

**Prisons &  
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**Ombudsman**  
Independent Investigations

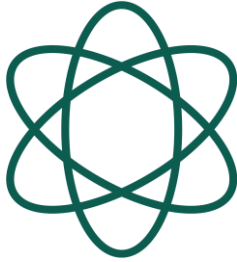
# **Independent investigation into the death of Mr Carl Smythe, a prisoner at HMP Manchester, on 4 May 2021**

**A report by the Prisons and Probation Ombudsman**



## 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 Smythe had been convicted of murder on 11 August 2020 and sentenced to life imprisonment with a long tariff. He struggled to come to terms with his sentence, which he felt was unfairly long.

Mr Smythe always denied that he had any thoughts of self-harm and I accept that he gave no sign that he was at imminent risk of suicide. However, I am concerned that Mr Smythe's recently imposed sentence was not recognised as a possible risk factor at Manchester. I am also concerned that there is no evidence that staff had any meaningful contact with him, apart from one conversation in early March, and that staff did not know him well enough to be able to identify that he was struggling.

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**

**February 2022**

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# Summary

## Events

1. Mr Carl Smythe was remanded to HMP Exeter in January 2020 charged with murder. He was convicted on 11 August and sentenced to life imprisonment (with a minimum term of 21 years).
2. He struggled to come to terms with his sentence and was managed under suicide and self-harm procedures (known as ACCT) until the beginning of September, although he always denied having any suicidal thoughts.
3. Mr Smythe was transferred to HMP Manchester on 10 February 2021. The reception nurse assessed Mr Smythe and referred him to the mental health team due to the nature of his offence and sentence. On 27 February, a mental health nurse completed a detailed mental health assessment of Mr Smythe and noted that he was “becoming hopeless” and was struggling with the length of his sentence. However, she concluded that he needed no further mental health intervention.
4. On 30 April, a friend of Mr Smythe’s telephoned the prison’s safer custody helpline and left a voice message expressing her concern about his safety and mental wellbeing. As a result, staff completed welfare checks on Mr Smythe but were satisfied that he was not at risk of suicide or self-harm.
5. During a morning roll check at 5.13am on 4 May, night patrol officers opened Mr Smythe’s cell observation panel and saw him hanging in his cell. They immediately radioed a medical emergency ‘code blue’, indicating a life-threatening situation. Although officers and healthcare staff responded quickly to the code blue, it was clear that Mr Smythe had been dead for some time. As a result, they did not attempt cardio-pulmonary resuscitation (CPR).
6. An ambulance crew arrived at the prison around 5.20am. At 5.50am, paramedics confirmed that Mr Smythe had died.

## Findings

### Clinical care

7. The clinical reviewer concluded that the physical and mental healthcare Mr Smythe received at Manchester was of a good standard and equivalent to that which he could have expected to receive in the wider community.

### Management of risk of suicide and self-harm

8. Mr Smythe always denied having any suicidal thoughts and gave prison staff no reason to consider that he was at imminent risk of self-harm and suicide in the days and weeks prior to his death. In that sense his death was not foreseeable.
9. However, apart from one conversation on 9 March there is no evidence that staff at Manchester had any meaningful contact with Mr Smythe, despite his recently

imposed life sentence (which was a significant risk factor). As a result, they were not in a position to identify that he was struggling. We consider that more should have been done to support him.

## **Recommendations**

- The Governor should ensure that staff engage frequently and meaningfully with prisoners who are serving long sentences, and consider whether they need additional support.
- The Governor should ensure that calls to the safer custody helpline are considered in the context of the prisoner's risk factors.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Manchester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Smythe's prison and medical records.
12. The investigator interviewed seven members of staff at Manchester. The interviews were completed by video link and telephone due to the restrictions imposed as a result of the COVID-19 pandemic.
13. NHS England commissioned a clinical reviewer to review Mr Smythe's clinical care at the prison. The majority of the interviews were conducted jointly by the clinical reviewer and the investigator.
14. We informed HM Coroner for Manchester City of the investigation. He provided us with a copy of the post-mortem report and we have sent the coroner a copy of this report.
15. The Ombudsman's family liaison officer wrote to Mr Smythe's next of kin, his mother, to explain the investigation. She asked for a copy of the report. She also asked whether staff knew about a telephone conversation Mr Smythe had with her on 26 April and another with a friend on 30 April. Mr Smythe's mother wanted to know what action staff took if they had listened to the calls, as Mr Smythe was very anxious about his sentence. We have addressed these questions in this report.
16. Mr Smythe's next of kin received a copy of the draft report. She raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Their action plan is annexed to this report.

## Background Information

### HMP Manchester

18. HMP Manchester is a high security category B prison. HMP Manchester is a training prison and accepts long term prisoners. There is a category A unit for prisoners posing greater security risks. The prison holds up to 744 prisoners. This is spread across nine residential units, a segregation unit, specialist intervention unit and a healthcare unit. Greater Manchester Mental Health NHS Foundation Trust provides 24-hour nursing care.

### HM Inspectorate of Prisons (HMIP)

19. The most recent full inspection of HMP Manchester was in September 2021. The findings of this inspection were not available at the time of writing our initial report. Prior to this, a full inspection took place in June and July 2018. Inspectors reported that they observed many positive interactions between staff and prisoners, although they also noted that a small but influential number of operational staff were disengaged and distant. Inspectors noted that there were a wide range of primary and secondary care services with improved waiting times and some good practices in systematic assessment of patients.
20. In June 2019, HMIP carried out an Independent Review of Progress to assess progress against the key recommendations from the 2018 inspection. Inspectors reported that promising work had recently begun to support prisoners in crisis but was too new to be assessed, and that this was very concerning given that there had been three further self-inflicted deaths since the full inspection. They commented that it was bewildering to find that actions to prevent deaths in custody simply had not been reviewed until shortly before their visit. Similarly, the introduction of key work and wing peer support had been so slow that they could not yet see sufficient progress in this area.
21. HMIP also conducted a Short Scrutiny Visit at Manchester in June 2021 to look at the care of prisoners during the COVID-19 pandemic. They reported that the key worker scheme had been suspended but that the safer custody team was proactive, and they were pleased to see the use of trained counsellors to support individual prisoners at risk of self-harm or in crisis. The counsellors could be directly involved in the management of each case and provide additional support, such as promoting coping skills, to those in crisis. However, they were concerned that routine mental health referrals were not being assessed and no monitoring of those waiting was taking place.

### 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 latest annual report, for the year to 28 February 2020, the IMB reported that there had been a reduction in the number of newly opened ACCT documents at Manchester, which had coincided with the establishment no longer receiving prisoners directly from local courts. The Board noted that the prison had

received a visit from the HMPPS Safer Custody team in September 2019 to review the ACCT process, and it was noted that there had been significant improvements. Manchester was currently training additional supervising officers to undertake ACCT reviews, a recommendation suggested by the auditors.

## **Previous deaths at HMP Manchester**

23. The last prisoner to take his own life at Manchester was in April 2019. There were no notable similarities in the previous case to the death of Mr Smythe. There were two unexplained deaths and one potentially drug-related death at Manchester during this time, none of which contain any notable similarities to this case.
24. Another self-inflicted death occurred at Manchester in July 2021, which is still being investigated.

## **Assessment, Care in Custody and Teamwork**

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.
26. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## **COVID-19 restrictions**

27. On 24 March 2020, in response to the COVID-19 pandemic and in line with Government advice, HM Prison and Probation Service (HMPPS) issued an instruction to all prisons to introduce social distancing and a restricted regime for staff and prisoners, wherever possible. On 27 March, HMPPS issued operational guidance to prisons on exceptional regime and service delivery, which reflected Government restrictions following the national lockdown of 23 March. This guidance resulted in significantly restricted prisoner activities. Prison visits were suspended, education and non-essential work was cancelled, and healthcare delivery was also affected. This meant that prisoners spent much of their day locked behind their cell doors.

## **Keyworker scheme**

28. The keyworker scheme aims to improve safer custody by engaging with prisoners, building better relationships between staff and prisoners and helping prisoners settle into life in prison. It provides that all adult male prisoners will be allocated a

dedicated key worker who will spend an average of 45 minutes a week on key worker activities, including having meaningful conversation with each of their allocated prisoners.

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

## Key Events

### Background

30. Mr Carl Smythe was first convicted of a criminal offence in 1989, aged 16. He served several short prison terms during his life for offences against the person, theft, public disorder and other minor offences. He had a history of substance and alcohol misuse.
31. On 28 January 2020, Mr Smythe was remanded to HMP Exeter charged with murder. He told the reception nurse that he had a history of depression and had self-medicated with diazepam (which is used to treat anxiety). Due to the nature of his alleged offence, staff began monitoring Mr Smythe under ACCT procedures on 29 January. Mr Smythe was also prescribed antidepressants at this time due to low mood. Staff closed the ACCT on 10 February, as they were satisfied that Mr Smythe was making plans for the future and engaging with the substance misuse team to address his drug and alcohol problems.
32. Mr Smythe was convicted of murder on 11 August and received a life sentence (with a 21-year minimum term) the following day. Staff monitored him under ACCT procedures from 11 August until 3 September, which is standard practice following a murder conviction and life sentence (although the officer who completed Mr Smythe's ACCT assessment interview recorded that Mr Smythe said he had "absolutely no intention of harming or taking his own life"). Mr Smythe was supported by the mental health team during the ACCT process and continued managing his low mood with citalopram (an antidepressant). Mr Smythe did not require any ongoing mental health input while at Exeter and decided to stop taking citalopram on 24 November.

### HMP Manchester

33. On 10 February 2021, Mr Smythe was transferred to HMP Manchester. The reception nurse assessed Mr Smythe and recorded on SystmOne (the electronic medical record) that he was "polite and appropriate". Mr Smythe told the nurse that he had previously used drugs but not for over a year. He also said he had no thoughts of suicide or self-harm and was not prescribed any medication. The reception nurse referred Mr Smythe to the mental health team due to the nature of his offence.
34. As part of the reception screening process, Mr Smythe was seen by a mental health nurse. In interview, she told us that all new prisoners receive a mental health screen when they arrive at Manchester. She recorded on SystmOne that Mr Smythe was "brittle and dismissive" during the assessment, and that he expressed his frustration and anger at his conviction and sentence. Mr Smythe told her that he had no thoughts of suicide or self-harm, however he did not fully engage with the assessment interview because he said he was tired.
35. Mr Smythe told her that he had suffered a breakdown before coming into prison. He reported using cannabis and unprescribed diazepam and he felt this, along with alcohol, had contributed to his offence. She referred Mr Smythe for a further mental

health assessment due to the nature of his offence, his conviction and his life sentence.

36. As Mr Smythe had told reception staff that he had used drugs in the past, he was seen by a community mental health nurse from the substance misuse team on 11 February. Mr Smythe said he did not need any support from the substance misuse team as he had no intention of using drugs in prison and knew how to access support if he required it.
37. Also on 11 February, Mr Smythe was seen by an officer for a key work session. She recorded that he was in “a pleasant mood” and that he said he was “settling in ok”, had no issues to raise and just wanted to get his head down and get on with his sentence.
38. Mr Smythe spent the next 14 days in isolation, in line with the COVID-19 guidelines in place at the time.
39. On 15 February, a nurse completed a second reception screen for Mr Smythe. She raised no serious concerns.
40. On 27 February, a mental health nurse, completed a more detailed mental health assessment of Mr Smythe, following on from his initial reception screen. She recorded on SystemOne that Mr Smythe engaged well and maintained good eye contact. She noted, however, that he was “becoming hopeless”. Despite this, Mr Smythe told her that he did not want to hurt himself or end his life by suicide and cited his partner, children and family as “protective factors”. He said he was struggling to come to terms with the length of his sentence and felt let down by the justice system and his legal team. She found that Mr Smythe had no clinical symptoms of depression or any symptoms of a mental illness and did not recommend any further mental health intervention.
41. On 9 March, an officer held a key work session with Mr Smythe (who had not yet been allocated a regular key worker). The officer recorded on the prison’s information management system (NOMIS) that Mr Smythe was polite and respectful but seemed agitated in mood. Mr Smythe told the officer that he was frustrated that he had not heard from his OMU (Offender Management Unit) worker since arriving at Manchester, which she assured him she would chase up. (The OMU is responsible for helping prisoners achieve their sentence plans.) Mr Smythe said he wanted to be transferred to a prison where he could do the relevant courses to aid his release date. The officer explained to Mr Smythe that due to COVID-19, moves to and from establishments were very limited. She recorded that Mr Smythe accepted this and thanked her for her time. In interview, the officer told us that she could not recall the session well, but that she did not have any major concerns about Mr Smythe’s wellbeing. She said he came across as just being a quiet person.
42. On 26 April 2021, Mr Smythe spoke to his mother on the telephone between 6.30 and 7.30pm. Mr Smythe’s mother told us that he said he was sorry and that he “can’t do this”. Prisoners’ personal telephone calls are recorded at Manchester and staff listen to a percentage of them. Staff did not listen to this call and were not aware of what was discussed.

43. On 27 April, an officer held a key work session with Mr Smythe. However, Mr Smythe told the officer that he did not want to talk as he was too tired. The officer recorded that he asked Mr Smythe if he was okay, and that he replied that he was “good” and asked if they could talk another time instead. The officer told Mr Smythe to speak to him if he saw him but, if not, he would catch up with him at their next key work session. (Mr Smythe died before the next key work session could take place.) In interview, the officer told us that he did not have any concerns about Mr Smythe, although he said that he did not know Mr Smythe well enough to pick up on any potential changes in behaviour or attitude.
44. At 7.30am on 30 April, a friend of Mr Smythe’s telephoned the prison’s safer custody helpline and left a voice message to express her concern about Mr Smythe’s safety. At 8.11am, an officer in the safer custody team recorded that he had rung Mr Smythe’s wing and that an officer had conducted a welfare check. He recorded, “no concerns at present but will monitor today.” He rang the friend back to tell her.
45. An officer said in his statement and interview that another officer asked him to conduct a welfare check on Mr Smythe in response to the welfare call (which he, wrongly, understood to have been from Mr Smythe’s mother). He said he and another officer went to Mr Smythe’s cell. Mr Smythe was asleep, so the officer woke him up and told him they had received a phone call about his welfare. The officer said he asked Mr Smythe if he would like to share anything with them and if he was okay, and Mr Smythe responded, “Yeah, I’m fine, boss.” The officer said that Mr Smythe may have added a few other words, however the “general feeling” was that he was fine and wanted to be left alone. The officer did not make a record of this at the time.
46. There is no information about Mr Smythe’s movements or mood on 1 and 2 May. There is no record of officers having any interactions with Mr Smythe or of him raising any concerns.

### **3 – 4 May**

47. At around 5.15 pm on 3 May, Mr Smythe’s cell was locked by officers. At around 8.00pm, the officer checked Mr Smythe through his cell observation panel during his evening roll check (count of prisoners). In his statement, the officer described Mr Smythe as “pottering around at the back of his cell with the lights on”. He said he had no concerns about him.
48. At 10.45pm, 12.35am and 3.20am, two officers conducted “door checks” on Mr Smythe’s wing. They raised no concerns. In interview, an officer told us that door checks, which are standard practice at Manchester during the night, are purely to check that the door is secure and that they are not visual and/or welfare checks.
49. At 5.13am, during the early morning roll check, the officer opened Mr Smythe’s cell observation panel and turned on the night light. The cell was still quite dark but the officer said he thought he could see Mr Smythe standing in front of the window at the end of the cell. His feet were not off the ground and he was not slumped, and the officer initially thought that he was under the influence of something.
50. The officer called a second officer, who was on the other side of the landing, to come over with his torch. The second officer shone his torch into Mr Smythe’s cell

and saw that his lips were a dark colour. He also saw a piece of green bed sheet sticking out that Mr Smythe had tied to the grill outside his window. The second officer said, "He's done it. He's done it." He told us in interview that the first officer knew what he meant by that and immediately radioed a medical emergency 'code blue', indicating a life-threatening situation.

51. Both officers went into the cell and found Mr Smythe hanging from the window bars. They noticed signs of rigor mortis, indicating that Mr Smythe had been dead for some time. Other officers responded quickly to the code blue and helped to support Mr Smythe's body and lay him on the floor. An officer cut the ligature, which was made from a piece of bedding.
52. Two nurses arrived around four minutes later. The nurses agreed that Mr Smythe had clearly been dead for some time. As a result, they did not attempt cardiopulmonary resuscitation (CPR). An ambulance crew arrived at the prison around 5.20am and were told by prison staff that the situation was a death in custody.
53. While healthcare staff were assessing Mr Smythe, an officer discovered a handwritten note in the cell which said, "You can stick your 20 years up your arse."
54. At 5.50am, paramedics confirmed that Mr Smythe had died.

### **Contact with Mr Smythe's family**

55. As the prison did not have up to date contact details for Mr Smythe's nominated next of kin, the prison's Duty Chaplain called Mr Smythe's ex-partner at 7.55am on 4 May and broke the news of Mr Smythe's death to her. Mr Smythe's mother was later established as his next of kin.
56. The prison's Duty Chaplain maintained contact with Mr Smythe's family, and in line with national instructions, the prison contributed to the costs of the funeral.

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

57. The duty governor held a debrief with prison staff involved in the emergency response. All staff were offered the support of the prison's care team.
58. The Governor posted notices informing other prisoners of Mr Smythe's death and offering support, in case they had been adversely affected.

### **Post-mortem report**

59. A post-mortem examination identified Mr Smythe's cause of death as hanging. Post-mortem toxicology tests found traces of promethazine (an antihistamine) and olanzapine (an antipsychotic), neither of which he was prescribed, but concluded that there was no evidence to suggest drugs, within the scope of analysis, contributed to the death.

# Findings

## Management of risk of suicide and self-harm

60. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
61. We have considered whether staff at Manchester should have recognised Mr Smythe was at risk in the weeks and months leading up to his death and begun ACCT procedures to support him.
62. Mr Smythe had two main risk factors for suicide: he had recently been convicted of a violent offence (murder) and had been sentenced to life imprisonment with a long tariff. We are satisfied that Mr Smythe's risk was well managed by staff at Exeter and that his reception screen when he arrived at Manchester was thorough and appropriate.
63. The clinical reviewer concluded that Mr Smythe received appropriate care from the mental health team at Manchester. He considered that the assessment undertaken by a mental health nurse on 27 February was comprehensive and her findings were clearly documented on SystemOne.
64. The clinical reviewer was satisfied that the physical and mental healthcare Mr Smythe received at Manchester was of a good standard and was equivalent to that which he could have expected to receive in the wider community. He concluded that there was no indication that Mr Smythe planned to take his own life.
65. Mr Smythe had no history of self-harm, and in the months leading up to his death he did not express any thoughts of suicide or self-harm during his contact with prison staff. In these circumstances, we cannot say that staff could have identified Mr Smythe as at imminent risk of suicide or self-harm before he died.
66. However, Mr Smythe was described to us as a quiet prisoner who kept himself to himself and we are concerned staff had virtually no meaningful contact with him that would have enabled them to identify any concerns. During the 12 weeks he spent at Manchester, Mr Smythe had just three key work sessions (on 11 February, 9 March and 27 April), each with a different officer, and a meaningful conversation only took place at the 9 March session. The long gaps between these sessions, the lack of continuity and the absence of any other recorded contact meant that staff did not know him well and were not in a position to assess if his mood had changed or how he was coping with his very long sentence.
67. Following the phone call made to the Safer Custody helpline on 30 April by Mr Smythe's friend, an officer conducted a welfare check on Mr Smythe, and Mr Smythe, who had just been woken up, replied that he was 'fine'. However, although the safer custody team had noted that Mr Smythe would also be monitored during the day, there is no evidence that this happened. We are concerned that too much weight was placed on what Mr Smythe said and that there is nothing to suggest that anyone considered the phone call in the context of Mr Smythe's risk factors (notably

his very long sentence) or considered whether ACCT proceedings should be opened. In addition, there is no evidence that staff had any meaningful contact with Mr Smythe over the three days following the call and preceding his death.

68. It is clear that Mr Smythe was struggling to come to terms with his sentence, but staff do not appear to have been aware of this. Mr Smythe told the mental health nurse on 27 February that he was struggling with his sentence and she also recorded that he was “becoming hopeless”. It is unfortunate that she did not share this information with prison staff since this might have prompted them to talk to Mr Smythe about his sentence and perhaps to put more support in place for him. As it was, there seems to have been no recognition that Mr Smythe was in the early stages of a very long sentence and might need some support.
69. Although we recognise that Mr Smythe always denied thoughts of suicide, we make the following recommendations:

**The Governor should ensure that staff engage frequently and meaningfully with prisoners who are serving long sentences, and consider whether they need additional support.**

**The Governor should ensure that calls to the safer custody helpline are considered in the context of the prisoner’s risk factors.**

## **Inquest**

70. From 18 – 20 July 2022, the inquest into Mr Smythe’s death took place. The inquest concluded that Mr Smythe’s cause of death was suicide by hanging.

**Sue McAllister CB  
Prisons and Probation Ombudsman**

**February 2022**

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