

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Smith, a prisoner at HMP Leyhill, on 10 February 2020

A report by the Prisons and Probation Ombudsman

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 Paul Smith died in hospital from heart disease on 10 February 2020, while a prisoner at HMP Leyhill. He was 54 years old. I offer my condolences to Mr Smith's family and friends.

Mr Smith had been released from prison on temporary licence to Quay House Approved Premises on the morning of his death and collapsed there a few hours later. He was taken to hospital, but suffered a cardiac arrest and died shortly after he arrived there.

The clinical reviewer was satisfied that the standard of care Mr Smith received at Leyhill was equivalent to that which he could have expected to receive in the community. However, she considered that staff had missed an opportunity to address Mr Smith's high cholesterol levels, a risk factor for heart disease, though she could not say whether this would have made any difference to the outcome.

The clinical reviewer found that staff at Quay House dealt with Mr Smith's sudden collapse in an exemplary manner.

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

Sue McAllister CB
Prisons and Probation Ombudsman

February 2021

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Summary

Events

1. In September 1998, Mr Paul Smith was sentenced to life in prison for rape.
2. In September 2018, Mr Smith was moved to HMP Leyhill. In 2019, as Mr Smith was coming to the end of his sentence, it was agreed that he could be released on temporary licence to Quay House Approved Premises.
3. On 10 February 2020, Mr Smith arrived at Quay House and said that he did not feel very well. Around midday, Mr Smith went to the shop to buy some paracetamol. At 12.22pm, he returned to Quay House and collapsed on the floor. Staff started cardiopulmonary resuscitation (CPR) and called an ambulance. Mr Smith was taken to hospital but when he got there, he had a cardiac arrest and died.
4. The post-mortem report concluded that Mr Smith died from ischaemic heart disease.

Findings

5. The clinical reviewer found that overall, the standard of care Mr Smith received at Leyhill was equivalent to that he could have expected to receive in the community. She also found that staff at Quay House gave Mr Smith an excellent level of care when he collapsed.
6. However, the clinical reviewer noted that, although Mr Smith's medical records showed that he had high cholesterol, a risk factor for heart disease, from 2007 onwards, there was no record of a discussion with Mr Smith about addressing this until 2017. When Mr Smith arrived at Leyhill, his secondary screening identified that he had cardiovascular risk factors, but no consideration was given to reviewing his previous blood tests results, or doing new ones. The clinical reviewer said it was impossible to say whether medical intervention from 2017 onwards would have made any difference to the outcome.

Recommendations

- The Head of Healthcare should ensure that, where cardiovascular risk factors are identified at reception screens, consideration is given to reviewing any previous blood test results so that any abnormalities can be addressed.
- The Governor should ensure that this report is shared with managers and staff at Quay House.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Leyhill and to staff and residents at Quay House Approved Premises informing them of the investigation and asking anyone with relevant information to contact her. One of the residents at Quay House responded anonymously.
8. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records.
9. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at the prison, and the emergency response at the approved premises. The clinical reviewer conducted joint interviews with the investigator.
10. We informed HM Coroner for South Wales of the investigation. The coroner gave us the results of the post mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Smith's next of kin, his ex-wife, to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not respond.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Leyhill

17. HMP Leyhill is an open prison in South Gloucestershire, holding up to 515 prisoners who require minimum security. Some are life sentence prisoners preparing for release.
18. Inspire Better Health, a partnership of eight health care providers led by Bristol Community Health, provides all health and substance misuse services. Primary care services are available on weekdays, 8.00am to 4.00pm. A local NHS centre, Hanham Health, provides GP and out of hours services

HM Inspectorate of Prisons

19. The most recent inspection of HMP Leyhill was in September 2016. Inspectors reported that Leyhill was, overall, a safe and decent establishment. In terms of the healthcare provision, the inspection found that a small team of experienced nurses ran effective clinics for most long-term conditions and GPs ran one for heart disease. Healthcare staff were easily identifiable and their interactions with prisoners were professional and compassionate. They were in date with all mandatory training and had good access to appraisals and clinical supervision.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 January 2020, the IMB reported that, there had been a 10% increase in the granting of ROTL and the number of prisoners taking resettlement overnight release (ROR) had increased by 14%. This was probably due to recruitment of new staff by the National Probation Service and OMU, coupled with better working relationships between them and also the holding of weekly ROTL surgeries (dealing on average with 100 prisoners a time). At these surgeries, the ROTL process is fully explained, the prisoner receives an immediate update on where his application is in the system and, if required, offender supervisors and other prison staff can take immediate remedial action.

Previous deaths at HMP Leyhill

21. Mr Smith was the fourth prisoner to die at Leyhill since January 2018. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Smith's death and our investigation findings for the previous deaths.

Key Events

22. In September 1998, Mr Paul Smith was sentenced to life in prison for rape. Over the next 20 years, Mr Smith was sent to various prisons. In September 2018, he was moved to HMP Leyhill.
23. In 2019, as Mr Smith was nearing the end of his sentence, it was agreed that he could be released on temporary licence (ROTL) for resettlement purposes, to Quay House Approved Premises. (Resettlement overnight release allows prisoners to spend time at their release address. This is to re-establish links with their family and local community. Release is for a maximum of four nights, then the prisoner returns to the prison.)
24. On 10 February 2020, Mr Smith was released on temporary licence from Leyhill and went to Quay House. During his induction, he said that he did not feel very well and that he thought he had a virus.
25. At around midday, Mr Smith said that he was going to the shop to buy some paracetamol. At 12.22pm, CCTV footage shows Mr Smith returning from the shop and sitting on the floor. He quickly became unconscious and is seen lying down. The staff at Quay House responded quickly. They collected the automated external defibrillator (AED), immediately started cardiopulmonary resuscitation (CPR) and called an ambulance.
26. At 12.30pm, the paramedics arrived and continued with CPR. At 12.44pm, the ambulance left Quay House to take Mr Smith to hospital.
27. When Mr Smith arrived at hospital he had a cardiac arrest and died within an hour.

Contact with Mr Smith's family

28. On 10 February, shortly after Mr Smith died, the prison appointed a Supervising Officer and a Custodial Manager as the family liaison officers. Mr Smith's ex-wife was listed as his next of kin so they went to her house to break the news of his death.
29. The prison paid for Mr Smith's funeral in line with national guidelines.

Support for prisoners and staff

30. After Mr Smith's death, the approved premises manager debriefed the staff involved in Mr Smith's resuscitation to ensure they had the opportunity to discuss any issues arising, and to offer support.
31. The approved premises manager posted notices informing other prisoners of Mr Smith's death, and offered support.

Post-mortem report

32. The post-mortem report concluded that Mr Smith died of ischaemic heart disease.

Findings

Clinical Care

33. The clinical reviewer concluded that the clinical care Mr Smith received overall at HMP Leyhill was equivalent to that which he could have expected to receive in the community.
34. However, the clinical reviewer was concerned that although Mr Smith's medical notes showed that he had high cholesterol levels from 2007 onwards, the first documented discussion he had with a health professional about a plan to address this was not until 2017. The clinical reviewer said it was not clear from the notes whether the recommended appointments to discuss the results did not occur due to patient choice, difficulties in communicating the blood test results to Mr Smith or due to him being moved to another prison.
35. When Mr Smith arrived at Leyhill in 2018, his secondary screening highlighted his cardiovascular risk factors, but no consideration was given to reviewing previous blood tests or arranging new tests. Instead he was given advice about diet, exercise and smoking.
36. The clinical reviewer said it was impossible to say whether medical intervention from 2017 onwards would have been acceptable to Mr Smith or whether intervention at this stage could have delayed his death. Nevertheless, we make the following recommendation:

The Head of Healthcare should ensure that, where cardiovascular risk factors are identified at reception screens, consideration is given to reviewing any previous blood test results so that any abnormalities can be addressed.

37. The clinical reviewer found that the staff at Quay House dealt with Mr Smith's sudden collapse in an exemplary manner. We recommend:

The Governor should ensure that this report is shared with managers and staff at Quay House.

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