A recurring narrative of bad decisions and a failure to protect vulnerable prisoners at HMP Elmley

By Beth Handley of Hickman and Rose solicitors and Sean Horstead of Garden Court Chambers

Name of deceased:
Levi Smith

Place of death:
Eastchurch, Kent

Date of death:
12 November 2014

Date of inquest:
1 – 20 February 2017

Coroner:
Alison Summers, HM Assistant Coroner for Mid-Kent and Medway

Solicitor:
Beth Handley of Hickman and Rose solicitors

Counsel:
Sean Horstead, Garden Court Chambers

Other interested persons represented:
Ministry of Justice; and an OSG on duty at the time Mr Smith passed away

Conclusion:
Critical narrative conclusion examining the application of prison policies and senior management's understanding of, and failure to use segregation where it is in a prisoner's own interest.

Whatever the lesson learned from the critical inquest findings into the death of Levi Smith (one of 9 people to die at HMP Elmley in 2014), the prison's refusal to accept that its litany of errors led to Mr Smith's death has left the family frustrated and with a sense of injustice.

Background

Levi Smith was born in 1972 in Epsom, Surrey to a traveller family and was known as a family man, devoted to caring for his younger siblings and his own children. In November 2014 he had less than 4 weeks left to serve of a 12 month prison sentence.

Mr Smith was remanded at HMP Elmley. In October 2014, he was moved into the same houseblock as a rival group of Kent-based travellers. Soon afterwards he was taken to hospital having complained of chest pains. On his return to the prison the following day he raised his concerns about being threatened and asked the prison to take immediate action to protect him from physical harm, but nothing was done.

On 23 October 2014, Mr Smith was taken to the segregation unit in response to what the Coroner has since described as "low level misconduct" which begs the question as to why Mr Smith engaged in this type of misconduct given the conventional wisdom that prisoners dislike a segregated experience of imprisonment. The Coroner concluded that Mr Smith was in effect forced to engineer his way on to the segregation unit to remove himself from association with those threatening him.

In the early morning of 12 November 2014 Mr Smith made a cry for help, taking preparatory steps to self-harm; later that day he was discovered hanging in his cell, that cry for help having gone wrong. On 20 February 2017, an inquest jury concluded his was an accidental death.

Inquest

The family's legal team focussed on the prison and healthcare staff's understanding of the relevant rules and policies, as well as the extent to which they were being followed. Much of the inquest revolved around PSO 1700, Segregation, and PSI 64/2011, Safer Custody, together with HMP Elmley's own Violence Reduction Strategy (VRS).

At no stage did the prison implement its own VRS which would have enabled an investigation into threats. Further, r.45 Prison Rules 1999 includes the power to segregate prisoners, if it is in the prisoner's own interests. Senior prison staff accepted that the policy and rules allowed the prison to consider where Mr Smith could be safely housed.

It is striking that Mr Smith was not segregated on the basis that it would be in his own interests, despite his repeated requests not to be placed on normal location. By 11 November 2014, and the day before he was due to return to normal location, Mr Smith had:

- made staff aware of his concerns;
- submitted transfer requests;
- explicitly referred to those threatening him when appearing before duty governors;
- asked his mother and his defence solicitors to raise his concerns directly with the governor (which they did); and
- submitted written reports, also naming names.

In spite of these attempts his concerns were repeatedly ignored.

On the night before Mr Smith's death he tearfully confided in the duty governor, asking him to stop his imminent return to houseblock 5. The duty governor's evidence was that Mr Smith had said "if you put me in houseblock then I will string myself up". The response was to open an Action, Care, Communication and Teamwork document, and trigger the

ACCT process, making provision for carrying out and logging hourly checks. The duty governor failed to reassure Mr Smith that he would remain in segregation but told him to sleep well so he would present well the next day to the governor.

The relevant guidance makes clear that hourly checks should be irregular, but there must be at least one check every hour. The night Operational Support Grade (OSG) staff member of seven years' experience was familiar with the paperwork, but her evidence was that the ACCT training was non-existent or at best, inadequate; consistent with other witnesses the OSG explained that on the one occasion where training was provided, it lasted 5 minutes and was delivered "over the x-ray machine".

It emerged during the inquest that the night manager, the de facto governor with overall responsibility for the OSG and other staff that night, scrupulously avoided the segregation unit. The OSG had sought assistance from him, but received no support. In her evidence, the OSG highlighted the pressures she had been under. This did not divert the family's attention away from her failings. She denied making entries before completing the hourly checks and when it was put to her that she was lying as the time-entries in the log were uncorroborated by CCTV footage she merely responded saying she was, "not thinking straight".

Footage was played to the jury who were asked to identify the moment when Mr Smith carried out his last act; the family claim that at the moment Mr Smith ties the ligature around his neck the OSG looked across the landing and returned to her office without completing a check. It was the family's position that a non-existent check shortly before 05.30am coincided with what appeared to be Mr Smith's last movements.

Mr Smith was discovered suspended in his cell shortly before 6.45am and was declared dead shortly afterwards.

Conclusions as to death

The jury returned a detailed narrative conclusion, confirming that the failure of a governor and his staff to segregate a vulnerable prisoner under r.45 possibly contributed to his death. The jury identified a raft of other failures and short-comings, but were not directed by the Coroner to determine whether these also contributed to Mr Smith's death. The family were understandably disappointed as they believed that the information before the jury meant they were in a position to reach more critical conclusions.

Preventing future deaths

Throughout the inquest the prison repeatedly sought to highlight the steps that had been taken following 9 fatalities in 2014. However, the following matters remained unaddressed by the prison in February 2017 and the Coroner was sufficiently alarmed and concerned about the risk of future deaths occurring that she sent a preventing future deaths' report (PFD) in which she raised the following:

- The inadequacy of systems required to ensure compliance with policies and procedures, particularly in relation the ACCT process;
- A lack of awareness among staff concerning their obligations in complying with the VRS strategy;
- Procedures were not necessarily fit for purpose and/or applied by staff; and
- The inadequate scrutiny of staff awareness.

Comment

The duty governor's decision to commence the ACCT process shows that the prison treated Mr Smith's threat of self-harm as genuine, but the governor's response was perfunctory; he told Mr Smith to "get some rest and calm down" so he would present well to the governor the following day. This provided no necessary assurance to Mr Smith.

It was striking that there was not one discussion between senior prison staff about what could be done to help Mr Smith, despite accepting that the threats he reported were believed to be genuine, and his concerns plausible. Further it was within the prison's powers to take action, but no-one would tell Mr Smith the governor would or might agree to him remaining in segregation.

Given the prison's obligation to keep him safe and Mr Smith's willingness to remain segregated, it beggars belief that a decision was not taken to leave him in segregation for his own interests.

The family continues to find it troubling that the prison's aim at the inquest was to divert attention from the only credible explanation for Mr Smith's death: that he died because he made a final desperate cry for help that appeared to coincide with the precise moment that he expected to be checked on. This strategy highlighted the multiple warnings to the prison and the clear lack of a good explanation for the failure to heed those warnings. The family was amazed that the Ministry of Justice argued that the cause of the high death toll in HMP Elmley in 2014 had been addressed and that accordingly that the Coroner need not to make a PFD report.

Two and half years later, whatever the improvements in the application of policy and procedure, the evidence at inquest demonstrated that things haven't changed much. If the prison's response to the PFD report says what has been said already then this only serves to demonstrate a continued refusal by the MOJ to accept that Mr Smith may still be alive today.