

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Christopher Smith, a prisoner at HMP Lowdham Grange, on 19 May 2019**

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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

**OGL**

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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 died in hospital of a pulmonary embolism (a blockage of an artery in the lungs) caused by deep vein thrombosis (a blood clot that develops in the body) on 19 May 2019 while a prisoner at HMP Lowdham Grange. He was 35 years old. I offer my condolences to his family and friends.

A week before he was admitted to hospital, Mr Smith, who was segregated at the time, began to behave bizarrely. Over the course of the week, his mental and physical health deteriorated further. He vomited, stopped eating and drinking, and appeared incapable of communicating with prison and healthcare staff. I am concerned by the poor quality of health assessments he received during this time, all of which took place from behind a locked door despite these worrying and worsening symptoms. Although I cannot be certain, it is possible that the failure to properly assess Mr Smith contributed to confusion about his diagnosis and a delay to hospital admission.

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**

**November 2019**

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# Summary

## Events

1. On 4 September 2017, Mr Christopher Smith was recalled to prison custody, a week after he had been released on licence from a term of seven years in prison. Mr Smith had been diagnosed with schizophrenic affective disorder and had taken antipsychotic medication since he was a teenager. On 30 March 2018, he was transferred to HMP Lowdham Grange. During his time in prison, Mr Smith was frequently violent and often spent time in segregation units.
2. On 23 April 2019, prison staff segregated Mr Smith after he assaulted another prisoner. His first week in segregation was uneventful. On 1 May, a segregation unit officer recorded that Mr Smith had been “off his head”. Prison staff recorded further incidents of unusual behaviour over the following days. On 3 May, a healthcare multidisciplinary team recorded that they would monitor Mr Smith, and that this would take place from outside his cell on the advice of segregation unit staff.
3. Mr Smith’s unusual behaviour continued over the following days. On 6 May, he vomited in his cell, was unsteady on his feet and did not respond to attempts from staff to communicate with him. Following a review, prison staff moved him to a clean cell with a CCTV camera in it so that they could monitor him more closely. They suspected Mr Smith’s deteriorating health might have been caused by using psychoactive substances (PS) and started monitoring him. On the same day, Mr Smith stopped eating and drinking.
4. On 7 May, a mental health nurse assessed Mr Smith. The mental health lead told us that they believed that Mr Smith’s deteriorating health was a physical rather than mental health issue. On the same day, the prison’s paramedic twice assessed Mr Smith. She recorded that he was staring into space and did not respond to her and concluded that his symptoms were of deteriorating mental rather than physical health. All the healthcare assessments on 7 May and the preceding days took place through the cell door observation panel.
5. On 8 May, segregation unit staff identified that Mr Smith was breathing heavily. A prison nurse assessed him in his cell and concluded that he required hospital admission. Prison staff called an ambulance and Mr Smith was admitted to a hospital in Nottingham.
6. Mr Smith was placed in an induced coma until 14 May. He was restrained by an escort chain until 12 May, when this was removed at the request of hospital staff. When he regained consciousness, prison staff applied double handcuffs. In hospital, Mr Smith was described as delusional and frequently aggressive.
7. On 19 May, Mr Smith lost consciousness and went into cardiac arrest. Prison staff removed the restraints and hospital staff began cardiopulmonary resuscitation. Shortly afterwards, they confirmed that he had died.

## Findings

### Clinical care

8. Managing Mr Smith's difficult behaviour and deteriorating health presented staff at Lowdham Grange with challenges. However, we consider that the care that he received fell below accepted standards. It has become practice that most healthcare assessments in the segregation unit take place through the cell observation panel, contrary to usual standards. There was confusion between healthcare and prison staff about who should decide the outcome when assessing a potentially violent prisoner. This meant that, despite his clearly deteriorating health, no one conducted a face-to-face assessment with Mr Smith for nearly a week, including when he was so ill that he had vomited and was unable to walk to a clean cell. It is likely that this contributed to uncertainty around Mr Smith's diagnosis and potentially to a delay to his hospital admission.

### Food and fluid refusal

9. Segregation unit staff appropriately began a food and fluid refusal log when Mr Smith stopped eating and drinking. However, no one assessed whether he had the mental capacity to make this decision or whether any mental or physical illnesses were affecting his decision, as national guidelines require.

### Substance misuse

10. When prison staff suspected that Mr Smith had used PS in March 2019, they did not refer him to the substance misuse team. This was a missed opportunity to address any substance misuse issues he had.

### Restraints, security and escorts

11. Restraints were inappropriately used on Mr Smith during his first four days in hospital, when he was in an induced coma. When he later complained of swollen wrists because the handcuffs which had been applied were very tight and restricted his blood flow, it took too long to arrange for larger handcuffs to be provided.

## Recommendations

- The Director and Head of Healthcare should ensure that all segregation healthcare assessments are conducted face-to-face rather than through the cell door observation panel, unless there are significant risks to the safety of staff that cannot be mitigated following a risk assessment by a unit manager.
- The Head of Healthcare should ensure that all prisoners refusing food or fluids are managed in line with local and national guidelines.
- The Director should ensure that any prisoners identified as or suspected of using psychoactive substances are referred to the substance misuse service.
- The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner's health and are based on the actual risk he presents at the time.

- The Director should ensure that when prisoners are restrained, staff apply handcuffs of an appropriate size.

## The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.
13. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
14. The investigator interviewed nine members of staff at Lowdham Grange on 8 and 9 July 2019. He interviewed an additional member of staff by telephone on 31 July. In October, the investigator interviewed a prisoner who said he had information about Mr Smith's death.
15. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The clinical reviewer joined the investigator for interviews with prison and healthcare staff.
16. We informed HM Coroner for Nottinghamshire of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
17. The Ombudsman's family liaison officer contacted Mr Smith's father to explain the investigation and to ask if he had any matters that he wanted the investigation to consider. Mr Smith's father said that he understood that his son had stopped taking his medication before he died and wanted to know why.
18. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS identified some factual inaccuracies and we have amended this report accordingly.
19. We also shared the initial report with Mr Smith's father. He did not make any comments.

## Background Information

### HMP Lowdham Grange

20. HMP Lowdham Grange is a medium security prison, managed by Serco, which holds a maximum of 888 men. Nottinghamshire Healthcare NHS Foundation Trust provides healthcare services, which includes 24-hour nursing cover.

### HM Inspectorate of Prisons

21. The most recent inspection of HMP Lowdham Grange was in August 2018. Inspectors reported that the use of segregation was high, and that segregation staff knew prisoners well but their relationships were functional. They also found that segregation review targets were often generic and that there was no consideration of care planning.
22. Inspectors found that nearly half of prisoners said that it was easy to obtain drugs. Supply reduction work had improved and the number of positive drug tests had fallen significantly in the year before the inspection. Inspectors also found that the mental health team provided a reasonably good service.

### Independent Monitoring Board

23. 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 January 2019, the IMB reported that the use of PS by prisoners was common, and presented challenges for staff ranging from catatonic to extremely violent prisoners. They reported that prison staff had taken proactive action and had successfully reduced the supply of drugs during the year. The IMB also reported that the staffing and management of the segregation unit was of a continually high standard, although they were concerned about the use of such accommodation for prisoners with complex mental health conditions.

### Previous deaths at HMP Lowdham Grange

24. Mr Smith was the sixth prisoner to die at Lowdham Grange since May 2017. In our investigation into the death of a man in December 2017, we found that he was too easily able to obtain drugs. In another investigation into the death of a man in October 2018, we found that he had used PS but there was no evidence that staff had referred him to substance misuse services. However, in our investigation into the death of a man in November 2018, we found that he received appropriate care for his PS misuse.

### Psychoactive Substances (PS)

25. PS (formerly known as 'new psychoactive substances' (NPS) or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure,

reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for PS precipitating or exacerbating the deterioration of mental health, and they are linked to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time, NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS, the need for more effective drug supply reduction strategies, better monitoring by drug treatment services and effective violence reduction strategies.
27. HM Prison and Probation Service now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

## **Segregation units**

28. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The segregation unit at Lowdham Grange is called the Reintegration Unit (RIU).

## Key Events

29. Mr Christopher Smith was convicted of several offences from 2001 and was first sent to prison in 2008. As a teenager, he was diagnosed with schizophrenic affective disorder (a combination of schizophrenia symptoms, such as hallucinations, and mood disorders such as anxiety and depression) and during his life, he had several psychiatric hospital admissions under the Mental Health Act. He was prescribed two antipsychotic medications: olanzapine, which he took as an oral tablet; and a fortnightly depot injection which contained zuclopenthixol. (A depot injection slowly releases antipsychotic medication into the body over a number of days or weeks.)
30. On 1 February 2013, Mr Smith was remanded in custody to HMP Pentonville. He was later sentenced to seven years in prison for robbery. Shortly after he arrived at Pentonville, his fortnightly depot was stopped, although he continued to be prescribed olanzapine. Mr Smith was transferred between several prisons in the London area during his sentence. He was frequently violent towards both staff and fellow prisoners and spent many periods in segregation.
31. On 4 September 2017, Mr Smith was released from prison on licence. He was recalled to HMP Thameside on 12 September, having absconded from the approved premises where he was required to live. During his time at Thameside, Mr Smith's previous pattern of violent behaviour continued.

## HMP Lowdham Grange

32. On 30 March 2018, Mr Smith was transferred to HMP Lowdham Grange. He was not referred to the mental health team when he arrived at the prison. Mr Smith was involved in some violence in his first weeks at Lowdham Grange but this reduced in June when he moved to the prison's social responsibility unit.
33. In late July, Mr Smith was segregated for three weeks after a fight with another prisoner. He subsequently came to the attention of the mental health team who discussed his history, diagnosis and treatment at their multi-disciplinary team meeting. The mental health team lead recorded that she had discussed Mr Smith with the visiting psychiatrist but that he required no input at present. The mental health team lead told us that Mr Smith's mental ill health was stable, that he took his medication as prescribed, and neither he nor any prison or healthcare staff had reported concerns that his mental health was deteriorating.
34. On 31 August, Mr Smith was segregated for damaging prison property. He remained in segregation until 28 December. During his time in segregation, Mr Smith received mostly positive reports from staff in the unit. A Custodial Operations Manager (CM) who was the segregation unit manager, told us that Mr Smith was civil and polite during his time in segregation, and was quite popular with the staff in the unit. She said that Mr Smith did not cause them any problems and was a man with whom staff could have a conversation.
35. On 31 December, a nurse assessed Mr Smith's mental health. He recorded that Mr Smith engaged well and reported that he was stable. The nurse noted that Mr Smith was compliant with his medication, and that he had not observed any

psychotic symptoms. He also recorded that Mr Smith had no substance misuse issues.

36. On 18 February 2019, Mr Smith fought another prisoner. He later told wing staff that the prisoner was involved in the drugs scene and he wanted to resolve this. A few weeks later, Mr Smith was in another fight, and told staff that he had been provoked by the other prisoner.
37. On 27 March, an officer recorded that Mr Smith had “clearly” been smoking PS. Earlier in the week, staff recorded that they had seen him being passed a package from a prisoner who was known to sell drugs on the wing. No one referred Mr Smith to the prison’s substance misuse service.
38. On 1 April, Mr Smith had another fight with a prisoner. A wing manager warned him that he might be transferred to another prison if this behaviour continued.

## **Segregation**

39. On 23 April, Mr Smith assaulted another prisoner. An operational manager segregated him under Prison Rule 45, which allows prisoners to be segregated for the good order of the establishment or in the prisoner’s own interests.
40. A mental health nurse assessed whether there were healthcare reasons not to segregate Mr Smith. He incorrectly recorded that Mr Smith was not currently taking antipsychotic medication. The mental health nurse concluded that there was no evidence to indicate that Mr Smith’s mental health would deteriorate significantly if he were to be segregated, or that he would not be able to “cope” with segregation. He therefore recorded that there were no healthcare reasons not to segregate Mr Smith.
41. On 24 April, the operational manager chaired a segregation review board, which are held within 72 hours of first segregation under Prison Rule 45 and then at least at 14-day intervals afterwards, with the aim of returning the prisoner to standard prison accommodation. She recorded that they would consider whether to transfer Mr Smith to another prison but would first consider his representations. A nurse, who was also present, recorded that no healthcare issues were raised. The operational manager authorised Mr Smith’s continuing segregation until 8 May.
42. On 25 April, a safer custody officer, visited Mr Smith to discuss his Challenge, Support and Intervention Plan (CSIP, a tool used to manage violent prisoners). He recorded that Mr Smith felt safe in the segregation unit, had no issues, and was not involved in substance misuse.
43. On 1 May, an officer recorded that Mr Smith had been “off his head” during the afternoon and evening.

## **2 May 2019**

44. On 2 May, a safer custody officer visited Mr Smith to discuss his CSIP. He recorded that he could not interview Mr Smith, as he was displaying “strange behaviour” in his cell. The safer custody officer told us that Mr Smith was

beckoning him to enter the cell and making boxing-style fist movements. (The safer custody officer said that Mr Smith had previously boxed and was known at Lowdham Grange by the nickname 'Boxer'.) He said that this was unusual behaviour for Mr Smith, who he normally found welcoming. He said Mr Smith did little to acknowledge him when he tried to speak to him. He recorded that segregation staff said that he had behaved strangely for the past 24 hours, and that they were monitoring him.

45. Healthcare staff are required to visit prison segregation units every day to see all prisoners, check their welfare and address any urgent health needs. On 2 May, a prison GP and a nurse conducted the healthcare rounds. Both recorded that no issues were raised for Mr Smith. The nurse told us that Mr Smith appeared normal and was pleasant when he spoke. She said that she did not see him behave strangely and segregation unit staff did not say anything to her about his behaviour.

### **3 May 2019**

46. An officer recorded that Mr Smith continued to demonstrate strange and unpredictable behaviour, and that he might be under the influence of drugs. He noted that Mr Smith was "dazy and not engaging".
47. A nurse completed the healthcare segregation round. He recorded that segregation unit officers told him of their concerns for Mr Smith due to his behaviour in the preceding 24 to 48 hours. The nurse recorded that Mr Smith was gesticulating, unable to stand still or engage in conversation, and made whispering and hissing noises. He noted that it was unclear whether Mr Smith had taken drugs or whether his mental health had deteriorated. He noted that he would make prison doctors and the substance misuse and mental health teams aware.
48. A substance misuse practitioner then recorded that she was advised by a nurse that segregation unit staff would not unlock Mr Smith's cell due to his unpredictable presentation. She noted that she could not therefore assess Mr Smith to determine whether he needed input from the substance misuse team.
49. In the afternoon, healthcare staff held a multidisciplinary team meeting to discuss Mr Smith. A healthcare administrator recorded that segregation staff believed that Mr Smith was under the influence of drugs and had advised them that it was not currently safe to open the cell door to assess him further. She recorded that Mr Smith was usually compliant with his antipsychotic medication but had not taken it in the last two days. She recorded that the multidisciplinary team concluded that healthcare staff should continue to monitor Mr Smith and engage with him when risk allowed.

### **4 May 2019**

50. A nurse completed the healthcare segregation round. He recorded that Mr Smith appeared agitated and did not reply to enquiries about his welfare.
51. Mr Smith's segregation history sheet for 4 May is missing. Segregation unit staff did not record anything about him in their observation book.

## 5 May 2019

52. An officer recorded that Mr Smith was “still acting strange”.
53. A prison GP completed the healthcare segregation round. She recorded that no concerns were raised. The prison GP told the clinical reviewer that she saw Mr Smith through the cell door observation panel as segregation unit staff said that he was “too volatile” to unlock. She said that she asked Mr Smith if he wanted to discuss anything but he shook his head. The prison GP said that she thought that he was experiencing the effects of PS and possibly a deterioration in his mental health.

## 6 May 2019

54. In the morning, Mr Smith vomited in his cell. A CM recorded that he was unsteady on his feet, drooling, staring into space and had vomited. A nurse assessed Mr Smith and recorded that he did not engage, and that the floor of his cell was wet and covered in rubbish. He recorded that he would ask the mental health team to review Mr Smith. (The mental health team at Lowdham Grange are not contracted to work on weekends or Bank Holidays. There was therefore no member of the mental health team on duty from 4 to 6 May inclusive.)
55. The Head of Residence then chaired a segregation review board. A CM, a nurse, an officer from the safer custody team and a member from the Independent Monitoring Board also attended. The Head of Residence recorded that Mr Smith was either “under [the] influence or having a psychotic episode more than likely drug-induced”. He asked segregation unit staff to move Mr Smith to a clean cell, and to allocate him a cell with a CCTV camera in it to allow them to monitor him more easily. The Head of Residence told us that he considered other locations for Mr Smith, but his current medical condition and behaviour meant this was the only feasible location for him in the prison. He said that this was because the staff-to-prisoner ratio in the segregation unit and the option of the camera cell made it far easier for staff to monitor his welfare. He authorised Mr Smith’s continuing segregation until 13 May.
56. Officers carried Mr Smith to his new cell because he did not respond when they asked him to move. A CM recorded that Mr Smith was non-compliant throughout and gave little sign of understanding. She opened a PS log, which is a document used to monitor the welfare of prisoners who might have used PS. Segregation unit staff were required to check Mr Smith every half an hour. During the remainder of the day, they recorded that he was unresponsive, did not engage with staff and stared into space.
57. An officer worked in the segregation unit overnight. He recorded that Mr Smith stood on the same spot in his cell until around 1.00am, after which he lay on the floor and stared at the wall.

## 7 May 2019

58. An officer recorded that staff continued to have concerns about Mr Smith’s welfare. He recorded that Mr Smith sometimes lay on the floor and sometimes stood up

swaying. At times he “twitched” his hands. The officer recorded that Mr Smith did not respond to staff other than “moving his eyes”.

59. A prison paramedic completed the healthcare segregation round. She told us that segregation unit staff told her that it was “too unsafe” to open the door, and she therefore observed Mr Smith through the observation panel. The prison paramedic said that Mr Smith was staring at the door and did not respond when she spoke to him. She said that it was clear that Mr Smith was conscious and breathing, and she could count his respiratory rate from the door so did not think that urgent action was needed.
60. A CM then telephoned a mental health lead and explained what had happened to Mr Smith over the preceding days, including that they were now unsure whether he was eating or drinking. The mental health lead told us that she thought that Mr Smith was experiencing physical rather than mental ill health. Nevertheless, she asked a mental health nurse, to visit and assess Mr Smith.
61. At the same time, the CM began a food and fluid refusal log. She recorded that Mr Smith appeared to be “in a psychotic state”, that he had first refused food on 6 May and that it was now unclear whether he was eating or drinking. The CM told us that they put all five choices of food from the prison menu around Mr Smith’s cell. She said that he ate and drank a small amount, although in the log she wrote that it was “untouched”.
62. The mental health nurse visited Mr Smith. He observed him through the observation panel and recorded that Mr Smith was lying on the floor of the cell. The mental health nurse asked segregation unit staff to contact prison healthcare if there was a significant change to Mr Smith’s presentation. The mental health lead told us that the mental health nurse spoke to her afterwards and agreed that Mr Smith appeared to be experiencing physical rather than mental ill health symptoms.
63. A prison paramedic visited Mr Smith again in the afternoon. She said that he was now lying on the floor, clearly breathing. She said that Mr Smith did not appear to be in pain, and she did not have any great concerns about his physical health. She sent a task to the mental health team for a further assessment.
64. An officer recorded that Mr Smith continued to display strange behaviour overnight. He recorded that Mr Smith initially spent some time lying on his back and did not respond to any attempt from staff to communicate with him. Mr Smith later spent several hours sitting on the toilet, seemingly asleep. He did not eat or drink anything.

## **8 May 2019**

65. An officer recorded that Mr Smith appeared unwell in the morning. He noted that Mr Smith appeared to have trouble moving his joints and was unable to communicate with segregation unit staff.
66. A prison GP completed the healthcare segregation round. He recorded that Mr Smith was staring upwards, talking under his breath, and not reacting to stimuli. The prison GP recorded that it was a “likely psychotic episode”, possibly induced by PS or the omission of olanzapine. He told the clinical reviewer that he was not

concerned about Mr Smith's physical health. He noted that Mr Smith was awaiting psychiatric review, although the mental health lead told us that no one had referred Mr Smith to the psychiatrist.

67. At around 12.50pm, segregation unit staff asked for a nurse to assess Mr Smith as they were concerned that his breathing had become "heavy". At 1.15pm, a mental health nurse, attended. After assessing Mr Smith, he requested that the response nurse attend for a second opinion.
68. At 1.55pm, the response nurse arrived at the segregation unit. She went into Mr Smith's cell to assess him, and recorded that he was sitting on the bed, unable to move and was not communicating. Mr Smith had been incontinent of urine. She also recorded that his feet were swollen and there was a rash on his legs. She took clinical observations and found that Mr Smith had a high pulse and respiratory rate. She concluded that he required hospital admission for further investigation and requested an ambulance.
69. A CM completed an escort risk assessment. She recorded that Mr Smith was "currently unpredictable due to ill health" and recorded that there was intelligence that he used weapons and was violent. The CM concluded that escorting staff should apply double cuffs (when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).

## **Queen's Medical Centre**

70. At 3.50pm, Mr Smith arrived at a hospital in Nottingham. Shortly afterwards, hospital staff placed him in an induced coma. Prison staff then changed the restraints to an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and another to an officer) and noted that they should return to double cuffs if Mr Smith regained consciousness.
71. On 12 May, hospital doctors expressed concern to the escorting officers about the use of handcuffs when Mr Smith was sedated in an induced coma. The officers contacted the prison and spoke to the duty senior operational manager, who authorised them to remove the escort chain when Mr Smith was sedated and to reapply handcuffs when he was brought out of the induced coma.
72. On 13 May, a prison nurse telephoned the hospital to enquire about Mr Smith. A hospital nurse told her that he was sedated and being treated for psychosis after withdrawal from PS.
73. On 14 May, Mr Smith regained consciousness and prison staff reapplied double cuffs, this time using an escort chain rather than standard handcuffs to attach Mr Smith's wrist to the officer. The escorting officers made entries over the course of the day that said that Mr Smith was "delirious" and swearing at hospital and prison staff.
74. On 15 May, Mr Smith was reportedly quiet and compliant but still delusional. The next day, escorting officers recorded that he was agitated, aggressive and unpredictable, and had tried to push or strike an officer. On 17 May, officers recorded that Mr Smith was "frequently aggressive".

75. At 6.50am on 19 May, officers recorded that Mr Smith was “becoming agitated and offensive to staff”. At 9.10am, an officer noted that Mr Smith’s hands were significantly swollen, and the handcuffs were restricting his blood flow. He loosened the cuffs as much as possible and advised Mr Smith to wiggle his fingers to increase the blood flow. The officer said that he spoke to hospital staff about the swelling, but they did not ask for the handcuffs to be removed.
76. At around 10.45am, a CM completed a management visit. The officer told us that a CM said that he would send some larger handcuffs with the night escort when they relieved the officer and his colleagues in the evening.
77. At around 11.55am, Mr Smith lost consciousness and went into cardiac arrest. An officer removed the handcuffs and hospital staff began cardiopulmonary resuscitation. At 12.51pm, they confirmed that Mr Smith had died.

### **Contact with Mr Smith’s family**

78. On 8 May, the Head of Security, telephoned Mr Smith’s father and told him that Mr Smith had been admitted to hospital. Mr Smith’s father subsequently visited him in hospital several times.
79. On 19 May, the Deputy Director and a family liaison officer visited Mr Smith’s father and told him that Mr Smith had died. Lowdham Grange contributed to the costs of the funeral in line with national instructions.

### **Support for prisoners and staff**

80. After Mr Smith’s death, the Head of Security debriefed the staff involved to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
81. The prison posted notices informing other prisoners of Mr Smith’s death and offering support.

### **Post-mortem report**

82. A post-mortem examination established that Mr Smith died due to a pulmonary embolism (blockage of an artery in the lungs) caused by a deep vein thrombosis (a blood clot that develops in the body). Toxicology tests identified no illicit drugs or medication.

# Findings

## Clinical care

83. Prison Service Order (PSO) 1700 provides guidance and mandatory instructions about the management of prisoners who are held in segregation units. It states that a doctor must visit each prisoner in segregation as often as their individual health needs dictate and at least every three days. A nurse must visit to assess the prisoner on all other days. The purpose of this assessment is to ensure the physical, emotional and mental wellbeing of the prisoner and whether there are any clinical reasons to advise against continuing segregation.
84. On 1 May 2019, prison staff first recorded that Mr Smith had displayed strange behaviour. They made similar entries over the following days, although it was not until 3 May that healthcare staff first recorded concerns. At a multidisciplinary team meeting, they decided to monitor Mr Smith, although noted that this should take place from outside his cell on the advice of segregation unit staff.
85. There appears to be a lack of clarity between prison and healthcare staff about the standards for conducting health assessments in the segregation unit. A nurse told us that segregation staff said that they would not open the door when she visited Mr Smith on 7 May, but in her experience they would do so if she asked them. Two nurses said that they would usually conduct all segregation healthcare rounds through the cell door observation panel. Another nurse agreed and highlighted that this practice differed from other prisons that she had worked in. A prison GP told the clinical reviewer that he sometimes had to do segregation rounds without an accompanying officer to open the door, if required.
86. A CM, who was the segregation unit manager, told us that officers would always open the cell door to facilitate a face-to-face healthcare assessment if requested, including for prisoners considered at risk of violence and who required a high level of supervision at unlock. The Head of Security told us that the expected standard was for healthcare assessments to be conducted face-to-face, unless there was a significant risk that could not be mitigated. There is no record that anyone conducted such a risk assessment for Mr Smith.
87. It appears that it has become assumed practice at Lowdham Grange that healthcare staff conduct assessments through the cell door observation panel in the segregation unit, rather than face-to-face. The clinical reviewer concluded that this was of great concern and noted that it was not possible to assess a patient's physical or mental health adequately in this way.
88. It was therefore the case that, as Mr Smith's health deteriorated, no one conducted a face-to-face examination until a response nurse assessed him on 8 May, at which point he was sent to hospital. The clinical reviewer concluded that this failure was unacceptable, particularly as Mr Smith had previously vomited and was so unresponsive that he had to be carried to a clean cell.
89. At the same time, there was an assumption that Mr Smith's behaviour was due to him having taken PS. He had a long-standing and significant mental health diagnosis and had stopped taking his antipsychotic medication. As the mental

health team are not contracted to work over weekends or bank holidays (this is a standard arrangement in Category C prisons), it was not until 7 May that a mental health assessment took place. The mental health lead told us that she and a mental health nurse (who conducted the assessment) considered that Mr Smith was experiencing a physical health problem. The prison paramedic, who assessed Mr Smith twice on the same day, said that her view was that Mr Smith was experiencing a mental health issue. It is possible that the failure to conduct a face-to-face assessment contributed to this confusion about Mr Smith's diagnosis.

90. It is not clear whether Mr Smith used PS, why he stopped taking his antipsychotic medication, and to what extent either of these factors contributed to the deterioration in his mental and physical health. The clinical reviewer noted that Mr Smith did not have a history of embolisms and that there are no entries in his medical record that indicate that he was at greater risk of a deep vein thrombosis. She concluded that the lack of attention to his deteriorating health might have contributed to a delay in admitting Mr Smith to hospital. She also concluded that the healthcare that Mr Smith received in prison was not equivalent to that which he might have expected to receive in the community. We make the following recommendation:

**The Director and Head of Healthcare should ensure that all segregation healthcare assessments are conducted face-to-face rather than through the cell door observation panel, unless there are significant risks to the safety of staff that cannot be mitigated following a risk assessment by a unit manager.**

## Food and fluid refusal

91. Department of Health guidelines on the clinical management of people refusing food in prisons state that healthcare staff must determine whether a prisoner refusing food or fluid has the mental capacity to do so. It states that there must be a full initial medical assessment to take baseline clinical observations, and clinical staff should consider whether there is an underlying mental or physical illness causing or contributing to the refusal.
92. Lowdham Grange's local protocol on reporting food refusals also states that a prisoner identified as refusing food should be offered a doctor's appointment to assess their mental health and capacity. Local guidelines also state that after 24 hours of fluid refusal, a prison doctor should determine whether the prisoner can remain at Lowdham Grange or be transferred to the healthcare centre at HMP Nottingham.
93. The first record that Mr Smith was not eating or drinking is on 6 May. Segregation unit staff appropriately began a food and fluid refusal log after 24 hours, in line with local guidelines. However, there is no record that anyone assessed Mr Smith's capacity to refuse food and fluids or to understand the consequences of this, and no one conducted a baseline health assessment. There was also no consideration about whether the healthcare centre at Nottingham might have been a more appropriate environment for Mr Smith. We make the following recommendation:

**The Head of Healthcare should ensure that all prisoners refusing food or fluids are managed in line with local and national guidelines.**

## Substance misuse

94. Lowdham Grange has a comprehensive drug and alcohol strategy dated March 2019 which is reviewed and updated annually. The strategy sets out local objectives to prevent supply and reduce demand for illicit substances. There is also a local PS patient pathway which highlights that prisoners suspected of or found using PS can be referred to the substance misuse service by a variety of means, including through wing officers or after a disciplinary hearing. It states that the substance misuse service will complete a triage within 48 hours of referral to determine whether the prisoner wants to engage with the service, with actions to take depending on the outcome.
95. In March 2019, an officer recorded that Mr Smith had “clearly” been smoking PS. Earlier that week, staff had seen him receiving a package from a known drug supplier. No one referred Mr Smith to the substance misuse service, which was a missed opportunity to identify and address any substance misuse issues he had. We make the following recommendation:

**The Director should ensure that any prisoners identified as or suspected of using psychoactive substances are referred to the substance misuse service.**

## Restraints, security and escorts

96. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner’s health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner’s risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner’s risk when he has a serious medical condition. The judgment indicated that medical opinion about the prisoner’s ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
97. In hospital, Mr Smith was restrained with double cuffs when he was conscious. He had a long history of violence in prison and in the community, and escorting officers made entries recording that he had been aggressive, unpredictable and agitated when conscious. In the circumstances, we consider that it was reasonable that staff applied restraints when Mr Smith was conscious.
98. However, we are concerned that restraints were initially applied when he was in an induced coma, and only removed after several days at the request of hospital staff. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity. While he was unconscious, Mr Smith presented no risk to the public or of escape and restraints should not have been used at this time.
99. On the morning of his death, officers noted that Mr Smith’s hands were significantly swollen and the handcuffs were restricting his blood flow. An officer said that he loosened the cuffs as much as he could but that this did not relieve the pressure on Mr Smith’s wrists. When the duty manager visited later that morning, he said that he would arrange for larger handcuffs to be brought in the evening. However, this

would have meant that Mr Smith spent most of the day in discomfort. It is not acceptable that the solution presented to him was to “wiggle his fingers” if larger handcuffs were available that might have alleviated his discomfort. Prison staff should have arranged for these to have been brought to hospital as soon as possible. We make the following recommendations:

**The Director should ensure that all staff undertaking and reviewing risk assessments for prisoners admitted to hospital understand the legal position on the use of restraints, that assessments fully take into account the prisoner’s health and are based on the actual risk he presents at the time.**

**The Director should ensure that when prisoners are restrained, staff apply handcuffs of an appropriate size.**

**Prisons &  
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