

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Smith, a prisoner at HMP Hewell, on 20 June 2022

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 Lee Smith was found hanged in his cell on 20 June 2022 at HMP Hewell. He was 42 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had been at Hewell for less than a week when he hanged himself. I am satisfied that there were no indications that Mr Smith was at imminent risk of suicide or self-harm in the days leading to his death. However, I am concerned that the induction process was not completed in full and that healthcare record keeping in Reception lacked sufficient detail.

I am concerned that not all staff were aware that they could enter a cell at night on their own when there was immediate risk to life. I am also concerned that not all staff on duty at night had immediate access to a sealed key pouch, which caused a short delay in opening Mr Smith's cell. Control room staff also used prison-specific terminology when phoning the ambulance service, which meant, in part, that the operator assigned the incorrect priority level.

There should have been a registered healthcare professional on duty at night. However, contrary to contractual arrangements, two healthcare assistants were on night duty when officers found Mr Smith hanged. This resulted in an unnecessarily prolonged resuscitation effort.

I am also concerned that the prison did not inform Mr Smith's next of kin that he had died, in line with Prison Service instructions.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

February 2023

Contents

Summary	1
The Investigation Process.....	4
Background Information.....	5
Key Events.....	6
Findings	11

Summary

Events

1. On 18 December 2021, Mr Lee Smith was remanded to HMP Peterborough, charged with arson. He used a wheelchair because he had limited mobility in his right leg. He also had a history of mental health difficulties, which included emotional unstable personality disorder (EUPD) and depression. The mental health team assessed him but did not accept him onto their caseload. Staff later referred him to the primary mental health team again but they did not review him before he was transferred to HMP Hewell on 14 June 2022.
2. At around 9.30pm on 14 June, an officer at Hewell saw him in a holding cell for a reception check. However, only one of the six questions in the reception assessment had a response recorded and the welfare check section was blank. At 9.55pm, a nurse conducted an initial reception screen and noted that Mr Smith had a history of mental health difficulties but did not report any thoughts of suicide or self-harm.
3. At 8.05am on 15 June, a nurse reviewed Mr Smith and assessed him as fit to attend court, where he was convicted of arson. At 7.14pm, the same nurse reviewed Mr Smith when he returned to the prison and recorded that he did not raise any concerns.
4. At 2.53pm on 17 June, a substance misuse recovery practitioner saw Mr Smith for a substance misuse and mental health triage assessment. Mr Smith told her that he had a history of mental health difficulties and suicide attempts. However, he said that he felt “hopeful” for the future and did not report any current thoughts of suicide or self-harm. Later that day, mental health staff discussed Mr Smith and allocated him a mental health nurse for his EUPD.
5. At 4.42am on 20 June, an officer looked through Mr Smith’s cell door observation panel and saw him sitting on the bottom bunk bed, with a ligature tied to the framework of the top bunk. The officer radioed a medical emergency code blue, shouted to a nearby officer and asked him to bring the sealed cell key pouch. In the meantime, an operational support grade (OSG) called the ambulance service and said, “We’ve had a code blue”, but provided little additional information. At 4.44am, an officer arrived at the cell, unlocked the door and entered the cell. The officers removed the ligature and started cardiopulmonary resuscitation (CPR).
6. At 4.48am, two healthcare assistants (HCAs) arrived at the cell and helped with resuscitation efforts. Paramedics arrived at Mr Smith’s cell at 5.03am, and at 5.05am, they advised staff to stop CPR as it was clear that Mr Smith had died.

Findings

7. Mr Smith gave no indication to staff that he was at risk of suicide and self-harm. While he had some risk factors, he did not display any unusual behaviour that might have indicated an increased risk and in the days before his death, he presented as hopeful for the future. However, we are concerned that Mr Smith’s induction process was not completed in full, that there was no evidence that prison staff

reviewed him when he returned from court on 15 June and that healthcare record keeping in Reception lacked sufficient detail.

8. We are concerned that not all staff were aware that they could enter a cell at night on their own when there was immediate risk to life. We are also concerned that not all staff on duty at night carry a sealed key pouch.
9. Control room staff used prison-specific terminology when telephoning the ambulance service which meant, in part, that the operator assigned the incorrect priority level.
10. A registered healthcare professional was not on duty when staff found Mr Smith hanged, contrary to contractual arrangements. This meant that two HCAs had to lead the resuscitation effort, which resulted in it being unnecessarily prolonged.
11. The clinical reviewer concluded that the clinical care that Mr Smith received at Hewell was equivalent to that which he could have expected in the community.
12. We are concerned that the prison did not inform Mr Smith's next of kin that he had died, in line with Prison Service instructions.

Recommendations

- The Governor should ensure that all aspects of the early days passport are completed and procedures implemented to identify prisoners who may have missed elements of their induction.
- The Head of Healthcare should ensure that healthcare staff who review prisoners returning from court make a detailed entry in their medical record, which should include whether the prisoner's circumstances have changed.
- The Governor should ensure that Reception staff review prisoners who have returned to prison with a change of circumstance so that any risks can be appropriately identified and addressed.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
 - all night staff working on residential units have access to emergency cell keys;
 - single members of staff can enter cells alone at night when there appears to be an immediate risk to life, following a dynamic risk assessment; and
 - control room staff do not use "code blue" when requesting an ambulance and relay as much relevant information as possible to the ambulance operative so that they can assign the correct priority level.
- The Head of Healthcare should review the contingency plan for when a qualified nurse is not available at night and provide clear guidance to healthcare assistants on the circumstances in which resuscitation is appropriate.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death, in line with national instructions.

- The Governor and Head of Healthcare should ensure that a copy of this report is shared with all named staff in this report so that they are aware of the Ombudsman's findings.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
15. The investigator interviewed seven members of staff at Hewell on 3 August and two members of staff by telephone on 8 August.
16. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed healthcare staff.
17. We informed HM Coroner for Worcestershire of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent him a copy of this report.
18. The Ombudsman's family liaison officer contacted Mr Smith's father to explain the investigation and to ask if there were any matters he wanted us to consider. His father wanted to know why staff did not monitor Mr Smith as a suicide risk as he had a history of mental health difficulties. We have addressed Mr Smith's risk in this report.
19. Mr Smith's father received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Hewell

21. HMP Hewell is a large Category B local prison in Worcestershire, holding up to 900 adult male prisoners. Practice Plus Group provides healthcare services at the prison.

HM Inspectorate of Prisons

22. HMIP carried out a full inspection of Hewell in June 2019. Inspectors reported that self-harm at the prison had doubled since their last inspection. They reported that many prisoners said that staff treated them respectfully. Inspectors said that they saw examples of positive interactions between staff and prisoners and that healthcare services had improved since their previous inspection. However, they identified several concerns, including that PPO recommendations following deaths in custody had not been fully implemented and oversight of their progress was inadequate.
23. The most recent inspection of HMP Hewell was a scrutiny visit in August 2020. Inspectors reported that they did not consider that Hewell was a safe prison. They noted that structures were not robust enough to identify and tackle violence and anti-social behaviour and keywork had stopped for most prisoners, leaving little meaningful interaction.

Independent Monitoring Board

24. 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 30 September 2021, the IMB reported that Hewell had improved since their previous reports and was safer. They reported that levels of self-harm were decreasing but still too high. The IMB noted that prisoners were generally treated compassionately.

Previous deaths at HMP Hewell

25. Mr Smith was the tenth prisoner to die at Hewell since June 2020. Of the previous deaths, three were self-inflicted and six were due to natural causes. In a previous investigation, we raised concerns about starting cardiopulmonary resuscitation (CPR) on a prisoner who had clearly died.

Key Events

HMP Peterborough

26. On 18 December 2021, Mr Lee Smith was remanded to HMP Peterborough, charged with arson.
27. Nurse A conducted an initial health screen and noted that Mr Smith used a wheelchair because he had limited mobility in his right leg. Mr Smith told him that he had not been to prison before, had previously sought help for agoraphobia (a fear of being in situations where escape might be difficult) and was known to community mental health services. The nurse recorded that Mr Smith presented as tearful at times and referred him to the mental health team. However, there is no record that staff took any action.
28. On 19 December, Dr A, a prison GP, reviewed Mr Smith and prescribed several medications, including venlafaxine (an antidepressant). (It is unclear from the records whether this was a new prescription or continuing a community prescription.)
29. On 19 February 2022, Nurse B reviewed Mr Smith in response to a request from prison staff. She noted that he looked unkempt and said that he had lost his appetite and was unable to use his hands. He also reported a history of emotionally unstable personality disorder (EUPD), anxiety and depression. The nurse made a mental health referral and arranged for Mr Smith's admission to the prison's inpatient unit for a period of assessment.
30. On 20 February, Dr B, a prison GP, reviewed Mr Smith. He noted that he could not find a physical cause for Mr Smith's reduced mobility and suggested that the problem may be psychological. Mr Smith returned to the wing on 22 February.
31. On 25 February, Nurse C, a mental health nurse, conducted the first part of a mental health assessment by telephone. She recorded that Mr Smith told her that he had EUPD, bipolar disorder and depression. He also reported regular mood swings and said that he had harmed himself since the age of 12.
32. The following day, Nurse C met Mr Smith to conduct the second part of his mental health assessment. She noted that he said that his mood was okay and that he was coping well. He also said that he had had mental health difficulties for over 20 years and had managed well on risperidone (an antipsychotic medication) in the past. The nurse referred him to the secondary care mental health team to assess his suitability for risperidone.
33. On 28 February, Nurse D, a mental health nurse, conducted a triage review and concluded that Mr Smith was not suitable for secondary care as there was no evidence to support a clinical need for risperidone. Mr Smith continued to take venlafaxine.
34. On 14 April, Nurse E referred Mr Smith to the mental health team but failed to record a reason. The mental health team did not receive the referral until 19 May, but the reason for the delay is unclear.

35. On 23 May, Nurse F, a mental health nurse, conducted a triage review and requested a primary care mental health assessment. However, there is no record that the assessment took place.

HMP Hewell

36. At 7.25am on 14 June, Prisoner Escort Custody Services (PECS) officers escorted Mr Smith to Warwick Combined Court. At 7.15pm, they took him to HMP Hewell. The Person Escort Record (PER, which accompanies prisoners on all journeys between police stations, courts and prisons to communicate risk factors) shows that Mr Smith was not assessed as posing a risk of suicide or self-harm.
37. At around 9.30pm, Officer A saw Mr Smith in a holding cell to conduct a reception check. However, only one of the six questions in the reception staff section of the early days passport document had a response recorded and the welfare check section was blank. (The early days passport is a document that staff at Hewell use to assist in the assessment and management of newly arrived prisoners.)
38. At 9.55pm, Nurse G conducted an initial reception screen and recorded that Mr Smith did not report any thoughts of suicide or self-harm. Mr Smith said that he had a history of mental health problems and had previously spent time in a mental health unit in Leicester. There is, however, no evidence that the nurse considered a mental health or social care referral.
39. A short while later, Officer B met Mr Smith on Houseblock Two (the early days unit) to complete a cell-sharing risk assessment (CSRA). He assessed Mr Smith as high risk. At interview, the officer told the investigator that Mr Smith presented as jovial throughout their interaction and that he primarily assessed him as high risk because of his mobility issues as it meant that he would be allocated a single cell.
40. At 8.05am on 15 June, Nurse H reviewed Mr Smith in Reception and assessed him as fit to attend court. (At court, Mr Smith was convicted of arson.) At 7.14pm, the nurse reviewed Mr Smith when he returned to the prison and recorded that he did not raise any concerns. However, there is no evidence to show that he or prison staff knew that Mr Smith's circumstances had changed. There is also no record that they reviewed the PER, which had not been fully completed but highlighted that Mr Smith was not at risk of suicide or self-harm.
41. At 7.30am on 16 June, Nurse H reviewed Mr Smith in Reception before he attended court and assessed him as fit to attend. At 8.56am, a substance misuse recovery practitioner, recorded that she visited Mr Smith for a mental health and substance misuse triage assessment as part of the induction process but was told that he had gone out to court. However, it subsequently transpired that while Mr Smith was in reception waiting to leave, staff became aware that was not required to attend court. Therefore, he did not leave the prison.
42. At 2.53pm on 17 June, the substance misuse practitioner saw Mr Smith for a triage assessment and noted that he presented as relaxed. Mr Smith told her that he had a history of cannabis use and had been diagnosed with EUPD, bipolar disorder and psychosis. He also said that he had a history of suicide attempts and self-harm but felt "hopeful" for the future. He did not report any current thoughts of suicide or self-harm. At 3.22pm, mental health staff discussed Mr Smith's case at an allocations

meeting and decided to allocate him to a mental health nurse for his EUPD. At 5.33pm, Healthcare Assistant (HCA) A conducted a secondary health screen and recorded that Mr Smith engaged well and did not report any thoughts of suicide or self-harm.

Events of 19 and 20 June

43. At around 8.38pm on 19 June, CCTV footage shows Officer C checking on prisoners by looking into their cells. He is seen walking past Mr Smith's cell and looking in the direction of his door, but it is not clear whether he looked through the observation panel. He told the investigator that although he could not specifically remember doing the check, he would not have seen anything concerning or out of the ordinary.
44. At around 4.35am on 20 June, Officer D and Officer C smelt smoke while in the wing office. At interview, they told us that they could not pinpoint where the smell was coming from so decided to do the morning roll check early.
45. At 4.42am, Officer D looked through Mr Smith's cell door observation panel and saw him sitting on the bottom bunk bed, with a ligature made from a piece of cloth tied to the upper framework. In her police statement, she said that she could not see how the ligature was attached to Mr Smith but that he appeared to be hanging. Around 10 seconds later, she radioed an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing difficulties). Officer D then shouted to Officer C and asked him to bring the sealed key pouch. (At night, officers on wings do not carry cell keys but have a sealed pouch, containing a key, for use in an emergency.) She then radioed the duty manager, Custodial Manager (CM) A, and asked for his permission to go into the cell.
46. In the meantime, an Operational Support Grade (OSG) called the ambulance service and said to the operator, "We've had a code blue". He confirmed the address of the prison and said that Mr Smith was over 21 years old, but did not provide any other details. Ambulance service records show that they assessed the urgency of the response as "C2", the second highest priority level.
47. At 4.44am, Officer C arrived at the cell. He broke the seal on his key pouch, unlocked the door and went into the cell with Officer D. Officer D cut the ligature that was around Mr Smith's neck and they laid him on the floor. At interview, Officer D told the investigator that as they moved Mr Smith, she heard air releasing and started cardiopulmonary resuscitation (CPR).
48. At 4.45am, CM A arrived and went into the cell. He radioed the control room to inform them that CPR was in progress and asked that they update the ambulance service. He then applied a defibrillator to Mr Smith, but it did not detect a shockable rhythm.
49. At 4.47am, the OSG telephoned the ambulance service and told the operator that someone had tried to hang themselves and that staff had started CPR. Ambulance service records show that they increased the urgency of the response to "C1", the highest priority level.

50. At 4.48am, HCA B and HCA C arrived at the cell with emergency medical bags and assisted with the resuscitation effort. At 4.58am, two ambulances arrived at the prison and, at 5.03am, paramedics arrived at Mr Smith's cell. They conducted an assessment and advised staff to stop CPR due to the presence of rigor mortis. At 5.05am, a paramedic confirmed that Mr Smith had died.

Contact with Mr Smith's family

51. At 9.45am, the prison appointed a managing chaplain, as the family liaison officer. Mr Smith had not named a next of kin, and despite identifying several names in his prison record, the managing chaplain was unable to establish a next of kin.
52. On 21 June, the managing chaplain sought advice from a prison manager, who contacted HMP Peterborough to see if they could help. However, they did not have any additional names or contact numbers on record. Later that day, the prison manager contacted a police liaison officer, and asked if the police could identify a next of kin.
53. On 22 June, the police liaison officer informed the prison manager that his colleagues had identified a sister living in the Northamptonshire area. He confirmed that her address did not have had any risk warnings and suggested that the prison should contact her in the first instance, as they would have more information about Mr Smith. The next day, the prison manager asked him if Northamptonshire Police could visit Mr Smith's sister as each time, she tried to call her, the phone went to voicemail.
54. On 25 June, the prison manager received confirmation that the police had broken the news of Mr Smith's death to his sister on 24 June. She then telephoned his sister to explain the next steps. Later that day, the managing chaplain telephoned Mr Smith's sister to introduce herself and to offer support.
55. On 27 June, Mr Smith's father contacted the prison, stating that he was Mr Smith's next of kin. The next day, the managing chaplain telephoned Mr Smith's father and offered support. She also contacted Mr Smith's sister and explained that his father would take over as the next of kin.
56. The managing chaplain provided ongoing support to Mr Smith's father until the funeral, which took place on 11 July. The prison offered a contribution toward the cost, in line with national policy.

Support for prisoners and staff

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

Post-mortem report

59. The post-mortem report established that Mr Smith died from hanging. Toxicology tests detected venlafaxine at a concentration higher than expected with therapeutic use. The pathologist noted that the level of venlafaxine was below that associated with fatalities and concluded that even if Mr Smith had experienced a toxic effect, it would not have contributed to his actions.

Findings

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

60. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm, and to take appropriate action. Any prisoner identified as at risk of suicide and self-harm must be managed under ACCT procedures.
61. Mr Smith had a number of risk factors for suicide and self-harm. He had a mental health diagnosis and was prescribed medication for depression. Mr Smith reported a history of self-harm. He had been convicted of arson a few days before his death and was awaiting sentencing.
62. Mr Smith was not subject to ACCT monitoring at Peterborough or Hewell. Prison records show that he did not have any difficulties with staff or prisoners and never reported any thoughts of suicide or self-harm. There is no evidence that Mr Smith displayed any unusual behaviour in the days leading to his death and the substance misuse practitioner told us that he appeared hopeful and forward planning when she reviewed him on 17 June. However, we identified two areas for improvement, namely the early days process and healthcare record keeping.
63. We are concerned that prison staff did not properly complete aspects of the early days in custody passport, including the reception screen and second day induction sections. This meant that some important questions about the risk of suicide and self-harm were not put to Mr Smith in his first days at Hewell. At interview, Officer A told us that inductions normally take place in the afternoon but that there was no process for identifying prisoners who could not attend. Transfers to new prisons can be unsettling and therefore, it is important that staff complete all required aspects of the reception and induction process to ensure that any risks are identified and managed appropriately. We cannot know whether Mr Smith would have disclosed any information that would have indicated an increased risk of suicide and self-harm, but we consider that prison staff missed at least two opportunities to check on his wellbeing.
64. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners says that events such as attending court or sentencing at court are factors that may have a significant impact on the health of a prisoner. When prisoners pass through reception, prisons are required to have protocols in place to assess and identify the risk of suicide and self-harm. While we are satisfied that Nurse H reviewed Mr Smith when he returned to prison on 15 June, we consider that the quality of the record keeping fell below expectations. There was no evidence that staff spoke to Mr Smith about what happened at court or considered the impact this might have had on his emotional wellbeing.
65. PSI 07/2015 on early days in custody also says that there must be arrangements in place to assess prisoners whose status or demeanour may have changed after a court appearance. We are concerned that there is no record that prison staff reviewed Mr Smith when he returned from court or that they were aware that his circumstances had changed. We make the following recommendations:

The Governor should ensure that all aspects of the early days passport are completed and procedures implemented to identify prisoners who may have missed elements of their induction.

The Governor should ensure that Reception staff review prisoners who have returned to prison with a change of circumstance so that any risk can be appropriately identified and addressed.

The Head of Healthcare should ensure that healthcare staff who review prisoners returning from court make a detailed entry in their medical record, which should include whether the prisoner's circumstances have changed.

Emergency response

Incident management

66. PSI 03/2013 on medical response codes requires prisons to have a two-code medical emergency response system. Hewell's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious or has breathing difficulties, and a code red when a prisoner is bleeding or has severe burn injuries. Calling a medical emergency code should automatically trigger the control room to call an ambulance, and for all healthcare staff to attend with the appropriate equipment.
67. PSI 24/2011 on the management and security of nights states that staff have a duty of care to prisoners, themselves and other staff, and that the preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life, a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.
68. Officer D responded promptly when she found Mr Smith unresponsive with what appeared to be a ligature tied to the top bunk bed and radioed the correct medical code. She told the investigator that she did not consider going into the cell as she did not know whether or not it was a ruse and that staff were not allowed to enter cells at night without support. While we accept that it was not unreasonable for the officer to be worried that it might be ruse as she could not see where the ligature was attached to Mr Smith, we are concerned that she was not aware that she could enter a cell alone at night.
69. Officer D would not, however, have been able to open Mr Smith's cell regardless of her decision-making as she did not have a sealed key pouch. The prison told us that the local night operating procedure requires one person on each houseblock to have a sealed key pouch. Although we appreciate that Officer C arrived swiftly, we consider that all staff working on the houseblocks at night should have a sealed key pouch on their person so that they can enter cells as quickly as possible if there is an immediate threat to life.

Calling an ambulance

70. PSI 03/2013 states that the HM Prison and Probation Service (HMPPS) codes 'red' and 'blue' are for use within the prison only and should not be used when

communicating with ambulance service staff, who are unlikely to be familiar with them. It states that referring to the codes in external communication may cause confusion and result in delays to ambulance attendance. Hewell's local emergency response policy does not specifically refer to the use of medical emergency codes when calling an ambulance, but does state that control staff should await updates from the scene.

71. When the OSG telephoned an ambulance, he told the operator that they had a "code blue" and provided very little additional information. The ambulance operator did not ask for specific details, but despite this, control room staff must make sure that they avoid using prison terminology and provide as much information from the scene as possible, so that the ambulance service can assign the correct priority level. While we consider that the initial assignment of the incorrect priority level is unlikely to have affected the outcome in Mr Smith's case, in other cases, it could be critical.

Resuscitation

72. In September 2016, the National Medical Director at NHS England, wrote to the Heads of Healthcare for prisons, introducing new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 (updated 2021), which state, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". It also states that when the decision not to resuscitate a prisoner has been made by a competent, qualified nurse or other healthcare professional, it is inappropriate for them to be overruled by prison staff.
73. Officer D told the investigator that when she removed the ligature from around Mr Smith's neck, she believed that he had died. However, she said that she made the decision to start cardiopulmonary resuscitation (CPR) as she was not qualified to make that judgement and heard air release when moving him to the floor. HCA B and HCA C told us that, when they arrived, Mr Smith was cold to touch and had signs of rigor mortis. HCA B said that they felt obliged to continue CPR as HCAs are unable to confirm that somebody has died. She said that after a while, it felt undignified to continue CPR and she suggested to staff that they should stop but did not get a response. She also added that not having a registered nurse on duty put additional pressure on her and made her question her own decision-making.
74. The clinical reviewer considered that while both HCAs had up-to-date life support training, the absence of an appropriately qualified professional made it difficult for them to implement the resuscitation guidelines. The Head of Healthcare told us that the formal arrangement for the provision of healthcare at Hewell overnight was one qualified nurse and one HCA. However, he said that the nurse due to work on 19 June rang in sick at short notice and despite trying to arrange agency cover, no nurses were available. He added that they subsequently arranged for two experienced HCAs to work the night shift, which effectively meant that they had to take the lead in the medical emergency instead of assisting a qualified member of staff, as would normally be the case.
75. The clinical reviewer considered that an emergency response should be headed by a suitably qualified member of healthcare staff who can lead the resuscitation effort

and be accountable for decision making. She added that it was likely that a suitably trained member of staff would have supported a decision to stop CPR as there were clear signs of irreversible death. While we therefore do not criticise the HCAs for taking over CPR from officers, we are concerned that the current contingency plan is not suitable and needs improvement. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **all night staff working on residential units have access to emergency cell keys;**
- **single members of staff can enter cells alone at night when there appears to be an immediate risk to life, following a dynamic risk assessment; and**
- **control room staff do not use “code blue” when requesting an ambulance and relay as much relevant information as possible to the ambulance operative so that they can assign the correct priority level.**

The Head of Healthcare should review the contingency plan for when a qualified nurse is not available at night and provide clear guidance to healthcare assistants on the circumstances in which resuscitation is appropriate.

Clinical care

76. The clinical reviewer concluded that the clinical care Mr Smith received at HMP Hewell was equivalent to that which he could have expected in the community. Healthcare staff completed appropriate reception health screens and a mental health and substance misuse triage assessment, which resulted in the allocation of a mental health nurse.
77. However, in addition to the recording issue when Mr Smith returned from court on 15 June, the clinical reviewer also found that Mr Smith should have been referred to social care. While we do not repeat the recommendation in this report, the Head of Healthcare will need to address this.

Contact with Mr Smith’s family

78. Prison Rule 22 states that if a prisoner dies or becomes seriously ill, the Governor should ‘at once’ inform a prisoner’s spouse or next of kin. PSI 64/2011 requires that wherever possible, the family liaison officer (and another member of staff) should visit the next of kin to break the news of the death. The national instruction also states that if the prisoner’s next of kin is not informed in person, or is told by another prison or the police, a follow-up visit by the prison must be arranged as soon as possible.
79. Mr Smith had not had any contact with his family for several years and had not nominated a next of kin. Although prison staff quickly tried to identify Mr Smith’s next of kin, we are concerned that they were slow to request assistance from the police. We are also concerned that when the police provided the prison with an address for Mr Smith’s sister on 22 June, they did not conduct a visit or consider asking a nearby prison for assistance. The prison manager told the investigator

that the prison did not send a family liaison officer to Mr Smith's address as they were not sure if she still lived there or whether in fact she was his sister. However, we consider that as the police had informed the prison that they had located a sister and confirmed that the address did not have risk warning, the prison should have sent a family liaison officer, in line with PSI 64/2011. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's next of kin of their death, in line with national instructions.

Learning Lessons

80. We consider it important that staff learn from our findings. We make the following recommendation:

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.

**Prisons &
Probation**

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