Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Smith, a prisoner at HMP Preston, on 4 May 2022

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 Anthony Smith was found hanged in his cell at HMP Preston on 4 May 2022. He was 34 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had been in prison for only 16 days when he died. When he arrived on 18 April, he told the reception nurse that he had attempted suicide many times before, most recently at the start of April. Despite this clear risk factor, staff did not start suicide and self-harm monitoring (known as ACCT).

Two days later, at his mental health assessment, Mr Smith told the nurse that he did not want to be alive much longer. At his psychiatric assessment on 26 April, Mr Smith said he had thoughts about ending his life. Staff did not start ACCT monitoring because they thought that Mr Smith was not at imminent risk of suicide.

I am concerned that staff did not properly assess Mr Smith's risk of suicide and self-harm and missed opportunities to put ACCT measures in place to support him. The clinical reviewer found that the care Mr Smith received at Preston was not equivalent to that which he could have expected to receive in the community. He found that there were clear gaps in the way clinical staff assessed Mr Smith's risk.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. On 18 April 2022, Mr Anthony Smith was remanded in prison custody, charged with arson. He was sent to HMP Preston.

2. Mr Smith told the reception nurse that he had attempted suicide several times, most recently at the start of April. However, he said he had no current thoughts of suicide. The nurse did not start suicide and self-harm prevention monitoring (known as ACCT).

3. A mental health nurse assessed Mr Smith on 20 April. Mr Smith told the nurse he felt fed up and "doesn't want to be on this earth much longer". He also said he "wouldn't be bothered if he fell asleep and didn't wake up". However, Mr Smith said he had no active plans to harm himself. Mr Smith told the nurse that he heard voices and that they were billionaires, trying to steal his ideas for inventions. The nurse thought Mr Smith was psychotic.

4. On 26 April, at a psychiatric assessment, Mr Smith told the trainee psychiatrist that his mood was low, he felt hopeless and had thoughts about ending his life. The trainee psychiatrist said that Mr Smith appeared to want to work with the mental health team and take his medication and he therefore assessed that he was not at imminent risk of suicide. He also said that Mr Smith did not want to be on an ACCT as he did not think it would be helpful.

5. Shortly after 5.00am on 4 May, during the morning roll check, an operational support grade (OSG) looked into Mr Smith's cell and saw him standing, facing his cell window, but she could only see his trainers and the bottom of his legs as he was hidden behind a curtain. The OSG repeatedly tried to get a response from Mr Smith but was unsuccessful. The OSG radioed senior officers for support, but they were dealing with another incident.

6. The Night Orderly Officer (senior officer in charge at night) called the OSG on the wing telephone and when the OSG explained the situation, she asked officers to go to Mr Smith's cell. A few minutes later, staff arrived and went into Mr Smith's cell. They found Mr Smith had tied a ligature around his neck and attached it to the window bars. An officer called a medical emergency code. They cut Mr Smith down and started cardiopulmonary resuscitation (CPR). Control room staff called an ambulance. A nurse then arrived and assisted with CPR. He said it was difficult to open Mr Smith's mouth as his body was stiff and his teeth were clenched. Paramedics arrived at 5.27am. They assessed that Mr Smith had been dead for some time.

Findings

7. We are concerned that staff did not properly assess Mr Smith's risk of suicide and self-harm and missed opportunities to put ACCT measures in place to support him.

8. The clinical reviewer found that the standard of care Mr Smith received at Preston was not equivalent to that which he could have expected to receive in the

community. He considered that there were clear gaps in the way clinical staff assessed Mr Smith's risk of suicide and that they did not take appropriate action when Mr Smith's risk increased.

9. The clinical reviewer also found that despite Mr Smith being on the Severe Mental Illness Register, this was not clearly highlighted in his medical records, and there was no care plan.

10. Staff called an old medical emergency code, 'code 1' rather than 'code blue'. While it did not delay the emergency response, staff should use the correct code.

11. We are concerned that the nurse continued CPR, even though there were clear signs that Mr Smith was dead.

Recommendations

- The Head of Healthcare should ensure that staff assess a prisoner's risk of suicide and self-harm based on their known risk factors and should not rely solely on the prisoner's stated intentions and wishes.

- The Head of Healthcare should review arrangements in place to ensure effective care planning and follow up is clearly documented for patients identified in the Severe Mental Illness Register.

- The Governor should ensure that staff understand their responsibilities during a medical emergency, including that they radio the correct medical emergency code immediately.

- The Head of Healthcare at Preston should ensure that staff are given clear guidance and understand the circumstances in which resuscitation is inappropriate in accordance with Resuscitation Council UK and NICE Guidelines.

- The Head of Healthcare should review the training compliance arrangements in place to ensure all healthcare staff are up to date with Basic Life Support training and Immediate Life Support training.

The Investigation Process

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

13. The investigator visited Preston on 13 and 14 June 2022. He obtained copies of relevant extracts from Mr Smith's prison and medical records.

14. The investigator interviewed nine members of staff. The investigator conducted most of these interviews in person while at Preston on 13 and 14 June. The remaining interviews took place over telephone on 20, 22 and 28 September. The investigator also tried to interview the prisoner who lived in the cell next to Mr Smith, but he declined.

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

16. We informed HM Coroner for Lancashire and Blackburn of the investigation. He gave us the results of the post-mortem examination. We have sent him 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 he wanted us to consider. Mr Smith's father wanted to know the reasons why Mr Smith decided to take his own life and asked for a copy of our report.

Background Information

HMP Preston

18. HMP Preston is a Category B local prison serving the courts in Lancashire and Cumbria. It holds up to 680 adult male prisoners. Spectrum Community Health C.I.C provide primary healthcare services 24 hours a day, seven days a week, as well as substance misuse services. Tees Esk & Wyre Valleys NHS FT provide mental health services at Preston.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Preston was in August 2020. Inspectors found that the number of recorded self-harm incidents was similar to the levels before March 2020 when the COVID-19 pandemic restrictions had been imposed. The management of prisoners at risk of suicide and self-harm (using the ACCT process) was generally reasonable, and Listeners (prisoners trained by the Samaritans to provide confidential emotional support to fellow prisoners) were available at most times.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that all staff treat prisoners fairly and decently. In its latest annual report for the year to March 2021, the IMB reported that the rate of self-harm had initially dropped slightly with the introduction of COVID-19 restrictions. Prisoners thought to be at risk from suicide or self-harm were managed by the ACCT approach. Even when staff shortages were severe, this section remained fully staffed. These prisoners received increased support by way of daily welfare checks around their normal reviews. These checks were also in place for other prisoners found to be vulnerable due to mental health issues, identified through the weekly safety intervention meetings (SIM).

Previous deaths at HMP Preston

21. Mr Smith was the third prisoner to die at Preston since May 2020. Of the previous deaths, one was self-inflicted and one was from natural causes. We have not yet completed our investigation into the previous self-inflicted death at Preston.

Assessment, Care in Custody and Teamwork (ACCT)

22. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

Key Events

23. On 18 April 2022, Mr Anthony Smith was remanded in prison custody, charged with arson, and sent to HMP Preston.

24. A nurse completed Mr Smith's reception health screen. Mr Smith told the nurse that he had tried to take his life on many occasions, most recently at the beginning of April 2022. Mr Smith told the nurse he had no current thoughts of suicide. The nurse referred him to the Integrated Mental Health Team (IMHT) for assessment.

25. The next morning, Mr Smith had his second health screen with a nurse, but he was rude and aggressive and did not fully engage. The nurse noted that she told Mr Smith that if he had any concerns about his physical or mental health, he should submit and application to Healthcare.

26. On 20 April, a nurse from the IMHT visited Mr Smith to conduct an assessment. Mr Smith had been referred to IMHT as he would not maintain eye contact, had a history of attempted suicide and addiction, and said "people made him do things". The nurse recorded that Mr Smith said he was fed up and did not "want to be on this earth much longer". He also said he "wouldn't be bothered if he fell asleep and didn't wake up". However, when asked, Mr Smith said he did not have active plans to harm himself.

27. Mr Smith told the nurse that he heard voices, that someone had put lenses over his eyes while he was sleeping and noise-cancelling earphones implanted in his head, which only let certain things through. Mr Smith said he believed the voices were billionaires who wanted to steal his ideas. The nurse concluded that Mr Smith was "vulnerable due to [his] delusional beliefs and psychotic presentation". (Psychosis is a condition where a person has difficulties in determining what is real and what is not.)

28. Between 21 April and 3 May, Mr Smith asked an officer not to unlock his cell door as he did not want to leave his cell. He missed a healthcare appointment with the blood clinic and refused to have bloods taken unless it was in a sterile environment but the next day, he complied. On two occasions, staff recorded that Mr Smith did not get out of bed in the morning and once, he refused to collect his medication.

29. On the afternoon of 21 April, the healthcare department held a multidisciplinary team meeting, where they added Mr Smith to the mental health team's caseload and put him on a waiting list to be reviewed by a psychiatrist.

30. On 22 April, Mr Smith appeared by video link at Blackburn Magistrates' Court, and pleaded guilty. After the video link ended, Mr Smith told staff he had no thoughts of self-harm. Mr Smith's sentencing date was set for 20 May.

31. On 25 April, Mr Smith was moved to F Wing. The next day, an officer recorded that Mr Smith had not looked after his new cell as it was in a poor state. The officer said that Mr Smith was acting bizarrely. He made a referral to the mental health worker on duty and officers asked for a prison chaplain to visit Mr Smith.

32. Later that morning, a prison chaplain, visited Mr Smith. Mr Smith told them that his "brain would not switch off". He said that his inventions had been stolen, and he

was frustrated that he had not been paid for them. The Chaplin left when the IMHT arrived.

33. A trainee forensic psychiatrist conducted a psychiatric assessment on Mr Smith. During the assessment, Mr Smith said his mood was low, he felt hopeless and had thoughts about ending his life but said he had no intention to harm himself. Mr Smith told the psychiatrist that he felt on edge, like he might do something to harm himself or others but did not want to. The psychiatrist's assessment concluded that Mr Smith was acutely psychotic and if not treated, he would be a risk to himself and others in the longer term.

34. The psychiatrist told the investigator and the clinical reviewer that IMHT staff considered that Mr Smith did not need to be monitored under suicide and self-harm prevention procedures (known as ACCT). He said that at the time of the assessment, Mr Smith's risk of suicide and self-harm appeared not to be imminent. The psychiatrist said Mr Smith told him that he harmed himself when he was more unwell and was using illicit drugs. He said Mr Smith was not using illicit drugs at the time of the assessment and appeared to want to work with IMHT and take his medication. The psychiatrist also said that a nurse had discussed starting ACCT monitoring for Mr Smith, but Mr Smith said it would not be helpful for him, and he did not need it.

Events of 3 and 4 May 2022

35. At about 8.20pm on 3 May, an operational support grade (OSG) carried out a welfare check on Mr Smith. The OSG said that Mr Smith was face down on his bed at the time.

36. At around 3.50am on 4 May, the OSG noticed that the light was on in Mr Smith's cell. Shortly after 5.00am, during the morning roll check, the OSG looked into Mr Smith's cell and saw him standing, facing the window. However, most of his body was hidden behind a curtain, and she could only see his trainers and the bottom of his tracksuit bottoms.

37. The OSG was concerned about Mr Smith and tried to get a response from him by rattling the door and calling out to him, but Mr Smith did not respond. She radioed Oscar 2, the officer who was second in command during the night and asked if he could attend F Wing. However, Oscar 2 was not available as he was dealing with another issue. The OSG continued to try and get a response from Mr Smith and radioed a custodial manager (CM) (who was Oscar 1, the senior officer in charge) who said they were in the healthcare unit. The OSG assumed she was dealing with the same issue as Oscar 2.

38. The OSG then noticed that Mr Smith had barricaded his door, but as she could see his feet were on the floor, she did not think he had hanged himself. The OSG said she still felt concerned and was just about to radio for staff assistance when the wing telephone rang. She went to the wing office to answer it and it was Oscar 1. Once the OSG explained Mr Smith's situation, Oscar 1 asked Oscar 2 and two officers to go to F Wing.

39. Shortly after 5.10am, Oscar 2 and two other officers arrived at Mr Smith's cell and pushed their way in. They found that Mr Smith had tied a ligature around his neck,

which was attached to the window bars. The officers cut him down and started cardiopulmonary resuscitation (CPR).

40. Oscar 2 then radioed a medical emergency code. (He called 'code 1', an old code, when it should have been 'code blue', used when a prisoner is unconscious or having breathing difficulties.) The control room staff asked Oscar 2 to repeat his message. He responded with 'code 1, F Wing', and shortly after, the control room responded saying 'received' and called for an ambulance.

41. A nurse arrived at Mr Smith's cell and took charge of the CPR. The nurse said Mr Smith was unresponsive, not breathing and had no pulse. The nurse said it was difficult to open Mr Smith's mouth as his body was stiff and his teeth were clenched.

42. Paramedics arrived on the wing at 5.27am and after examining Mr Smith, pronounced him dead.

Contact with Mr Smith's family

43. On 4 May, the prison appointed a prison chaplain, as the family liaison officer. He tried to contact Mr Smith's family that morning, and again in the afternoon, but was unsuccessful. On 5 May, the chaplain managed to contact Mr Smith's father. He maintained contact with Mr Smith's father over the following days, offering support and advice.

44. The prison contributed to the costs of Mr Smith's funeral in line with national policy.

Support for prisoners and staff

45. After Mr Smith's death on 4 May, the Head of Safer Custody and Equalities, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The prison posted notices under prisoners' cell doors informing them of Mr Smith's death and offering support.

Post-mortem report

47. The post-mortem report concluded that the cause of Mr Smith's death was due to suspension (hanging).

Findings

Assessment of Mr Smith's risk of suicide and self-harm

48. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, provides guidance to staff on identifying prisoners who might be at risk of suicide and self-harm. It lists the risk factors and triggers that might increase a prisoner's risk and sets out the procedures (known as ACCT) that staff should follow when they identify a prisoner at risk of suicide and self-harm.

49. When Mr Smith arrived at Preston on 18 April, he told the reception nurse that he had attempted suicide on many occasions, most recently at the start of April, so only a couple of weeks before. The reception nurse recorded that Mr Smith said he had no current thoughts of suicide. She did not start ACCT monitoring.

50. On 18 April, a nurse referred Mr Smith to IMHT. The nurse noted that the referral was made as Mr Smith as had a history of attempted suicide and that "people made him do things".

51. Later that day, during a mental health assessment, Mr Smith told the nurse that he did not "want to be on this earth much longer" and that he "wouldn't be bothered if he fell asleep and didn't wake up". On 26 April, during a psychiatric assessment, he told the trainee psychiatrist, that he felt hopeless and had thoughts about ending his life. On neither occasion did healthcare staff start ACCT monitoring for Mr Smith.

52. The psychiatrist told us that IMHT staff did not consider that Mr Smith needed to be monitored using ACCT as, in their view, he did not appear to be at imminent risk of suicide and self-harm. The psychiatrist said Mr Smith told him that he had harmed himself in the past when he had been more unwell and been using illicit drugs. As Mr Smith was not using drugs, appeared willing to work with IMHT and take his medication, the psychiatrist believed Mr Smith was not at imminent risk.

53. IMHT staff failed to identify that Mr Smith was at risk of suicide and self-harm, and failed to support him using the ACCT process. We are concerned that they placed too much emphasis on Mr Smith's statement that he did not want to be managed using ACCT, rather than considering the clear risk factors he presented. We recommend:

    The Head of Healthcare should ensure that staff assess a prisoner's risk of suicide and self-harm based on their known risk factors and should not rely solely on the prisoner's stated intentions and wishes.

Clinical care

54. The clinical reviewer concluded that the care Mr Smith received at Preston was not equivalent to that which he could have expected to receive in the community. He considered there were clear gaps in the way the clinical team assessed Mr Smith's risk of suicide and self-harm, and that they did not take appropriate action when Mr Smith showed signs that his risk had increased.

55. Mr Smith's mental health diagnoses included paranoid schizophrenia and experiences of psychosis. Mr Smith was identified by IMHT staff as having a severe mental illness and was on the Severe Mental Illness Register. However, this was not clearly highlighted in his medical records, and there was no care plan which outlined interventions that would address his needs. This was not in line with NICE Clinical Guidance (CG) 178: Psychosis and schizophrenia in adults: prevention and management. We recommend:

The Head of Healthcare should review arrangements in place to ensure effective care planning and follow up is clearly documented for patients identified in the Severe Mental Illness Register.

Emergency response

56. PSI 03/2013 *Medical Emergency Response Codes* says that all Governors should have a Medical Emergency Response Code protocol in place that enables staff to quickly convey the nature of the medical emergency. This should ensure that staff take the relevant equipment to the incident and that an ambulance is called immediately. Preston uses the emergency codes 'code blue' (to indicate unconsciousness) and 'code red' (to indicate heavy bleeding). (The old system used to be 'code 1' and 'code 2' and while the PSI says these may still be used, most prisons have moved to the 'code blue' and 'code red' system.)

57. When staff found Mr Smith hanging, Oscar 2 called a 'code 1'. The control room asked Oscar 2 to repeat the code, which he did. An OSG, one of the control room staff, said that when Oscar 2 called the code, he was shouting and sounded in a panic and what he said was unclear. The OSG said they asked Oscar 2 to repeat the code, and then someone called by telephone to confirm it was a 'code blue'. The OSG then immediately called an ambulance. The OSG said that she knew what a 'code 1' meant, and that the use of this code was not the reason there was a slight delay in responding to it.

58. Oscar 2 told the investigator that he knew the correct medical emergency code to use for a prisoner who was hanging was a 'code blue' but he used the old code in the heat of the moment.

59. We accept that Oscar 2 was dealing with a stressful situation and that he made a simple mistake in calling a 'code 1' which did not impact on the emergency response. However, we are concerned that Oscar 2 told the investigator that he would use a 'code 1' in a similar situation again as, "I know this gets staff to attend quicker". Firstly, a 'code 1' should no longer be used and secondly, staff should respond to a 'code blue' immediately as it indicates a medical emergency.

60. It appears that there is still some misunderstanding about the medical emergency response codes in use at Preston. We recommend:

The Governor should ensure that staff understand their responsibilities during a medical emergency, including that they radio the correct medical emergency code immediately.

Resuscitation

61. In September 2016, the National Medical Director at NHS England, wrote to Heads of Healthcare for prisons to introduce new guidance to support staff on when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address concerns about inappropriate resuscitation following a sudden death in a prison. It was taken from the European Resuscitation Council Guidelines 2015 which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The European Guidelines were updated in 2021, but the same principles apply.

62. An officer had already started CPR when a nurse arrived at Mr Smith's cell. The nurse told the Investigator that Mr Smith was unresponsive, not breathing and his body was cold and rigid, his eyes were bulging, tongue was swollen, and he had no pulse. He attached an automated external defibrillator (AED) to Mr Smith. (An AED is used to help when a person's heart has stopped beating normally.) However, the AED indicated that there was no 'shockable rhythm'. The nurse wanted to open Mr Smith's mouth to clear the airway but found this difficult as Mr Smith's body was stiff, and his teeth were clenched.

63. The nurse told the investigator that after completing his observations, he did not think it was possible to save Mr Smith's life. However, he said that due to the nature of the situation, that Mr Smith was relatively young, and there was always an outside chance that resuscitation would work, the nurse considered that on moral and professional grounds, the right thing to do was to perform CPR until the paramedics arrived.

64. When the paramedics arrived**,** they assessed that Mr Smith had rigor mortis (stiffening of the body that occurs two to six hours after death) and told staff to stop CPR as Mr Smith was clearly dead.

65. The nurse told the investigator that at the time, he was not aware of the guidance on resuscitation from the National Medical Director at NHS England and the European Resuscitation Council. Since Mr Smith's death, the Head of Healthcare has circulated this guidance by email.

66. We understand the commendable wish of staff to attempt resuscitation, but they should also be aware of situations when CPR is inappropriate. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We recommend:

    The Head of Healthcare at Preston should ensure that staff are given clear guidance and understand the circumstances in which resuscitation is inappropriate in accordance with Resuscitation Council UK and NICE Guidelines.

67. The clinical reviewer also found that healthcare staff were not up to date with Immediate Life Support training, which indicates a need to review training at Preston to ensure it is routinely completed and updated. We recommend:

The Head of Healthcare should review the training compliance arrangements in place to ensure all healthcare staff are up to date with Basic Life Support training and Immediate Life Support training.

Inquest conclusion

68. There was a narrative conclusion to the inquest, which found that while Mr Smith died as a result of self-suspension, his intentions could not be determined.

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