Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Michael Smith, a prisoner at HMP Altcourse, on 10 July 2024

## A report by the Prisons and Probation Ombudsman

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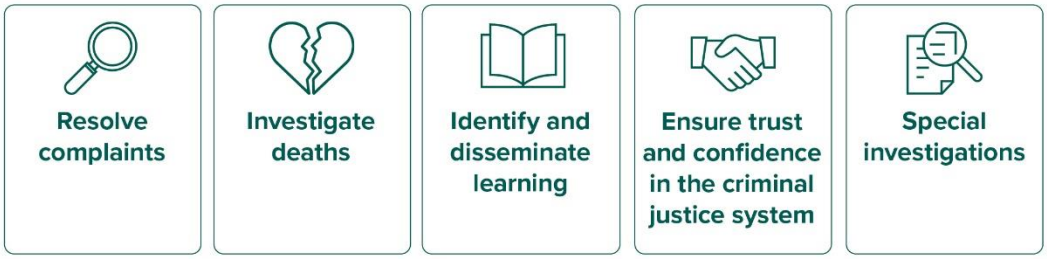
## OUR VISION

**To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.**

## WHAT WE DO




## WHAT WE VALUE

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 1 March 2024, Mr Michael Smith was sentenced to 22 years in prison for sexual offences.

4. Mr Smith died of acute kidney injury due to obstructive uropathy (a blockage that prevents urine from flowing naturally) and hydronephrosis (where the kidneys swell because urine does not fully empty from the body) leading to multiorgan failure, while a prisoner at HMP Altcourse. He was 65 years old. We offer our condolences to Mr Smith's family and friends.

5. The Ombudsman's office wrote to Mr Smith's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

6. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at Altcourse.

7. The clinical reviewer concluded that the clinical care Mr Smith received at Altcourse was of a good standard and equivalent to what he could have expected to receive in the community. She found that Mr Smith's medical records contained evidence of attentive, efficient nursing care which allowed Mr Smith to be able to die pain free and with dignity. She made two recommendations not directly linked to Mr Smith's cause of death, which the Head of Healthcare will wish to address.

8. The PPO investigator investigated the non-clinical issues relating to Mr Smith's care. We did not find any non-clinical issues of concern. We make no recommendations.

## Inquest

9. Following an inquest hearing on the 30 July 2024, the Coroner concluded that Mr Smith died from natural causes.

10. The initial report was shared with HM Prison and Probation Service (HMPPS) and Practice Plus Group. HMPPS and Practice Plus Group did not find any factual inaccuracies.

11. Mr Smith's family received a copy of the initial report. They did not reply.

**Adrian Usher**
**Prisons and Probation Ombudsman** **March 2025**

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