

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Rodney Smith a prisoner at HMP Lewes on 19 October 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## 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*



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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 Rodney Smith died in a hospice on 19 October 2015, of lung cancer while a prisoner at HMP Lewes. He was 67 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith received a good standard of care at Lewes and there was effective liaison with hospice staff about his palliative care. Staff at the prison treated Mr Smith with compassion and dignity during his illness and I am satisfied that he received care equivalent to that he could have expected to receive in the community.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**May 2016**

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# Summary

## Events

1. On 21 July 2015, Mr Rodney Smith was remanded to HMP Lewes for violent offences. Mr Smith had a longstanding diagnosis of lung cancer, which had spread to his liver. He had been in a hospice immediately before he went to prison. He also had chronic obstructive pulmonary disease, high blood pressure and an irregular heart beat. On 12 July 2015, Mr Smith had decided he did not want to be resuscitated if his heart or breathing stopped.
2. Mr Smith was admitted to the prison's healthcare unit when he arrived and remained there for the rest of his time at Lewes. Healthcare staff began palliative care plans and reviewed him regularly.
3. On 22 July, a community based palliative care nurse was allocated to oversee Mr Smith's care. She visited him on 24 July and remained closely involved in his care and care planning.
4. As Mr Smith's condition declined, he was admitted to hospital four times, including between 28 September and 10 October, when he was treated for a chest infection.
5. On 19 October, after a multidisciplinary meeting about his care, Mr Smith was moved to a hospice, accompanied by one prison officer. The hospice settled Mr Smith into a private room where he spent the afternoon with family members, who left at approximately 5.00pm. At 5.55pm, a senior nurse recorded that Mr Smith had died.

## Findings

6. We are satisfied that Mr Smith received a good standard of care and that the prison met his healthcare needs. Healthcare and prison staff treated him with compassion, dignity and respect. There was a close working relationship with the hospice and, in particular, with his community palliative care nurse to inform end of life care plans. Mr Smith was appropriately involved in decisions about his care. We consider that Mr Smith's care was equivalent to that he could have expected to receive in the community. Restraints were not used when Mr Smith went to the hospital or hospice and there was appropriate liaison with his family.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.
10. We informed HM Coroner for East Sussex of the investigation, who gave us the cause of death. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Smith's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Although Mr Smith's daughter was confident that her father had received all his medication, she was not confident that the drug chart kept in his cell at the prison had always been completed and that this had led her to her father becoming confused about his medication.
12. The investigation has assessed the main issues involved in Mr Smith's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.
13. Mr Smith's family received a copy of the initial report. They did not make any comments.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

# Background Information

## HMP Lewes

15. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. The Sussex Partnership NHS Foundation Trust provides primary care services. Healthcare staff are on duty at the prison at all times.
16. The report of the most recent inspection of Lewes has not yet been published. At the previous inspection in November 2012, inspectors found that health services were reasonable with good partnership working. Standards of prescribing and administering medication were variable and needed attention. There was a designated lead for older prisoners. Palliative care needs were well managed and there were established links with the local hospice, including training for healthcare staff.

## Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its most recently published report, for the year to 31 January 2015, the IMB noted that the healthcare team cared for prisoners with chronic and life limiting conditions with respect and understanding.

## Previous deaths at HMP Lewes

18. Mr Smith was the fourth prisoner to die of natural causes at HMP Lewes since January 2014. There were no significant similarities with the circumstances of the other deaths.

## Findings

### The diagnosis of Mr Smith's terminal illness and informing him of his condition

19. Mr Smith was remanded to HMP Lewes on 21 July 2015 for violent offences. He had already been diagnosed with lung cancer. He also had hypertension, an irregular heart beat and chronic obstructive pulmonary disease (COPD - the name for a collection of lung diseases including chronic bronchitis and emphysema).

### Mr Smith's clinical care

20. When Mr Smith arrived at Lewes, he had a discharge plan from the Royal Sussex County hospital and the prison admitted him to the healthcare unit immediately. Hospital doctors had prescribed Mr Smith a nebuliser and inhalers. He had already signed an order dated 12 July 2015, to say that if his heart or breathing stopped, he did not want to be resuscitated. Doctors reviewed this decision with him periodically throughout his illness.
21. On 22 July, the hospital referred Mr Smith a community palliative care nurse, who visited him at Lewes on 24 July. The nurse began to coordinate care plans with healthcare staff and doctors reviewed Mr Smith's pain relief medication frequently.
22. On 25 July, nurses first noted that Mr Smith was becoming confused about when he received his medication. This confusion continued throughout his time at Lewes. The clinical reviewer considered his confusion was due to a number of factors, including the strength of his medication, urinary tract and chest infections and low oxygen levels in his blood due to the lung cancer.
23. On 22 August, a nurse gave Mr Smith a photocopy of his drug chart and a calendar so that he could tick off each dose he received. His daughter also brought in a 24hr digital clock to help him.
24. On 29 August, Mr Smith developed a chest infection and was admitted to Brighton and Sussex University Hospital. After treatment with antibiotics, he returned to the prison on 1 September.
25. From 14 September, a healthcare manager gave Mr Smith typed sheets for him to sign each time he received his medication. On 28 September, Mr Smith's daughter was concerned that nurses were not signing this sheet and they were asked to do this in addition to the usual prescription chart. Although nurses did not always remember to do this, the record was originally intended for Mr Smith and we are satisfied that he received his medication as prescribed.
26. On 23 September, Mr Smith attended an ear, nose and throat (ENT) appointment, as he was having problems swallowing and breathing. The ENT consultant told Mr Smith that this was because of the progression of the lung cancer and advised him to use his nebuliser and inhalers as much as he needed to relieve his symptoms.

27. On 28 September, Mr Smith complained of breathlessness and chest pains, and was taken to hospital as an emergency. The hospital treated him for pneumonia, anxiety, poor appetite and fatigue. He was discharged from hospital on 10 October. On 16 October, he was taken to hospital again after he complained of breathlessness. The hospital treated him for constipation and he went back to the prison that day.
28. Mr Smith's health declined over the weekend of the 17 and 18 October, and his condition deteriorated rapidly in the early hours of 19 October. An urgently arranged multidisciplinary meeting, that included senior prison and healthcare staff, the family liaison officer and the community palliative care nurse, agreed that he should move to St Peter and St James Hospice, Lewes, that day.
29. The hospice settled Mr Smith into a private room and he spent the afternoon with his family, who left at approximately 5.00pm. His condition declined rapidly after they left and a member of hospice staff called his daughter. At 5.55pm, a senior nurse recorded that Mr Smith had died. Mr Smith's daughter arrived at the hospice a few minutes later.
30. The clinical reviewer concluded that the care Mr Smith received at Lewes was equivalent to that he could have expected to receive in the community. We are satisfied that he received a good standard of care at the prison throughout his illness.

### **Mr Smith's location**

31. Mr Smith was admitted to the prison's healthcare unit as soon as he arrived at Lewes. Nurses moved him to more suitable cells in the healthcare unit in response to his increasing needs as his illness progressed. When his health declined at the very end of his life, the prison arranged for him to transfer to St Peter and St James Hospice. We are satisfied that Mr Smith was appropriately located throughout his time in prison, and that his move to a hospice at the end of his life was considerate and humane.

### **Restraints, security and escorts**

32. When prisoners have to travel outside prison a risk assessment determines the security arrangements required. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and take into account factors such as the risk of escape, the risk to the public and the prisoner's health and mobility.
33. The prison did not use restraints to take Mr Smith to hospital appointments or the hospice. One officer accompanied him to the hospice but was not in uniform. We consider that decisions about security appropriately took into account Mr Smith's condition and level of risk.

### **Liaison with Mr Smith's family**

34. Mr Smith had named his daughter as his next of kin. On 31 July, the prison appointed their family liaison officer. The family liaison officer contacted Mr Smith's daughter that day and explained her role and offered support.

35. The prison's family liaison officer in contact with Mr Smith's daughter both before and after his death. Mr Smith's funeral was on 3 November, and the prison contributed towards the costs, in line with national policy. We are satisfied that there was appropriate contact with Mr Smith's family.

### **Compassionate release**

36. Sentenced prisoners can be released on compassionate grounds for medical reasons before their sentence has expired. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. As Mr Smith was on remand, he was not eligible for compassionate release but we consider the transfer to the hospice at the end of his life allowed Mr Smith a dignified death outside prison.

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