



# **Independent investigation into the death of Mr William Smith, a prisoner at Landguard Road Approved Premises, on 1 October 2023**

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

## 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



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## Summary

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. Mr William Smith died on 1 October 2023, at Landguard Road Approved Premises. His cause of death was acute myocardial infarction (a heart attack) caused by coronary atherosclerosis (build-up of fats, cholesterol and other substances in and on the artery walls), with diabetes mellitus and hypertension (high blood pressure) contributory factors. He was 62 years old. We offer our condolences to those who knew him.
4. Mr Smith had resided at Landguard Road since his release from prison on 10 March 2023. He had a history of heart disease and diabetes, for which he was prescribed medication. We did not find any issues of concern in how AP staff managed Mr Smith.

## The Investigation Process

5. We were informed of Mr Smith's death on 2 October 2023.
6. The investigator issued notices to staff and residents at Landguard Road informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She obtained copies of relevant extracts from Mr Smith's probation records.
7. We informed HM Coroner for Hampshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found two factual inaccuracies, and this report has been amended accordingly.

## Background Information

### Landguard Road Approved Premises (AP)

9. Landguard Road AP is a 26-bed approved premises for men in Southampton. Approved Premises (formerly known as probation and bail hostels) accommodate offenders released from prison on licence and those directed to live there by the courts as a condition of bail. Their purpose is to provide an enhanced level of residential supervision in the community, as well as a supportive and structured environment. Residents are responsible for their own health and are expected to register with a GP.
10. Landguard Road is managed by HM Prison and Probation Service (HMPPS). Each resident is allocated a keyworker to oversee his progress and wellbeing, and to ensure that they adhere to licence conditions and the AP's rules. HMPPS staff are on duty at Landguard Road for 24 hours a day.

### Previous deaths at Landguard Road AP

11. Mr Smith was the first resident to die at Landguard Road since 2009.

## Key Events

12. On 25 September 2017, Mr William Smith was convicted of sexual offences and sentenced to 11 years in prison. He was sent to HMP Exeter.
13. Mr Smith reported a history of heart disease. On 9 October, he was admitted to hospital for a suspected heart attack, after complaining of chest pains.
14. On 17 November, Mr Smith was transferred to HMP Isle of Wight.
15. On 29 December, Mr Smith complained of tightness of chest and chest pains. He was escorted to the healthcare unit for further monitoring.
16. On 31 January 2019, Mr Smith was transferred to HMP Woodhill, and, on 27 January 2021, he was transferred to HMP The Verne. During his time at The Verne, Mr Smith was referred to hospital for heart disease and diabetes.
17. On 11 January 2023, probation staff submitted an approved premises (AP) referral for Mr Smith. He was accepted at Landguard Road on 22 January. Probation staff requested an extended AP placement, which was granted.
18. On 10 March 2023, Mr Smith was released from prison to Landguard Road Approved Premises.

## Landguard Road Approved Premises

19. There is no record that Mr Smith experienced any significant health incidents while a resident of the AP. He registered with a local GP and was prescribed medication which included bisoprolol (for high blood pressure and heart failure), and metformin and atorvastatin (for diabetes and elevated cholesterol), which he kept at the AP in line with local policy.
20. On the evening of 30 September, AP staff noted that Mr Smith did not come out of his room to socialise with other residents, as he usually did. They also heard him coughing during the evening. At 11.00pm, during a routine curfew/welfare check a residential worker at Landguard Road asked Mr Smith about his wellbeing. Mr Smith reported that he did not feel well. Mr Smith confirmed that he had taken his medication. He asked Mr Smith if he wanted to speak to the NHS (111 number), but Mr Smith declined and said he was fine.
21. At 2.17am on 1 October, a residential worker conducted an additional welfare check on Mr Smith and noted that he was sleeping on his back. He recorded that he had observed Mr Smith breathing and his body moving.
22. At 7.07am, a residential worker conducted a routine welfare check on Mr Smith in his room and found him unresponsive. He telephoned for an emergency ambulance and told them that he believed that Mr Smith had died. He went to Mr Smith's room and found his body to be cold to touch. He began cardiopulmonary resuscitation, but stopped after around two minutes, having concluded that it was futile. Paramedics attended and confirmed that Mr Smith had died.

## Contact with Mr Smith's family

23. Mr Smith did not nominate a next of kin at Landguard House and no one was identified after his death.

## Support for residents and staff

24. After Mr Smith's death, the AP manager spoke to the residential workers and offered them support. Residents were informed of Mr Smith's death and offered support.

## Post-mortem report

25. A post-mortem examination concluded that Mr Smith died of acute myocardial infarction (a heart attack) caused by coronary atherosclerosis (build-up of fats, cholesterol and other substances in and on the artery walls), with diabetes mellitus and hypertension (high blood pressure) contributory factors.

## Findings

26. Mr Smith had long-standing heart and diabetes health issues, for which he was prescribed medication. On the night that he died, he told AP staff that he felt unwell. Given the symptoms that Mr Smith presented with, an additional welfare check and offer to call the NHS non-emergency number were appropriate measures of support. Mr Smith's symptoms did not indicate that an emergency ambulance was required.

**Adrian Usher**  
**Prisons and Probation Ombudsman**

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