of violence and self-harm had reduced at the start of the COVID regime restrictions. There had been a subsequent rise in the number of incidents, but this remained below pre-pandemic levels. They found evidence of good staff engagement with prisoners, key work had been well embedded in the prison before the pandemic, and weekly checks on the wellbeing of more vulnerable prisoners and those near to release had continued during the COVID-19 period. However, the impact of the lack of time spent unlocked for most prisoners was a serious concern.

Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 March 2018, the IMB reported that 53% of prisoners on A-E Wings did not feel safe. The number of prisoners on suicide and self-harm monitoring procedures at Risley had decreased.

Previous deaths at HMP [Prison]

27. Mr Smith was the third prisoner to take his life at Risley since May 2018. There were no similarities between our findings in the investigations of those deaths and those of Mr Smith's.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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. There should be regular multidisciplinary review meetings involving the prisoner.

29. As part of the process, a caremap (a 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.

Exceptional Delivery Model for Key Work

30. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation which each of their allocated prisoners.

31. The key worker scheme was suspended across the prison estate on 24 March 2020 due to the COVID-19 pandemic. To ensure that meaningful interaction continued for priority prisoners, such as those who were at risk of suicide or self-harm, the Prison Service introduced the Exceptional Delivery Model for keywork in May 2020. This provides that an officer will have a weekly conversation with prisoners identified as vulnerable.

Key Events

32. Mr Timothy Smith had a history of mental health issues, including low mood, anxiety, depression and attempted suicide and self-harm (including taking an overdose and jumping off a bridge in 2015). He had a history of substance misuse which was often linked to hallucinations and anti-social behaviour. He had spent time in a mental health hospital but had not been diagnosed with a mental health illness.

33. In October 2016, Mr Smith was sentenced to two and a half years in prison for actual bodily harm. He received an indefinite restraining order against the two victims, one of whom was his partner. This was his first time in prison.

34. Mr Smith served time in a number of prisons. In January 2017, he was sentenced to a further four years in prison for robbery and assault.

35. Mr Smith was monitored under suicide and self-harm procedures (known as ACCT) on two occasions in prison: once in 2016 when he harmed himself after he was sentenced and once in July 2019 when he expressed thoughts of suicide after a panic attack.

Release from prison

36. On 29 January 2020, Mr Smith was released on licence to an approved premises (probation hostel). Mr Smith's community probation officer recorded that he had been stable in prison, though his anxiety had significantly increased before his release.

37. After his release, the community probation officer noted that Mr Smith breached the conditions of his licence, began to use crack cocaine and amassed debts which affected his anxiety. Despite warnings about his behaviour, Mr Smith continued to misuse illicit substances daily. He subsequently reported that he was hearing voices and he tested positive for crack cocaine on eight occasions. He declined support for his substance misuse and presented with indications of possible self-harm. The probation officer noted that Mr Smith's behaviour suggested he was deliberately trying to be recalled into custody.

38. On 12 February, a community consultant psychiatrist saw Mr Smith, who admitted using alcohol and crack cocaine. He said that he felt low and struggled to sleep. The consultant noted that Mr Smith had a depressive illness, suicidal thoughts and auditory hallucinations. He prescribed him citalopram (an antidepressant) and asked his GP to follow up his care and refer him to the community mental health team.

Mr Smith's return to custody

39. On 10 March 2020, the Probation Service recalled Mr Smith to prison because of his behaviour. On 11 March, he was taken to HMP Forest Bank. Mr Smith's person escort record (PER) that travelled with him to Forest Bank noted that he had psychosis.

40. A nurse completed Mr Smith's initial health screen when he arrived at Forest Bank. She recorded in his medical record that he had a history of mental health issues, self-harm and substance misuse, namely cocaine and cannabis. She noted that he had psychosis and anxiety for which he was prescribed olanzapine (an antipsychotic) and citalopram. Mr Smith admitted that he had used drugs the previous day but declined the support of substance misuse services. The nurse referred Mr Smith to the mental health team, and he was subsequently prescribed olanzapine.

41. Over the next few days, Mr Smith completed his prison induction and received his recall pack which explained why he had been returned to custody.

42. A substance misuse worker saw Mr Smith on 16 March. Mr Smith wanted to stop smoking and was prescribed nicotine replacement therapy treatment.

43. A community probation officer recorded that Mr Smith had phoned him and told him that he was happy to be back in prison. He said he was no longer taking drugs and therefore did not need to participate in drug support programmes. He said that whenever he was next released from prison, he intended to comply with his licence conditions.

44. A community probation officer was due to meet Mr Smith at the prison on 19 March, but all prison visits were stopped due to the COVID-19 pandemic.

45. On the morning of 25 March, healthcare staff assessed Mr Smith as fit to transfer to HMP Risley. His prescribed medication was recorded as olanzapine.

HMP Risley

46. Mr Smith arrived at Risley on the afternoon of 25 March. A nurse completed Mr Smith's initial and second health screen as a full health assessment in line with the standard procedure at Risley.

47. The nurse noted Mr Smith's history of attempted suicide and self-harm and that he had anxiety, depression and intermittent psychosis and had spent time in a psychiatric hospital. Mr Smith said he had last misused drugs three weeks earlier in the community and had no current thoughts of self-harm. Mr Smith had no outstanding medical appointments, no physical health issues and had not seen a doctor recently. Mr Smith said that his olanzapine helped him. She referred Mr Smith to the prison GP and mental health team.

48. That evening, a prison GP continued Mr Smith's olanzapine prescription.

49. An officer completed Mr Smith's first night induction. Mr Smith said that he had asked to be moved to Risley because they could support his mental health, and that he was aware of the channels to use if he needed any help.

50. Mr Smith arrived at Risley at the start of the COVID-19 pandemic. To minimise transmission of the virus, prisoners spent 23 hours a day in their cells, association with other prisoners was very limited, the key worker scheme was suspended, visits from family and others were stopped, and much face-to-face contact between prisoners and healthcare staff was also stopped.

51. On 2 April, a prison GP wrote to Mr Smith saying he could not see him to review his medication, olanzapine, due to the COVID-19 situation. He said that if Mr Smith was happy with his current medication, it would continue to be prescribed but, if it was not working or if he wanted to change his medication or have a different dose, he should speak to the nursing staff or send a letter to the prison doctors.

52. On 20 April, an officer from the Offender Management Unit (OMU) introduced herself to Mr Smith as his Offender Manager. Mr Smith raised concerns that his probation officer would be unable to visit him due to the COVID-19 lockdown. She told him she would support him as much as she could, and that Mr Smith's keyworker could also help him. Mr Smith said that he had previously completed a number of prison courses and wanted to get a job at Risley. He also asked for substance misuse support and she referred him to the substance misuse team.

53. On 21 April, a community mental health nurse asked the prison's mental health team for an update about Mr Smith as he had been referred to the community mental health team. A nurse told them that Mr Smith was currently under the care of the prison's mental health team and that his care would be transferred to relevant community services on his release.

54. That day, the Offender Manager visited Mr Smith to give him the parole decision paperwork about his recall. Mr Smith said he intended to ask for an oral hearing, for which his solicitor would have to submit an application on his behalf. He also wanted to contact his probation officer.

55. On 22 April, a medical record entry noted that Mr Smith had not attended his appointment with the pharmacy. The Head of Healthcare told the investigator that this was not a missed appointment as the pharmacist would not have seen Mr Smith in person and was only reviewing prescriptions.

56. On 24 April, a substance misuse worker wrote to Mr Smith with a welcome pack and said that she would await his response to engage with him.

57. On 27 April, Nurse A, a mental health nurse, assessed Mr Smith by telephone. She noted his history of attempted suicide, self-harm, mental health issues and contact with community psychiatric services. Mr Smith told her that he was just about managing to cope in prison at that time. He said that he was hearing voices, which had increased when he felt stressed, and that he also had paranoia. Mr Smith said that his medication, olanzapine, worked. He told her that he had previously been prescribed citalopram in the community and did not know why this had stopped when he arrived at Forest Bank. She sent a task to her healthcare colleagues to restart prescribing citalopram for him and noted that he would remain on the mental health team's caseload.

58. Nurse A noted that Mr Smith said that he had some thoughts of self-harm, which he attributed to having long periods locked in his cell. However, Mr Smith said that he had no suicidal thoughts. He admitted using crack cocaine approximately seven weeks earlier. She told the investigator that Mr Smith did not give her any significant cause for concern. She noted that Mr Smith needed substance misuse support.

59. On 28 April, the Offender Manager met Mr Smith to complete his public protection paperwork, which related to his restraining order. Mr Smith said he fully understood the implications of the paperwork. She noted that Mr Smith was a little anxious and she agreed to help him make sure that his probation officer's telephone number was registered on his PIN phone contact list.

60. The prison GP authorised Mr Smith's citalopram prescription which started on 1 May 2020. He was permitted to have the medication in possession, alongside his already prescribed olanzapine.

61. On 6 May, the community probation officer recorded that she had received a phone call from Mr Smith's mother who said that she had sent Mr Smith £265 over the last week to pay debts that he had amassed before he was recalled to prison. However, his mother believed that her son's debts had actually been accumulated since his return to prison. The probation officer agreed that this was likely. Mr Smith's mother said that her son had called her again that day and told her that he had been beaten up for an outstanding debt of approximately £90 and that she had paid this as well. The probation officer told Mr Smith's mother that she should stop sending him money, and that Mr Smith appeared to be replicating the behaviour he had shown in the community. The probation officer said she would contact his offender supervisor.

62. On the morning of 7 May, the community probation officer emailed the prison's Offender Management Unit and shared her concerns about Mr Smith and asked them to look into the matter.

63. Later that afternoon, the Offender Manager spoke to wing staff and asked them to follow up on the community probation officer's concerns about Mr Smith. Wing staff visited Mr Smith that day. Mr Smith said that he was 'fine' and thanked staff for checking on him. He denied that he had been assaulted, and said he was fine. The prison staff did not see any marks on Mr Smith that could have been attributed to an assault.

64. The Offender Manager relayed this information to Mr Smith's mother, who said she was unsure if he was lying to her and trying to manipulate her into sending him money. The Offender Manager submitted a security intelligence report to ask staff to keep an eye on Mr Smith.

65. On 11 May, Mr Smith phoned his mother and a friend from the prison PIN phone.

66. That day, Mr Smith also phoned his community probation officer. Mr Smith told her that he was 'okay' but 'fed up' with the COVID-19 situation. He asked about his parole date. The community probation officer told him that he could expect a review in around 12 months' time. She advised him that he needed to work with the prison's substance misuse services and that he may have to complete a Thinking Skills Programme course before his release from prison. Mr Smith said that he had not taken drugs since he returned to prison and assured her that everything was okay. Mr Smith did not mention any debt issues nor raise any concerns about his mental health.

67. The Offender Manager next saw Mr Smith on 14 May for another welfare check after the community probation officer had raised concerns. Mr Smith said he had

spoken to the probation officer and believed he would be in custody for another 12 months before a parole hearing. He talked about his time at HMP Kirkham, a Category D prison and he said how supportive it was. Mr Smith said that he was bored being locked up for extended periods. The Offender Manager told Mr Smith that the prison regime would change once it was safe, but he had to be patient.

68. On the morning of 19 May, the community probation officer received a phone call from Mr Smith's mother, who said that he had asked her for money to pay off his drug debts. She said that she was worried about him and thought that he might be harmed as a result of his debts. She had told him that she would not send him any money. She noted that Mr Smith's mother was clearly angry with her son but was also worried about his safety. She said that she would ask his offender supervisor to check on him.

69. That evening, the Offender Manager checked on Mr Smith, who was in bed watching television. He said he was 'fine'. She asked Mr Smith twice if he wanted to talk about anything or raise any concerns. Mr Smith said, "No, I'm fine, Miss". Wing staff had not reported any concerns about Mr Smith. The Offender Manager relayed this information to the community probation officer and submitted a security intelligence report noting that concerns had been raised about Mr Smith.

20 May

70. Risley told the investigator that they were unable to download a copy of the CCTV footage for 20 May as the file was too large, and the investigator was unable to visit the prison to view it due to the COVID-19 pandemic.

71. Mr Smith telephoned his mother in the morning. (After his death, Mr Smith's mother told prison staff that this had been a "bad" phone call.) The investigator was unable to listen to the recording as he could not visit the prison, and Risley did not provide a summary of the call.

72. In his police statement, Officer A said he completed a roll check on the wing at around midday. He said he opened the cell door and spoke to Mr Smith who was standing at the back of his cell. He said that he had no concerns about him.

73. That afternoon, an administrator in the Safer Custody Team reviewed the security intelligence report submitted the previous evening. She telephoned B Wing at 3.15pm and spoke to Officer B and asked for a member of prison staff to conduct a further welfare check on Mr Smith. In his police statement, he said he passed the concerns onto Officer A, who said he left the wing office to check Mr Smith around a minute later. Mr Smith's cell was located around 20 to 25 metres from the office.

74. When Officer A arrived at Mr Smith's cell, he looked through the cell door observation panel. He saw Mr Smith hanging at the back of the cell from a ligature (made from a cut piece of bed sheet), attached to the mesh on the window. Mr Smith was facing towards the cell door and was in a kneeling position. He shouted for staff assistance and immediately entered the cell. He supported Mr Smith's body while he cut the ligature.

75. Two officers arrived at Mr Smith's cell in seconds, just as Officer A had placed Mr Smith on the cell floor. Officer B radioed a medical emergency code blue and

asked for an ambulance to be called. (A code blue tells the control room that a prisoner is unresponsive or not breathing and that an ambulance must be called immediately). The control room recorded that this occurred at 3.17pm.

76. Officer A said that Mr Smith was cold to the touch and his body was clammy and rigid. He started chest compressions. Within a minute, another officer arrived at Mr Smith's cell with the emergency medical bag. They took turns trying to resuscitate Mr Smith.

77. Two nurses arrived at the cell at 3.24pm. While the staff continued with CPR, a nurse attached a defibrillator to Mr Smith, but it advised no shock. The officers continued with chest compressions, but Mr Smith showed no signs of life. He had no pulse, his pupils were fixed and dilated, and his face was cyanosed (a blue-purple discolouration of the skin due to insufficient oxygen in the blood).

78. A prison GP arrived at the cell at 3.26pm. After examining Mr Smith, he stopped CPR efforts and pronounced at 3.27pm that he had died. Paramedics arrived at the prison at 3.34pm and completed an electrocardiogram (ECG) to monitor heart activity. They agreed that Mr Smith had died.

Contact with Mr Smith's family

79. Risley appointed a prison manager as the family liaison officer (FLO). Mr Smith's nominated next of kin was his mother. Due to the COVID-19 pandemic, a Deputy Governor phoned Mr Smith's mother at around 4.30pm and broke the news of Mr Smith's death. Risley maintained contact with Mr Smith's family, and in line with national instructions, they contributed to the costs of his funeral.

Support for prisoners and staff

80. A duty governor debriefed prison staff involved in the emergency response individually. All staff and prisoners were offered the support of the prison's care team.

81. The prison posted notices informing other prisoners of Mr Smith's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm, in case they had been adversely affected by Mr Smith's death.

Post-mortem report

82. A pathologist concluded that Mr Smith died from compression of the neck due to hanging. Toxicology tests found that Mr Smith had used psychoactive substances (PS) before he died. Traces of olanzapine and citalopram (both of which he had been prescribed) were also found.

Inquest

83. An inquest was concluded in November 2024 which concluded that Mr Timothy Smith deliberately applied a ligature whilst alone in his cell; but it cannot be said whether he intended the act to be fatal. Given that prisoners were in their cells for

23 hours per day, in response to COVID-19, failure to increase routine checks and a lack of (insufficient) sufficient face to face support contributed to his mental state.

Findings

Assessment of risk of suicide and self-harm

84. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and that they manage prisoners identified as at risk under ACCT procedures. The PSI lists several risk factors and states that potential triggers should be continually assessed. It notes that any member of staff, who observes behaviour which may indicate a risk of suicide or self-harm, must start ACCT procedures.

85. When Mr Smith was recalled to custody, he had a number of risk factors: apart from the fact that he had been recalled, he had a long history of mental health issues and was taking antipsychotic medication, he had substance misuse issues and a history of suicide attempts and self-harm. He had not, however, been monitored under ACCT procedures since July 2019, and there was no immediate reason to monitor him under ACCT at that point.

86. Mr Smith's transfer to Risley coincided with the COVID-19 pandemic which resulted in a severely restricted prison regime and reduced access to support services. Most contact with healthcare staff, including mental health reviews, took place by telephone and not face to face.

87. Approximately four weeks after he arrived at Risley, a mental health nurse who had never met Mr Smith in person completed a mental health triage by telephone on 27 April. This had been delayed due to the restricted COVID-19 regime. The nurse recorded that Mr Smith had a number of new risk factors: he had stated that he was just about coping in prison, he had thoughts of self-harm due to the extended periods locked in his cell and he had auditory hallucinations.

88. Although the nurse prescribed antidepressant medication and Mr Smith remained on the mental health team's caseload, we are concerned that she did not give sufficient weight to Mr Smith's risk factors during this telephone assessment and placed too much emphasis on his assertion that he had no suicidal thoughts.

89. While staff judgement based on a prisoner's apparent mood and state of mind is important, it is only one indication of their risk. Staff should also recognise that prisoners often try to hide their distress, particularly in different settings and with people they do not know. Assessments based on behaviour and presentation must, therefore, be balanced against the available risk information.

90. We appreciate the difficulties staff face when conducting assessments by phone, as a person's body language cannot be gauged. However, we consider that the nurse should have recognised Mr Smith's multiple risk factors: his history of substance misuse, suicide attempts and self-harm, his potential mental health deterioration and current thoughts of self-harm and started ACCT procedures. At the very least, she should have told prison staff that Mr Smith was having thoughts of self-harm.

91. We make the following recommendations:

The Governor and Head of Healthcare should ensure that staff take into account all relevant risk information about prisoners when assessing their risk of suicide and self-harm and start ACCT procedures when appropriate.

The Head of Healthcare should ensure that healthcare staff share important information about a prisoner's risk to himself with prison staff.

COVID -19 restrictions

92. The restrictions imposed in response to the COVID-19 pandemic meant that prisoners were spending long periods locked in their cells, with significantly less interaction with staff and other prisoners than would normally have been the case. The key worker scheme was also suspended for prisoners unless they were identified as priority prisoners (such as those who were considered to be at risk of suicide or self-harm). We cannot say if the long periods of isolation affected Mr Smith's decision to take his life, or whether staff might have picked up on signs of distress if they had had more contact with him.

93. Staff on Mr Smith's wing had not known him before the pandemic and had very reduced opportunities to get to know him once the restricted regime was in place. Although prison staff took action promptly when Mr Smith's mother raised concerns about drug debts and bullying, Mr Smith denied having any problems and said he was 'fine'. If staff had had regular daily contact with Mr Smith and had seen him interacting with other prisoners – as they would have done in normal times – it is possible that they would have identified that he was taking drugs or being bullied or that his mental health was deteriorating, although we cannot be sure. Just as importantly, the restricted regime meant that Mr Smith had not had the opportunity to get to know staff and this may have limited his willingness to tell them about his concerns.

Clinical care

94. The clinical reviewer concluded that the care that Mr Smith received from healthcare staff at Risley was of a good standard and equivalent to that which he could have expected to receive in the community. The clinical reviewer noted that Mr Smith was appropriately prescribed antipsychotic and antidepressant medication.

Substance misuse

95. Mr Smith was appropriately referred to the substance misuse team. Despite his history of substance misuse and the post-mortem result which identified PS in his system, there was no intelligence to suggest that Mr Smith was misusing illicit substances at Risley. It is troubling that he was able to access PS, unknown to staff, particularly during the COVID-19 lockdown when severe restrictions had been put in place on prisoner and visitor movement.

96. Risley has a substance misuse strategy that sets out a number of actions to reduce the demand for and supply of illicit substances. HM Inspectorate of Prisons completed a scrutiny inspection in November 2020 and noted that violence and drug-related activity featured regularly. Although they found that Risley took an

active role in working with the police to reduce drug supply, it is clear that work is still needed to disrupt the supply and demand for PS.

Learning lessons

97. It is important that staff learn the lessons from the Ombudsman's investigations. We recommend:

The Head of Healthcare should share this report with Nurse A and discuss the Ombudsman's findings with her.

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Independent Investigations

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