Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arthur Smith, a prisoner at HMP Wakefield, on 7 February 2025

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

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 Arthur Smith died from aspiration pneumonia, bowel obstruction and sigmoid diverticular stricture (a narrowing of part of the large intestine) on 7 February 2025, while a prisoner at HMP Wakefield. He was 75 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Smith received at Wakefield was equivalent to what he could have expected to receive in the community. She made no recommendations.

5. We found that when Mr Smith became unresponsive in hospital on 6 February 2025, the Category A team did not approve the removal of restraints until the following day. We consider that this was not justified or proportionate to the risk Mr Smith posed at the time. There was a breakdown in the process when considering removal of restraints for a Category A prisoner, and decision-making was not recorded.

Recommendation

- **Category A team should ensure that their risk assessments when considering the removal of restraints fully take into account the prisoner's health and are based on the actual risk they present at the time, and all decisions are recorded clearly.**

The Investigation Process

6. HMPPS notified us of Mr Smith's death on 7 February 2025.

7. NHS England commissioned an independent clinical reviewer, to review Mr Smith's clinical care at HMP Wakefield. The clinical review is attached as Annex 1.

8. The PPO investigator investigated the non-clinical issues relating to Mr Smith's care. After issuing the initial report, the investigator interviewed the Category A team manager on 7 August 2025.

9. 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.

Previous deaths at HMP Wakefield

10. Mr Smith was the 21st prisoner to die at HMP Wakefield since February 2022. Of the previous deaths, 17 were from natural causes and three were self-inflicted. There are no similarities between the findings in our investigation into Mr Smith's death and the findings from our investigations into the previous deaths.

Key Events

11. On 17 September 1979, Mr Arthur Smith was sentenced to life imprisonment for manslaughter, with a minimum tariff of six years. He had several Parole Board reviews (with the latest in 2024) but they considered that his offences, and therefore his risk, remained poorly understood and concluded that he was not suitable for release.

12. On 9 October 2003, Mr Smith transferred to HMP Wakefield, where he was given the highest security categorisation (Category A).

13. On 12 February 2020, Mr Smith was diagnosed with chronic obstructive pulmonary disease (COPD). A visiting respiratory consultant prescribed Mr Smith inhalers, which he refused to use. Mr Smith's COPD was monitored and reviewed regularly over the following years.

14. On 2 July 2023, Mr Smith was hospitalised with acute exacerbation of his COPD. He remained in hospital until 4 July. Following his return to prison, staff created a Personal Emergency Evacuation Plan (PEEP) due to Mr Smith's mobility issues and age.

15. On 28 March 2024, healthcare staff held an annual review for Mr Smith's COPD. Mr Smith said that he did not want to engage and did not want a review of his medication. The care plan was reviewed and agreed.

16. On 14 August, prison staff escorted Mr Smith to hospital due to him having shortness of breath. While at hospital, a doctor diagnosed Mr Smith with hypercapnic respiratory failure (occurs when the body cannot effectively remove carbon dioxide, leading to a buildup in the blood and potentially acidosis) and atrial fibrillation (a common heart rhythm disorder characterised by an irregular and often rapid heartbeat). The following day, Mr Smith said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order (DNACPR) to that effect.

17. On 19 August, Mr Smith was discharged from hospital and returned to the prison's healthcare unit.

18. On 3 October, prison staff escorted Mr Smith to hospital as he had an exacerbation of his COPD. He was treated with nebulisers and steroid therapy. He returned to the prison's healthcare unit on 12 October.

19. On 18 October, Mr Smith was moved to a standard residential wing as he refused long-term oxygen therapy.

20. On 18 December, a visiting respiratory consultant saw Mr Smith. Mr Smith agreed to commence long-term oxygen therapy and he was moved to the healthcare unit for observations and treatment.

21. On 25 January 2025, a nurse saw Mr Smith because he was not feeling well and had a stomach ache. The nurse took his observations and noted that his National Early Warning Score 2 (NEWS2 - a standardised scoring system used in healthcare

to assess the physiological condition of patients and alert staff to potential deterioration) was two, indicating a low risk of clinical deterioration.

22. On 26 January, a nurse saw Mr Smith after he complained of not eating and had not had any bowel movements. Healthcare staff continued to monitor and observe Mr Smith over the following days.

23. On 1 February, a nurse noted that Mr Smith opened his bowels multiple times throughout the day, which was not usual for him. She gave him a shower, cleaned his cell and gave him clean clothes. Throughout the day, healthcare staff continued to monitor Mr Smith and encouraged him to use his oxygen. At 2.21pm, a nurse observed him. His NEWS2 score was seven, indicating a high risk of clinical deterioration. The nurse contacted the out of hours GP for advice and arranged his urgent admission to hospital by ambulance. When the paramedics arrived, at 5.04pm, Mr Smith's NEWS2 score was two. The paramedics assessed that Mr Smith did not require admission to hospital and said the GP should continue to monitor him.

24. At 10.24am on 2 February, a nurse saw Mr Smith after he had vomited and looked pale and clammy. A nurse took his observations and his NEWS2 score was 12, indicating a high risk of clinical deterioration. Two prison officers escorted Mr Smith to hospital. He was restrained using a double handcuff (where a prisoner has their hands cuffed together with one set of handcuffs, and then another handcuff on one wrist attached to an officer). Later that day, prison staff removed the double handcuff and replaced it with an escort chain (where a prisoner is restrained by a single cuff and long cable attached to an officer). While at hospital, Mr Smith was diagnosed with a bowel blockage.

25. On 6 February, hospital staff planned to operate on Mr Smith, but he was deemed unfit for surgery due to his frailty.

26. At 10.00am, Mr Smith became unresponsive. The escorting officer notified the Category A team at HMPPS headquarters, who said that unless Mr Smith was subject to end-of-life care the escort chain must remain in place.

27. At 10.45am on 7 February, the escorting officer told the Category A team that Mr Smith was now receiving end-of-life care. The Category A team authorised the removal of all restraints.

28. At 9.46pm, Mr Smith died in hospital.

Post-mortem report

29. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The hospital doctor gave Mr Smith's cause of death as aspiration pneumonia, bowel obstruction and sigmoid diverticular stricture (a narrowing of part of the large intestine).

Findings

Clinical care

30. The clinical reviewer concluded that the clinical care Mr Smith received at Wakefield was equivalent to what he could have expected to receive in the community. She found that relevant care plans were in place for Mr Smith's COPD, oxygen therapy and cardiovascular disease. She noted that Mr Smith had impressive access to Wakefield's visiting respiratory consultant following his COPD diagnosis. She found that Mr Smith was managed with compassion and cared for by confident, competent staff during his time at Wakefield.

Use of restraints

31. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

32. A judgment in the High Court in 2007, known as the Graham Judgment, made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The Prevention of Escape: External Escorts policy framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and ill health.

33. The practice of restraint removal for Category A prisoners is covered within a restricted PSI (09/2013). The policy states that when the removal of restraints is being considered for a Category A prisoner, approval from the Category A team must be obtained.

34. On 2 February, Mr Smith was taken to hospital restrained with a double handcuff. The prison later assessed it was more appropriate to restrain him with an escort chain. Mr Smith was 75 years old. Healthcare staff noted in Mr Smith's risk assessment that he had long-term respiratory failure, was frail and used a wheelchair. Mr Smith had limited mobility, had no disciplinary hearings in prison and there was no intelligence to suggest he posed a risk of escape or harm to staff.

35. On 6 February, Mr Smith became unresponsive while in hospital. At 10.00am the escorting officer noted in Mr Smith's bedwatch log that he spoke to the deputy governor about the removal of Mr Smith's restraints, given his current condition. A short while later, the escorting officer called the prison to see if a decision had been made regarding the removal of restraints. He was told that the Category A team were requesting further information. He noted that he then called the Category A team directly to seek approval to remove Mr Smith's escort chain but was told they needed confirmation that Mr Smith was on end-of-life care before they could authorise the removal of the escort chain.

36. When interviewed, Mr A, Operational Manager of the Category A team, said that he was responsible for considering requests to remove restraints. Once he has the necessary information, he discusses the decision with the Prison Group Director (a senior HMPPS manager). Initially, Mr A said he could not recall speaking with the escorting officer. However, during a later interview, he said he did remember a conversation, though he could not recall the exact details. When asked about the entry in the bedwatch log, Mr A said that the wording used was not language he would typically use. Mr A said the escorting officer had contacted him directly on his personal phone number (as the two know each other outside of work) to discuss the removal of Mr Smith's restraints. Mr A explained that this was not usual practice, and normally the request and decisions would be formally documented, using an 'Approval to Remove Handcuffs – Part 11' form. Mr A also confirmed that this conversation was not recorded anywhere.

37. At 2.16pm, the Category A Team emailed the prison requesting an update on Mr Smith's condition to review the removal of restraints decision. The prison responded saying there had been no changes since Mr A's initial call with the escorting officer. At 4.26pm the Category A Team responded saying that Mr A was waiting for an update from the doctor before discussing Mr Smith's case further with the Prison Group Director, as it sounded like there could potentially be an improvement in Mr Smith's condition.

38. At 9.15am on 7 February, the hospital doctor told the escorting officer that Mr Smith was now on end-of-life care. The escorting officer informed the duty governor, who updated the Category A Team. Mr A told the investigator that once the prison updated him on Mr Smith's condition, he discussed Mr Smith's case with the Prison Group Director and approved the removal of restraints via the Part 11 document. At 10.45am, the escorting officer removed Mr Smith's escort chain.

39. Mr A said he and his team are aware of the Graham Judgement and as a matter of decency would not approve of restraints being used on an unresponsive prisoner regardless of whether they were end-of-life care. However, Mr A accepted that there was no audit trail of the decision making on 6 February as the discussions happened over the phone.

40. We consider that staff at Wakefield followed the correct policy and appropriately reviewed the level of restraints used. However, the process to consider removal of restraints was not followed and the decision-making was not recorded. There was no justification that the use of restraints on Mr Smith was proportionate to the risks he posed when he was unresponsive. The decision to restrain him with an escort chain while he was unresponsive in hospital was unjustified, particularly as two escort officers escorted him. We make the following recommendation:

    The Category A team should ensure that their risk assessments when considering the removal of restraints fully take into account the prisoner's health and are based on the actual risk they present at the time, and all decisions are recorded clearly.

Inquest

41. At the inquest held on 27 February 2025, the Coroner concluded that Mr Smith died of natural causes.

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

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
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