Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Smith a prisoner at HMP Durham on 25 June 2018

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*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 died on 25 June 2018 after being found hanging from a ligature in his cell at HMP Durham. He was 42 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had a history of mental health problems and he received regular support from the mental health team throughout his time at Durham. He was appropriately managed under Assessment, Care in Custody and Teamwork (ACCT), suicide and self-harm monitoring procedures when he arrived at Durham and again after a serious self-harm incident in January 2018.

I am satisfied that Mr Smith received good support from both mental health staff and wing staff during his trial and that they could not reasonably have foreseen that he would take his life a few days after his trial ended.

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 **March 2019**

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Summary

Events

1. On 29 December 2017, Mr Mark Smith was remanded to prison custody, charged with murder and attempted murder. This was his first time in prison custody.

2. Mr Smith had a history of mental health issues and had spent time in a secure psychiatric hospital where he had been diagnosed with a psychopathic personality disorder. When he arrived at Durham, he was located in the prison's healthcare unit because of his past mental health issues and the nature of the charges he was facing. He was monitored under suicide and self-harm prevention procedures (known as ACCT) until 4 January.

3. He was later moved to the vulnerable prisoner unit. He was regularly supported by the mental health team throughout his time at Durham and was seen by a consultant psychiatrist every month from January to April.

4. On 25 January, Mr Smith self-harmed by cutting his chest with a razor. He was taken to hospital where surgeons found that he had pushed 12 razor blades into the wound in his chest. They said that Mr Smith might have been inserting the blades into his chest for some time.

5. When he returned to prison on 27 January, staff monitored him under ACCT. Mr Smith said that he had no memory of self-harming and did not know why he had done it. Staff reported that he appeared positive and that he said he had no thoughts of suicide and self-harm and the ACCT was closed on 13 February.

6. Mr Smith attended court for his trial between 18 and 20 June, and was seen and assessed on his return each time by a member of the mental health team. He was found guilty on 20 June, and his case was adjourned until 3 August for sentencing. On his return to the prison, Mr Smith told mental health staff that he was relieved that it was over. He said that he had no thoughts of suicide or self-harm. Nurses and wing staff had no concerns about his wellbeing.

7. At 5.10am, on 25 June, an officer discovered Mr Smith during a routine check, suspended by a ligature from his toilet door. The officer radioed a medical emergency code and requested an ambulance. Staff responded quickly, but it was obvious that Mr Smith had been dead for some time, so they did not attempt resuscitation. Paramedics arrived and confirmed death at 5.36am.

8. The post-mortem report concluded that Mr Smith died from hanging. A toxicology test found no illicit drugs in Mr Smith's system.

Findings

9. The investigation found that Mr Smith was appropriately monitored under ACCT procedures when he arrived in prison and after he self-harmed, and that on each occasion procedures were followed to a good standard. Case reviews were held regularly, completed on time and always attended by a multidisciplinary team of people who were involved directly in Mr Smith's care.

10. The clinical care received by Mr Smith was of a good standard and at least equivalent to that which he would have received in the wider community. Mr Smith's mental health needs were met by both medical and nursing teams, and he appropriately remained under the care of the mental health team throughout his time at Durham.

11. It is arguable that, given his history of serious self-harm, Mr Smith should have been monitored under ACCT procedures during his trial, as court proceedings are a recognised trigger for suicide and self-harm. He was seen and supported on his return from court each day by both mental health and wing staff and gave no indication that he was at raised risk, but ACCT monitoring would have provided the additional safeguard of regular observations by staff.

12. However, we accept that Mr Smith gave no cause for concern during the trial and that, even if he had been subject to ACCT monitoring, the ACCT would probably have been closed once the trial ended. We are satisfied that staff could not have foreseen that Mr Smith would take his life a few days later.

The Investigation Process

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

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

15. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at the prison.

16. The investigator and clinical reviewer interviewed four members of staff at HMP Durham. The interviews took place on 15 August 2018.

17. We informed HM Coroner for Durham of the investigation. The coroner sent us the results of the post-mortem examination. We have given the coroner a copy of this report.

18. One of the Ombudsman's managers, contacted Mr Smith's father to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. The family wanted to know:

    - What safety measures were in place for Mr Smith at the time of his death?
    - Were there any signs of Mr Smith's care being neglected?

19. Mr Smith's parents received a copy of the initial report. They contacted the investigator to say that they had read the report, and commented that in their opinion, 'from the time of his offence, their son always intended to take his own life, and was biding his time'.

Background Information

HMP Durham

20. HMP Durham, which holds up to 996 men, is a local prison serving the courts of Durham, Tyneside and Cumbria. Care UK provides primary healthcare services and Tees, Esk and Wear Valley NHS Trust provides mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Durham was in October 2016. Inspectors reported that the quality of ACCT documents was improving but too many still lacked attention to detail. Personal factors and significant events which might have been a trigger to self-harm were identified in only some cases, and too many documents did not include next-of-kin information. Reviews were multidisciplinary and caremaps were completed in sufficient detail. Observational entries did not always record mood or interaction with staff but some included examples of positive engagement and regular contact. Too many post-closure reviews were incomplete or late, which was unsatisfactory. The quality assurance procedure to monitor the completion of ACCT documentation was not adequate and managers did not carry out sufficient checks.

Independent Monitoring Board

22. 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 annual report for the year to 31 October 2017, the IMB reported that mental health care had been consistently provided by the Tees Esk Wear Valley NHS Trust (TEWV) and was very well regarded by the users. The IMB reported that mental health services were well integrated with voluntary services (MIND, Rethink). Waiting times were monitored and delays were addressed by the provision of extra psychiatric sessions. Mental health awareness training was provided for all new prison staff.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Previous deaths at HMP Durham

24. Mr Smith's death was the third apparently self-inflicted death at Durham in 2018. In one of those cases we found that prison staff had not assessed the prisoner's risk appropriately because they had placed too much weight on his presentation

and not enough on the presence of triggers for suicide and self-harm. The other case is still being investigated.

Key Events

25. Mr Mark Smith arrived at HMP Durham on 29 December 2017. He had been remanded to prison custody charged with murder of his partner and the attempted murder of his parents on Christmas Day. The offences attracted significant local media coverage. Mr Smith had not been in prison custody before.

26. Mr Smith had a long history of mental health problems and when he arrived at Durham, he told staff that he was feeling low and depressed and that he regularly bit himself as a means of coping. Due to his presentation, the seriousness of his charges and his mental health history, reception officers started Assessment, Custody, Care and Teamwork (ACCT) procedures.

27. At an initial health screen, a nurse reviewed Mr Smith's Person Escort Record (PER – a document that accompanies prisoners between courts, police custody and prison establishments), which noted concerns about self-harm and mental health. Mr Smith told the nurse very little during the initial screen but he said that he had no thoughts of suicide or self-harm. The nurse recorded that he had referred Mr Smith to the prison GP for medication and to the mental health team for assessment. The nurse told Mr Smith that due to his charges and concerns about his wellbeing, he would stay in the healthcare centre as an in-patient until the mental health team had assessed him.

28. A nurse assessed Mr Smith when he arrived at the healthcare centre. She recorded that Mr Smith had been admitted so that staff could check his mental well-being. She noted that Mr Smith's court report said that he had been diagnosed with autism spectrum disorder and recommended a full psychiatric report. The nurse recorded that Mr Smith had difficulties with social communication, showed repetitive behaviours, had had contact with mental health services from the age of 14 and had been an in-patient at a secure mental health hospital for five and a half years, during which time he had been diagnosed with a personality disorder of the psychopathic type. He had been discharged from hospital in 2003.

29. The nurse recorded that Mr Smith's perceived risk to others was high, but he told her that his risk to himself was low and he said he had no thoughts of suicide. Mr Smith said that he self-harmed by biting himself when he felt stressed. He said that he had been using amphetamines (stimulant drugs) with his partner to lift his mood and stimulate him and had also used ketamine (an anaesthetic drug which can induce hallucinations) as he had hoped to have an out of body experience. Mr Smith had arrived from court with medication, including paracetamol, cetirizine (used to treat allergies,) naproxen (a non-steroidal anti-inflammatory) and co-codamol (a pain killer). A prison GP re-prescribed all his medication apart from his naproxen, which she said she could not prescribe until Mr Smith's blood pressure was stable.

30. As well as the physical health screening, a mental health nurse carried out an initial mental health screen on 29 December. The nurse recorded that she had no immediate concerns about Mr Smith's safety at the time of her assessment. Mr Smith told her that he had used a lot of amphetamines in the community and

had drunk vodka on the day of his offence. The nurse recorded that due to Mr Smith's diagnosis of autism and the high-profile nature of his alleged offence, he would be vulnerable if located on a standard residential wing. She recorded that Mr Smith answered 'yes' to let her know he was understanding what she was asking, that he had good eye contact and that some rapport was established. She recorded that the plan was for Mr Smith to be supported by the mental health team and to have a learning disability assessment. Mr Smith told her that he had not been prescribed any medication for his mental health issues, but had tried medication in the past that was not helpful.

31. On 30 December, a Custodial Manager (CM) assessed Mr Smith as part of ACCT procedures. Mr Smith told the CM that he was "ok" and was taking one day at a time. He said that he bit himself, but described this as a 'nervous' thing and mostly an 'unconscious act'. Mr Smith also told the CM that he struggled with anxiety, which caused him to aggravate old injuries. He said he had no thoughts of suicide or self-harm, and told the CM that if this changed he would speak to staff. Mr Smith said that he wanted to contact his family, however, as they were the victims of some of the offences Mr Smith had been charged with, the CM said that the prison would need to check that he was allowed. Mr Smith agreed that he would remain on the healthcare unit until after his court appearance on 2 January 2018.

32. Following the assessment, a nurse chaired an ACCT review attended by the CM and the mental health nurse. It was agreed that the ACCT would remain open until after his court appearance, with a further review scheduled for 3 January.

33. A further multidisciplinary ACCT review took place as scheduled in the healthcare centre on 3 January. Mr Smith said that he had attended court the previous day and, while in reception, some prisoners had made gestures toward him which had unsettled him. Mr Smith's location was discussed and it was agreed that due to his level of vulnerability, caused by both his mental health issues and his high-profile offences, he would be moved to the vulnerable prisoner unit on F Wing later that day. The ACCT remained open and a further review was scheduled for the following day, after he had settled onto F Wing.

34. A prison officer spoke to Mr Smith when he arrived on F Wing. She recorded that he had no issues and she had asked another prisoner to explain the PIN system to him.

35. The next day, a Supervising Officer (SO) chaired an ACCT review, attended by Mr Smith and a mental health nurse. The SO recorded that Mr Smith had not self-harmed or had any thoughts of doing so since arriving at Durham. He had been considered vulnerable due to his diagnosis of autism and because it was his first time in prison custody. Mr Smith told the review that he struggled with new environments, and the SO and mental health nurse reassured him about the regime on F Wing, and recorded that he seemed relieved to know that he would not have to leave the wing much. Mr Smith told the SO that he had a video link court appearance scheduled for 26 January, and that he would prefer that all his court appearances were completed this way. The SO explained to Mr Smith that the prison had no control over how he appeared in court and that he needed to discuss this with his solicitor. Mr Smith said that he had no thoughts of suicide or

self-harm, and the SO and mental health nurse agreed with him that the ACCT document could be closed.

36. On 10 January, another SO, carried out an ACCT post closure interview with Mr Smith. The SO recorded that Mr Smith told him that he was nervous and upset when he had first arrived at Durham, but was beginning to settle into prison life. He said that he was receiving support from prison staff and his family. Mr Smith said that he had a job and mixed with other prisoners. Mr Smith also said that he had no other problems and no thoughts of self-harm or suicide.

37. On 11 January, Mr Smith was visited and assessed by a consultant psychiatrist. The psychiatrist's assessment covered Mr Smith's childhood, current mental state, and an initial psychiatric assessment. He recorded that Mr Smith had been diagnosed with autism in early 2016. Mr Smith also spoke of a previous diagnosis of post-traumatic stress disorder and chronic fatigue syndrome. When asked about self-harm, Mr Smith told the psychiatrist that he unconsciously banged his head and bit his hands when his stress levels increased. However, he said that he had no current thoughts or feelings of self-harm. The psychiatrist recorded that Mr Smith would continue to be supported by the mental health in-reach team and that he had no significant concerns that he would self-harm.

38. At approximately 6.30am on 25 January, a prison officer found Mr Smith lying in the toilet recess of his cell. He immediately radioed for medical assistance and went into the cell. Mr Smith was conscious but had stabbed himself in the chest with a razor. More nurses arrived, then paramedics took over his treatment and transferred him to hospital. A scan showed that Mr Smith had pushed up to 12 razor blades into the wound in his chest, which were surgically removed. Surgeons at the hospital told escorting officers that Mr Smith might have been inserting the blades into his chest for some time.

39. While at hospital, Mr Smith told staff that he did not remember how he became injured. Mr Smith stayed in hospital, accompanied by two members of staff, until 27 January, when he was discharged and was returned to the prison. A nurse recorded that officers had started ACCT procedures.

40. A prison officer assessed Mr Smith as part of ACCT procedures. When asked about his recent self-harm, Mr Smith said that he could not remember how it happened, which worried him. He told the officer that he only recalled feeling anxious and then he blacked out. He said that he had never previously attempted suicide, however he had banged his head and had been biting himself. The officer recorded that Mr Smith appeared anxious, but said he had no thoughts of suicide or self-harm.

41. She told Mr Smith that he would spend the night on the first night centre in a photochromatic cell. These cells have doors that are made of 'smart glass' which can be turned from clear to opaque with the turn of a key. They are used for prisoners assessed as at high risk of harming themselves. Mr Smith was told that he would spend the night in the cell and return to F Wing the next day, if his cell had been cleaned.

42. After the assessment, Mr Smith attended an ACCT review with the officer, chaired by a CM. They agreed that Mr Smith should be checked hourly.

43. On 28 January, Mr Smith was seen by a community psychiatric nurse (CPN). The CPN reviewed Mr Smith's mental health after his recent self-harm. Mr Smith told the CPN that he was anxious, he was still in the photochromatic cell, and he could not go back to F Wing as his cell was still sealed. He told the CPN that he did not know why he had self-harmed and he had no recollection of it. He said that he did not think he was any more stressed or anxious at that time than at any other time. The CPN recorded that Mr Smith was bright and alert and engaged well during the review. Mr Smith said he had no thoughts of self-harm, and the CPN saw no evidence of psychosis or thought disorder. He decided that Mr Smith would continue to be supported by the mental health in-reach team.

44. On 29 January, an SO chaired an ACCT review with Mr Smith attended by a CM, and a mental health nurse, who provided input via the telephone. Mr Smith repeated that he could not recall self-harming. He told the review that he did not want to die and he had been quite frightened by what had happened. The review discussed Mr Smith's location and he was referred to be assessed for a possible move to I Wing (a wing for prisoners with severe and enduring mental illness who need additional support). Mr Smith was recorded as relaxed and calm and grateful for the support offered by staff. All agreed that observations should remain at least once an hour, and a further review would take place on 30 January. Mr Smith was moved back to F Wing later that day.

45. An SO and a mental health nurse completed the ACCT review with Mr Smith on 30 January. Mr Smith said that moving back to F Wing had settled his anxiety, but he felt he would be better on I Wing because his behaviour was unpredictable and his recent self-harm had scared him because he could not remember it. The SO asked Mr Smith to show both her and the mental health nurse his surgical dressing as she said she was concerned that he had been tampering with it. When Mr Smith lifted his top, there was a white substance over his wound. He said this was toothpaste which he said he had used to keep the dressing on. The SO arranged for Mr Smith to attend the healthcare unit and have the wound cleaned and the dressing changed. It was agreed that observations would remain hourly, and the mental health nurse would consider a possible move for Mr Smith to I Wing.

46. On 5 February, an SO chaired an ACCT review attended by the mental health nurse. The SO recorded that this was the first case review he had completed since becoming a case manager so he went over past issues with Mr Smith. Mr Smith said he had no more thoughts of self-harm, but it was agreed that he should remain subject to suicide and self-harm procedures. The SO recorded that observations would be reduced to once in the morning, once in the afternoon and once in the evening, with three observations during the night. A further review was scheduled for 13 February.

47. On 8 February, Mr Smith attended a further consultation with the consultant psychiatrist. The psychiatrist recorded that he did not consider that Mr Smith was at risk of suicide or self-harm. He said that Mr Smith's alleged diagnosis of autism was still unclear and the team was still waiting for more information from external healthcare providers. Mr Smith told the psychiatrist that he wanted to move to I Wing. The psychiatrist said he could not make that decision because Mr Smith needed a separate assessment. He recorded that Mr Smith's request

to move to I Wing would be discussed at a meeting on 12 February. On 12 February, a mental health nurse assessed Mr Smith's suitability for I Wing and he was moved later that day.

48. On 13 February, an SO chaired an ACCT review, attended by another SO, a nurse, and a mental health support worker. Mr Smith was positive and said he had no thoughts of self-harm. In view of his progress and location on I Wing, it was decided that the ACCT would be closed. Mr Smith was not subject to ACCT monitoring at any other point during his time at Durham and there were no further incidents of self-harm.

49. Mr Smith remained on I Wing for nearly a month, during which time he attended group sessions and received daily support from the mental health team. On 8 March, Mr Smith was returned to F Wing and Mr Smith's personal officer told the investigator that Mr Smith was 'like a different lad'. She said that he was not outgoing, but when he came back onto F wing he would regularly come out of his cell to interact with other prisoners. No concerns were raised by Mr Smith or by staff after he returned to F Wing.

50. The consultant psychiatrist saw Mr Smith again on 19 April. He recorded that Mr Smith denied any plans to deliberately self-harm or any thoughts of suicide. The psychiatrist documented that Mr Smith did not show any signs of acute risk that needed further intervention at that time. However, he recorded that Mr Smith would remain under the care of the mental health in-reach team because of his previous impulsive act of self-harm and the serious nature of the charges against him.

51. He noted that he would see Mr Smith again when he next visited the prison, which was normally monthly. However, Mr Smith did not see the psychiatrist again after 19 April. Although he did not see Mr Smith again, the psychiatrist told the clinical reviewer that he had discussed his well-being with the mental health in-reach team, and had been told that he was doing well and that there were no active concerns about him.

52. Mr Smith continued to be supported regularly by the mental health team, and although there were no further significant issues, he remained under their care.

53. On 29 May, he was seen by a mental health support worker, and told her he would like to see the psychiatrist on his next visit to the prison. The mental health support worker saw him again on 7 June and Mr Smith again asked for an appointment with the psychiatrist as he felt he would like some support after his trial. She completed a mental health review and recorded that Mr Smith maintained good eye contact throughout the review. The mental health support worker reviewed Mr Smith again on 15 June. She recorded that he denied any thoughts of suicide and self-harm and that he said he was getting a little stressed about his trial, starting in three days, but was trying to stay positive.

Events from the 18th June – 25th June

54. Mr Smith pleaded guilty to two counts of attempted murder and not guilty to murder during a video link court appearance on 31 May. His trial was scheduled for four days and began on 18 June. The mental health team had identified that

Mr Smith would need more support during his trial and has arranged for the duty mental health nurse to speak to him each day when he got back from court.

55. Mr Smith's mental health key worker reviewed Mr Smith's mental health when he returned from court on 18 June. Mr Smith told her that he was tired and said he had no thoughts of self-harm or suicide. He said that he was feeling fine about the trial. The nurse recorded that Mr Smith presented as very positive in nature, and that he made good eye contact and was bright and facially reactive throughout. She reminded Mr Smith to alert staff if he had any concerns and told him that he would be reviewed by the duty mental health nurse each time he got back from court.

56. On 20 June, Mr Smith told the duty mental health nurse that he had been found guilty of all charges, but the hearing had been adjourned until 3 August when he would be sentenced. The nurse had not had any contact with Mr Smith before 20 June, but she told the investigator that she reviewed his medical record and discussed him with colleagues before she reviewed him. She said that Mr Smith appeared bright and happy to speak to her. He explained that the case had been adjourned for further psychiatric reports to be completed, and he thought this could help him secure a transfer to a secure mental hospital, which was where he wanted to be. He said he had no thoughts of suicide or self-harm and reported no other concerns. The nurse told Mr Smith that she would be on duty until 8.00pm, if he wished to speak to her again.

57. On 22 June, the mental health support worker visited Mr Smith on the wing. Mr Smith told her that he had felt a huge relief from being at court and 'getting it over and done with' and said he had no thoughts of suicide or self-harm. The mental health support worker recorded that Mr Smith maintained good eye contact and that she had no immediate concerns about his current mental state or safety, and that he would remain under the care of the mental health team.

58. At around 5.00am on 25 June, a prison officer began routine checks and looked through Mr Smith's observation panel. He saw Mr Smith suspended from his toilet door with a ligature around his neck. The officer radioed a medical emergency code blue to alert other staff and request medical assistance. The radio call was logged by the control room at 5.10am, who automatically requested an emergency ambulance.

59. The officer broke the seal on his key pouch and went into Mr Smith's cell. He tried to lift Mr Smith while cutting the ligature. Other staff arrived and helped the officer. Once the ligature was cut free of the door frame, officers lowered Mr Smith to the floor. Mr Smith's body was rigid and cold to the touch. Two nurses, arrived shortly afterwards and immediately checked Mr Smith for any signs of life. The nurses assessed that there were signs of rigor mortis, so staff did not attempt resuscitation. Paramedics arrived at Durham at 5.33am, and confirmed Mr Smith's death at 5.36am.

60. After Mr Smith's death a note was discovered in his cell which he had been writing to a friend. The note appeared to have been written over a period of days, but was not dated. Mr Smith wrote of his memories coming back to him that night and said that he hated the person he had become. He said that the amnesia he had experienced had been psychological and he had hoped that

psychiatrists were going to tell him it was psychosis, so he did not have to face what he had done. He did not finish the letter before he died.

Contact with Mr Smith's family

61. Mr Smith's father was listed as his next of kin. Two officers went to Mr Smith's parents' temporary home address on 25 June at approximately 10.50am. His family had been informed of his death before they got there by the police liaison officer. The officers explained to Mr Smith's family what would happen next and answered their immediate questions. The prison remained in contact with Mr Smith's family.

62. The prison contributed to the cost of his funeral in line with Prison Service instructions. The prison chaplain, officiated at Mr Smith's funeral at his family's request.

Support for prisoners and staff

63. Staff involved in the emergency response attended a debrief led by a senior manager, along with healthcare staff. Staff told the investigator that they were offered support by the prison's care team and felt supported by managers and other colleagues.

64. The prison posted a notice for prisoners informing them 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.

Post-mortem report

65. The post-mortem report concluded that Mr Smith's death was due to hanging. Toxicology results showed no presence of illicit drugs in Mr Smith's system.

Findings

Identifying and managing risk of suicide or self-harm

66. Prison Service Instruction (PSI) 64/2011 on safer custody, sets out how prisoners considered at risk of self-harm and/or suicide should be supported and managed. The PPO's Learning Lessons Bulletin, *Early days and weeks in custody*, published in February 2016, highlights the importance of identifying prisoners who are at heightened risk of suicide and self-harm when they first arrive so that appropriate monitoring can be put in place.

67. We are satisfied that Mr Smith was appropriately identified as being at risk, both from himself and others, when he arrived at Durham, and appropriately located and monitored under ACCT to reduce those risks.

68. We are also satisfied that Mr Smith was appropriately monitored under ACCT after he self-harmed in January 2018.

69. The investigation found that on each occasion that Mr Smith was subject to ACCT monitoring, procedures were followed to a good standard. Case reviews were held regularly, completed on time and always attended by a multidisciplinary team of people who were involved directly in Mr Smith's care.

70. It is arguable that, given the serious self-harm incident in January, Mr Smith should have been monitored under ACCT procedures during his trial, as court proceedings are a recognised trigger for suicide and self-harm. We recognise that he was seen and supported on his return from court each day by both mental health and wing staff and gave no indication that he was at raised risk, but ACCT monitoring would have provided an additional safeguard of regular observations by staff.

71. However, we recognise that Mr Smith gave no cause for concern during the trial and that, even if he had been subject to ACCT monitoring, the ACCT would probably have been closed once the trial ended. As Mr Smith appeared positive about his forthcoming sentencing, we accept on balance that it would not have been reasonable or desirable to monitor him under ACCT for over a month until his sentencing on 3 August. It follows that we are satisfied that staff could not have foreseen that Mr Smith would take his life a few days after his trial ended.

Clinical care

72. Having reviewed the clinical care extended to Mr Smith, the clinical reviewer concluded that the care received by Mr Smith was of a good standard and was at least equivalent to that which he would have expected to receive in the community.

73. The clinical reviewer found that Mr Smith's mental health needs were met by both medical and nursing teams and he appropriately remained under the care of the mental health team throughout his time at Durham.

74. Mr Smith was assessed and reviewed by a consultant psychiatrist, between January and April. Mr Smith did not see him again after 19 April, although Mr Smith twice asked to do so. The Consultant Psychiatrist was asked why he had

not followed up with Mr Smith as he had indicated he would do when he saw Mr Smith on 19 April. He said that there was no specific reason for him to see Mr Smith, he just wanted to ensure that a slot was available in the event of the mental health in-reach team thought he needed to be reviewed. The psychiatrist said that Mr Smith had spent several weeks on I wing, and there had been no evidence of mental illness. He said that he had regularly discussed Mr Smith's well-being with the mental health in-reach team.

75. The clinical reviewer was satisfied that, although Mr Smith had no clear diagnosis of autism, both prison and healthcare staff were reactive to his needs and put processes in place to support him.

76. We have not made any recommendations about Mr Smith's clinical care.

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