Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Smith a prisoner at HMP Thameside on 6 September 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
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Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Smith was found hanged in his cell at HMP Thameside on 6 September 2015. He was 39 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith hanged himself on his first night at the prison. I am concerned that reception and first night staff did not know that Mr Smith had been recalled to prison, that he was charged with a violent offence against his partner, that he had previously attempted suicide, or that these factors increased his risk. Instead, staff relied too much on how Mr Smith appeared, rather than his risk factors for suicide. This is of particular concern as the prison had promised, after a previous death, to improve risk assessment of new arrivals, but this had clearly not happened.

Mr Smith was withdrawing from drugs, but – as we have also found in a previous investigation at Thameside - there were no effective instructions for checking such prisoners and a nurse did not check Mr Smith during the night as should have happened. The emergency response was extremely poor. No one properly examined Mr Smith for signs of life when he was found hanging and it is both unacceptable and disrespectful that staff did not cut the ligature until the police arrived more than two hours later.

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 **April 2016**

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Summary

Events

1. On 28 August 2015, Mr Mark Smith was released on licence from HMP High Down. On 3 September, he was arrested for an alleged violent offence against his partner. He was recalled to prison for breaching the conditions of his licence and remanded in custody for the further charge. On Saturday 5 September, he was taken to HMP Thameside.

2. Mr Smith had been recalled to prison, was potentially facing a long sentence for violence against his partner, had previously attempted suicide in prison and was withdrawing from drugs. These are factors that indicate a heightened risk of suicide. However, there is no evidence that reception and first night staff were aware of this or took them into account when assessing his risk of suicide. Instead, they relied only on Mr Smith's presentation and no one considered that he was at risk of suicide.

3. A doctor prescribed a low dose of methadone to help counter the effects of opiate withdrawal and Mr Smith was taken to the induction wing for substance users for observation. A nurse recorded that he had checked Mr Smith twice during the night, but there is no evidence of this. At 6.44am, an officer found Mr Smith hanged in his cell by a sheet and believed he was dead. The officer did not use a medical emergency code. Nurses arrived but left quickly as one of the nurses was upset. No one checked Mr Smith for signs of life or cut the ligature from around his neck. Paramedics arrived at Mr Smiths's cell about 25 minutes after Mr Smith was found hanged and recorded that he had died. Mr Smith's body was left hanging until the police arrived about two hours later. The police informed Mr Smith's family that he had died.

Findings

4. The investigation found that reception staff relied too heavily on Mr Smith's presentation when he arrived. We have previously found this at Thameside. The staff knew little about the circumstances of his return to prison and had little understanding of the risk factors they needed to take into account when assessing his risk of suicide.

5. We are concerned that during his first night at the prison a nurse recorded two checks, when there is no evidence they were done. Managers had not made it clear how often prisoners withdrawing from drugs should be checked, and there were no local instructions.

6. The emergency response was very poor. The officer who found Mr Smith hanged in his cell did not radio an emergency code, nurses did not bring emergency equipment, there was a delay calling an ambulance and no one examined Mr Smith for signs of life. It was extremely disrespectful to leave Mr Smith's body hanging for so long.

7. Although Prison Service instructions require prison staff to inform families of a death, the prison left it to the police to break the news to his partner and sister. We have criticised Thameside for this in a previous investigation.

Recommendations

- The Director and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception, first night staff and all others who assess risk:
    - Have a clear understanding of their responsibilities and the need to record relevant information about risk;
    - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm;
    - Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.
- The Head of Healthcare should ensure there is clear guidance outlining how often healthcare staff should check prisoners withdrawing from drugs or alcohol when they arrive at the prison and that checks continue until their condition has stabilised.
- The Director and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency, call an ambulance immediately, bring relevant emergency equipment and that there is no delay in ambulances and paramedics reaching the prisoner. Staff who find a prisoner hanging, should cut the ligature, lay the prisoner on a flat surface, check for signs of life as soon as possible and start resuscitation, if appropriate.
- The Director should ensure that, in line with PSI 64/2011, where possible, prison staff inform the next of kin of a prisoner's death without delay.

The Investigation Process

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

9. The investigator visited Thameside on 8 September 2015. She obtained copies of relevant extracts from Mr Smith's prison and medical records.

10. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.

11. The investigator interviewed 12 members of staff at Thameside in October. The clinical reviewer joined her for interviews with healthcare staff. The investigator interviewed three staff by telephone in November and two in January.

12. We informed HM Coroner for Inner South London of the investigation, who have us the interim cause of death. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Smith's sister and his partner to explain the investigation. Mr Smith's sister had no specific issues for the investigation to consider. We did not receive a response from Mr Smith's partner.

14. Mr Smith's family received a copy of the initial report. They raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

15. The prison also received a copy of the report. They pointed out a factual inaccuracy, and the report has been amended accordingly. The prison provided an action plan for the recommendations.

Background Information

HMP Thameside

16. HMP Thameside is a local prison in south east London that holds up to 900 men. It is privately run by Serco. Health services were delivered by Care UK until 31 March 2015, when the contract passed to Oxleas NHS Foundation Trust. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of Thameside was in September 2014. Inspectors reported that drug-dependent prisoners received consistent first night treatment. Prisoners were very positive about drug interventions and the vast majority surveyed said they received helpful support. Inspectors considered that the identification of those at risk of suicide and self-harm, and their management, had improved since the previous inspection. Inspectors noted that the prison was working on implementing recommendations made by the PPO from previous investigations into deaths.

Independent Monitoring Board

18. 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 June 2015, the IMB reported that Thameside was a good prison that had improved rapidly during the year. The IMB considered that communication between healthcare staff and custody staff was poor, but substance misuse services were effective.

Previous deaths at HMP Thameside

19. Mr Smith was the fifth prisoner to die at Thameside since it opened in March 2012. Two of the four previous deaths were due to natural causes, one was apparently self-inflicted and the most recent, in December 2014, was a result of drug toxicity.

20. We have previously made recommendations about identifying risk factors for suicide and self-harm and following national guidelines when breaking news of a death to families. In our investigation into the death in December 2014, we found failures in clinical care and that healthcare staff did not carry out clinical observations as instructed.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. Mr Mark Smith had been in prison before, most recently from May 2014 until August 2015, when he served a sentence for burglary. He had previously been treated for substance misuse problems. In February 2015, at HMP Bullingdon, he had handed segregation staff a ligature and threatened to kill himself because he wanted to speak to his daughter, who was unwell. In March, Mr Smith tried to suffocate himself, because he said he could not cope with being segregated. He was briefly supported by Prison Service suicide prevention measures (known as ACCT). He did not try to kill himself or harm himself again before he was released on licence from HMP High Down on 28 August.

23. On 3 September 2015, Mr Smith was arrested for an alleged serious violent offence against his partner. Police recorded that Mr Smith had broken his wrist and a couple of fingers and his arm was in plaster. Mr Smith said he did not take drugs and he received no treatment for drug dependency in police custody. The police did not assess Mr Smith as at risk of suicide or self-harm. On 4 September, police contacted Mr Smith's offender manager to notify her that he had been arrested for a serious violent offence. She agreed with her manager that Mr Smith should be recalled to prison, due to the nature of the alleged offence and revoked his licence.

24. The police completed Mr Smith's Person Escort Record (PER), a document which accompanies all prisoners when they move between police stations, courts and prisons. They wrote that Mr Smith had been charged with a serious violent offence against his partner, but did not record that he had been recalled to prison or any other risk factors. After a court appearance on 5 September, Mr Smith was remanded to HMP Thameside. He arrived at the prison around 2.30pm.

25. The reception manager said he recognised Mr Smith from a previous prison sentence at HMP Peterborough. Mr Smith told him that he had been released from High Down recently, but said that he did not think he had been on licence. The manager did not check this and accepted that Mr Smith had not been recalled to prison. He did not notice that Mr Smith had been remanded for a serious charge of violence against his partner. The manager said that he seemed polite and chatty during their conversation, and Mr Smith asked him to speak to wing officers so that he could get a job in the prison as soon as possible. He did not think that Mr Smith was at risk of suicide.

26. A prison custody officer booked Mr Smith into the prison when he arrived. He noted Mr Smith's previous prison number, which meant that staff had access to his previous records. He noted that Mr Smith had been remanded, although he did not know the circumstances of the charge. He told the investigator that he knew Mr Smith had been recalled to prison, but he did not record this. He said that it was the reception manager's job to check a prisoner's documents, so he did not look at Mr Smith's escort records, although he thought he might have seen his recall paperwork but could not remember specifically if he had. The officer did not record Mr Smith's history of attempted suicide and threats of self-harm. He said that Mr Smith seemed comfortable being in prison and he did not consider that he was at risk of suicide.

27. An officer completed a cell sharing risk assessment and considered Mr Smith as a high risk of violence towards a cellmate. He noted a previous assault on a cellmate at another prison. This meant that Mr Smith would not be allowed to share a cell.

28. Mr Smith phoned his partner (his alleged victim) from the prison reception area. An operational support officer told the investigator that she had supervised the call but she could not hear the conversation. Mr Smith told his partner that he expected a long sentence, between 8 and 12 years. He said he had told the prison that she was his next of kin, so "if anything happens to me, they will come to you first".

29. At an initial health screen, Mr Smith told a mental health nurse that he had been prescribed 55ml methadone each day at High Down. He said he had now not taken any for eight days and said he felt rough because of withdrawal symptoms. (Mr Smith was not prescribed methadone at High Down.) She assessed that Mr Smith had mild withdrawal symptoms (11 on the Clinical Opiate Withdrawal Scale, or COWS), and recorded that he was jittery and had a slight tremor. She noted that a urine test was positive for cocaine and opiates. She completed an initial assessment for the prison's integrated drug treatment system (IDTS), and recorded that he should be monitored for withdrawal symptoms. She did not specify how often. Mr Smith said that he was too tired to discuss his substance misuse care plan and she referred him to the reception GP.

30. The mental health nurse did not review Mr Smith's previous medical records and told the investigator that she did not know he had a history of attempted suicide or self-harm in prison. She said that she had never seen a prisoner's escort record. Mr Smith told her that he had had no thoughts of suicide or self-harm. She did not record the nature of Mr Smith's charge or alleged victim and said that she relied on prisoners to tell her whether they have been convicted and if they were facing a long sentence. She did not consider that Mr Smith was at risk of suicide.

31. At 4.15pm, Mr Smith saw the reception GP and told him that he smoked three to four bags of heroin daily and had last used it three days previously. The GP took Mr Smith's blood pressure and pulse and recorded both as normal. The GP agreed that Mr Smith's withdrawal symptoms were mild and assessed that he had a reduction in symptoms since the mental health nurse's assessment (a COWS score of 6). The GP prescribed 10ml methadone in line with the national prescribing protocol, but did not record how often staff should check him. He did not review Mr Smith's previous medical records and did not know that he had a history of attempted suicide or self-harm. He said that he did not know the nature of Mr Smith's charge and focussed on assessing his substance misuse needs. He did not consider Mr Smith at risk of suicide.

32. An officer completed the first night centre induction and noted nothing of concern. Mr Smith was given a single cell on the ground floor of the substance misuse stabilisation unit on A Wing. He was locked in his cell at 7.18pm.

33. CCTV records shows that Mr Smith was unlocked from his cell at 8.07pm and went to the medication hatch next to his cell. The mental health nurse gave him 10ml methadone, as prescribed by the reception GP. At 8.09pm, Mr Smith was

locked in his cell again. Mr Smith asked Officer A, the night officer, for some paper at 8.46pm. At 9.51pm, she went back to his cell and gave him some paper.

34. CCTV shows that Nurse A came onto A Wing from the clinic station next to the wing at 11.51pm. As he arrived he looked towards Mr Smith's cell and raised his hand, as if someone had spoken to him. He did not go to the cell door or speak to Mr Smith.

35. At 12.04am, Mr Smith asked Officer A for some more paper, which she gave him a short while later. She told us that Mr Smith had joked with her and there was nothing in his manner that had concerned her.

36. Nurse A wrote two entries in Mr Smith's medical records: the first at 12.54am and the next at 4.00am. He recorded that Mr Smith was awake and he could see no change on either occasion. CCTV shows that the nurse was only on A Wing at 11.51pm that night.

37. The next morning, Officer A checked prisoners on A Wing and got to Mr Smith's cell at 6.44am. She saw Mr Smith hanging and ran back to the wing gate shouting for help. The night manager and two operational support officers went to Mr Smith's cell. The manager then radioed for immediate medical assistance. The investigator listened to the radio transmission and the duty nurse acknowledged his call. Immediately after the request for medical assistance, an officer radioed a 'code blue' medical emergency, (indicating a life threatening incident involving breathing difficulties). When the investigator listened to the call, she found it difficult to hear due to background transmission noise. Neither the duty nurse nor Nurse A heard the code blue call. The control room did not hear the code blue either.

38. At 6.45am, the night manager opened the cell door but did not go in. An officer went into the cell and established that Mr Smith had hanged himself from a sheet tied to the light fitting. He touched Mr Smith's arm which was cold and indicated to the manager that he believed Mr Smith was dead.

39. A minute later, at 6.46am, the duty nurse and Nurse A arrived at the cell. They had brought no medical equipment with them. They did not go into the cell or examine Mr Smith, but stood at the door. The duty nurse was shocked when she saw Mr Smith, and, at 6.49am, Nurse A took her off the wing. The night manager rang for an ambulance directly from the wing telephone. London Ambulance Service recorded that they received the request for an ambulance at 6.52am.

40. At 6.58am, a rapid response car arrived at Thameside. No one opened the gate and, at 7.00am, the driver got out of the vehicle and went into the gate office. He returned to the car and sat outside the gate until 7.04am when the gate opened. At the same time an emergency ambulance arrived and both vehicles drove into the vehicle lock beyond the gate. It was 7.07am, when they were let into the prison. Paramedics arrived at Mr Smith's cell at 7.09am, 11 minutes after the rapid response car had first arrived at the prison. The paramedics assessed Mr Smith and recorded that he was dead. They did not cut the sheet from Mr Smith's neck and staff locked the cell after the paramedics left.

41. The prison notified the police of Mr Smith's death and they arrived at Mr Smith's cell at 8.28am. The duty nurse had contacted the Deputy Head of Healthcare at home, and told him that Mr Smith had died. He arrived on the wing at 8.39am with the Deputy Head. The Deputy Head told us he did not realise until someone opened the cell door that Mr Smith was still hanging. He was surprised that no one had moved him to the floor or the bed and covered him with a blanket out of respect. He finally cut the sheet around Mr Smith's neck at 8.51am, over two hours after he was discovered.

42. Mr Smith had written a letter to his family, which he left in his cell. He wrote about his funeral arrangements and said that he could not cope with another long prison sentence.

Contact with Mr Smith's family

43. Mr Smith had named his partner as next of kin when he arrived at Thameside and had listed his sister as another contact. The police told prison managers they would break the news of Mr Smith's death to his family and prison managers agreed. The police told Mr Smith's sister and partner later that morning. Prison staff did not suggest that they should inform his family or accompany the police.

44. The prison's family liaison officer contacted Mr Smith's sister and partner two days later and offered condolences and support. The prison contributed towards the cost of the funeral in line with national instructions.

Support for prisoners and staff

45. The duty governor debriefed the prison staff involved in the emergency response and offered his support and that of the staff care team. Healthcare staff were not included in the debrief as Prison Service instructions require, but said that the healthcare trust had supported them.

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

Findings

Assessment of risk of suicide and self-harm

47. Staff judgement is fundamental to the ACCT system. The system relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. Prison Service Instruction (PSI) 64/2011, which covers safer custody, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. None of the staff who had contact with Mr Smith considered him to be at risk of suicide despite his risk factors.

48. When he arrived at Thameside on 5 September, Mr Smith had been recalled to prison from a previous sentence and charged with a serious violent offence against his partner. He was facing a long prison sentence if found guilty. None of the reception and first night staff we spoke to indicated that they had considered whether any of these factors increased Mr Smith's risk of suicide. None of them were aware of the nature of Mr Smith's charge or his alleged victim so they could not have taken this into account.

49. PSI 64/2011 and PSI 07/2015 (Early Days In Custody), both list a number of risk factors and potential triggers for suicide. These include those charged with a violent offence, particularly against family members, those dependent on drugs, with a history of self-harm and attempted suicide, remand prisoners and those who have been recalled to prison after their licence had been revoked. The NHS document 'Clinical Management of Drug Dependence in the Adult Prison Setting' also highlights the heightened suicidal risk among opiate dependent prisoners. All of these risk factors applied to Mr Smith, yet there is little evidence that staff recognised them or considered them.

50. PSI 7/2015 requires that the PER and any other available documentation must be examined in reception to assess the risk of self-harm or harm to others by the prisoner, or harm from others. As reception staff did not properly consider the information on Mr Smith's escort record or his previous prison records, we do not think that the prison complied with this instruction. A prisoner's presentation can reveal something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is judged holistically.

51. In a thematic report about risk factors in self-inflicted deaths published by the Prisons and Probation Ombudsman in April 2014, we identified that too often reception assessments place too much weight on staff's perception of the prisoner and they do not consider all relevant information. We reinforced these messages in a recent learning lessons bulletin, issued in February 2016, about early days and weeks in custody. We also raised this issue in an investigation into a death at Thameside in December 2013. In response to our recommendation that prison provided an action plan which stated the following would be in place by August 2014:

- All first night centre staff, reception staff and healthcare staff will be subject to awareness training on the signs of self-harm/self inflicted deaths including information from suicide and self-harm warning forms, PERS and other sources.

- In addition to the guidance in PSI 64/2011 on identifying and managing risk, documentation will be produced locally so that any new reception will have a clear trail of notes identifying any known triggers, or any new concerns. This will include all identified risks from the safer custody PSI. The initial entries will be made by reception staff, followed by the healthcare staff stationed in reception, and then handed over to the first night centre. The document will be signed by each department including the final handover to the first night centre officer. The document will be accompanied by the CSRA, which will also highlight any concerns of risk. The information used for the document will come from court documentation, PERs, verbal handover from the escort staff and any first hand observations.

- Included in the documentation will be a separate check and signature for the reception manager and the first night centre manager.

52. The investigator found no evidence of these actions in Mr Smith's records or her interviews with staff. We make the following recommendation:

The Director and Head of Healthcare should produce clear guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that reception, first night staff and all others who assess risk:

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk;**
- **Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm;**
- **Open an ACCT whenever a prisoner has significant risk factors, irrespective of their stated intentions.**

Clinical care

53. Mr Smith told the mental health nurse he had been prescribed a 55ml dose of methadone daily at High Down. There is no evidence that he was prescribed methadone at High Down in his prison medical record, but neither the reception GP nor the nurse checked the record. Mr Smith did not tell police he was prescribed methadone when he was arrested, and did not receive methadone in police custody. However, Mr Smith's urine tested positive for opiates in prison and he had withdrawal symptoms during his initial health screen. The clinical reviewer concluded that the GP's decision to prescribe 10ml of methadone, a very low dose, was therefore appropriate.

54. CCTV footage shows that Nurse A did not go to Mr Smith's cell (or any other cells) after 11.51pm and had no meaningful interaction with Mr Smith that night, although he recorded two checks. Oxleas Healthcare Trust carried out an internal investigation, which concluded that the nurse's entries in Mr Smith's

medical record had been falsified. The nurse no longer works at Thameside. The clinical reviewer was satisfied that this was dealt with appropriately.

55. Prison Service Order (PSO) 3550 – clinical service for substance misusers and the national clinical guidelines for substance misuse prescribing and drug treatment require that prisons have a protocol for the management of prisoners' substance misuse needs on their first night in prison. The protocol should be clear about how often staff should check prisoners withdrawing from drugs or alcohol on their first night and who is responsible for the checks. There was no local protocol. The prison's substance misuse lead said that the prison was developing one.

56. Neither the mental health nurse nor the reception GP recorded how frequently Mr Smith should be checked that night. The then Deputy Head of Healthcare told the investigator that he expected healthcare staff to check newly arrived prisoners withdrawing from drugs or alcohol at least every two hours, but ideally hourly, from about 11.30pm until 6.00am. However, there were no instructions for staff about this. The duty nurse said she thought that they should be checked every hour after midnight, but whether the checks were carried out or not depended on how busy the nurse was. She was in the office next to A Wing all night, but thought it was Nurse A's responsibility to do the checks, so did none herself. Nurse A did not know how often he should check prisoners on their first night in prison, and said he waited for prisoners to tell him if they were having withdrawal symptoms.

57. There were clear signs that Mr Smith had been dead for some time when the night staff opened his cell at 6.45am. Had Nurse A carried out more frequent observations, it is possible that Mr Smith would have been found hanging much earlier. We cannot know whether this would have made a difference to the outcome.

58. We are concerned that nurses had no clear instructions about how often they should check prisoners withdrawing from drugs on A Wing on their first night in prison. This was a managerial failure and the clinical reviewer concluded that this aspect of Mr Smith's care was not acceptable. In another recent investigation into a death at Thameside we also found similar managerial failures to ensure appropriate checks for prisoners held in the prison's healthcare inpatient unit. We make the following recommendation:

The Head of Healthcare should ensure there is clear guidance outlining how often healthcare staff should check prisoners withdrawing from drugs or alcohol when they arrive at the prison and that checks continue until their condition has stabilised.

Emergency response

59. PSI 3/2013 requires prisons to have a medical emergency response code protocol, which states how staff communicate the nature of a medical emergency, and that the control room calls an ambulance immediately when a code is used. Thameside's local emergency response codes protocol states that a code blue should be used if a prisoner is unconscious or not breathing.

60. Officer A did not radio an emergency medical code, but shouted for assistance. The night manager in operational charge of the prison, who ought to have known the correct procedure, radioed for immediate medical assistance. An officer then radioed a code blue shortly afterwards, but the prison's control room and nurses did not hear it. When nurses arrived they had no medical equipment with them, even though the duty nurse had acknowledged the night manager's message. The control room did not call an ambulance, as they had not received the code blue message. The night manager did not check this with them but called an ambulance directly from the wing, seven minutes after Mr Smith was found hanged. It was clear from our interviews that staff did not understand Thameside's emergency medical code protocol.

61. None of the staff cut the sheet around Mr Smith's neck, checked him for signs of life or began emergency first aid. When nurses arrived, the duty nurse was shocked when she saw Mr Smith hanging and Nurse A left the wing with her, without examining Mr Smith or going into his cell. Neither nurse examined Mr Smith for signs of life. Thameside's internal investigation concluded that there were serious concerns about the duty nurse's actions that day, and she should have more training before a phased return to work with the agency which employed her.

62. Prison Service Order (PSO) 1400 ("Incident Management") provided guidance for staff on what actions to take when they discover an apparent death. In Chapter 5, the PSO stated that when a prisoner was found hanging, staff should:

> "Ask for immediate medical assistance and ambulance. Ensure your own safety first. Render first aid as appropriate. If the incident has occurred by hanging:
>
> a) first support the body to reduce constriction,
> b) cut the inmate down,
> c) remove the ligature and retain in the cell,
> d) place the prisoner onto his back on a flat surface,
> e) check for signs of life,
> f) if the prisoner is not breathing attempt resuscitation,
> g) if conscious/revived, place in the recovery position,
> h) disturb the scene as little as possible."

63. PSO 1400 was replaced in March 2014 by Prison Service Instruction 09/2014. The new instruction does not contain guidance on actions when a prisoner is hanging but we consider that the same principles should apply. We consider that staff should have cut the ligature, placed Mr Smith on his back and then checked for signs of life, before deciding that he had died.

64. The first response car arrived at the prison at 6.58am and was delayed outside the prison for six minutes. Once the prison gate was open, an ambulance and the first response car were delayed for three more minutes in the prison's gate. It took two more minutes for paramedics to reach Mr Smith's cell. The prison could not explain why it had taken so long to get the paramedics through the gate.

65. The delay in calling an ambulance and subsequent delay getting paramedics to Mr Smith's cell could have been crucial. Leaving a prisoner hanging is not a safe or respectful procedure. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff use an appropriate code to communicate a medical emergency, call an ambulance immediately, bring relevant emergency equipment and that there is no delay in ambulances and paramedics reaching the prisoner. Staff who find a prisoner hanging, should cut the ligature, lay the prisoner on a flat surface, check for signs of life as soon as possible and start resuscitation, if appropriate.

Family liaison

66. Senior managers agreed that the police should notify Mr Smith's sister and partner that he had died. No manager from the prison contacted Mr Smith's family to offer condolences or support and it was two days later before the prison's family liaison officer contacted Mr Smith's partner and his sister.

67. PSI 64/2011 Safer Custody, Chapter 13, states:

> "*Wherever possible, the FLO [family liaison officer] and another member of staff must visit in person the next of kin or nominated person to break the news of the death.…*
>
> "*If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable.*"

68. The decision to leave it to the police to inform Mr Smith's family of his death was not in line with Prison Service mandatory instructions. At the very least, someone should have contacted Mr Smith's family after the police had informed them that he had died to offer sympathy, support and give them further information about what had happened. We consider that this delay was disrespectful. We have previously made a recommendation to Thameside about the requirement for prison staff to inform families when a prisoner dies. We make the following recommendation:

The Director should ensure that, in line with PSI 64/2011, where possible, prison staff inform the next of kin of a prisoner's death without delay.

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