

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Smith, a prisoner at HMP Risley, on 27 August 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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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. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Trevor Smith died in a hospice on 27 August 2020 of cancer while a prisoner at HMP Risley. Mr Smith was 74 years old. I offer my condolences to Mr Smith's friends.
4. The clinical reviewer concluded that the clinical care Mr Smith received at HMP Risley was not equivalent to that which he could have expected to receive in the community. She made four recommendations.
5. We found no non-clinical issues of concern. We make no recommendations.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- **The Head of Healthcare should ensure that all staff are fully aware of the process, policy and risk assessments in place for prescription, administration and safe storage of controlled/opiate medication, including the process for assessing in-possession status of prisoners and the procedure following an overdose of opiate medication in line with the relevant guidelines.**
- **The Governor and Head of Healthcare should ensure that risk information about a prisoner is shared with staff appropriately in a structured and formal way to enable those staff involved in the care of a prisoner to make risk informed decisions about their management and care.**
- **The Head of Healthcare should ensure that all communications in the SystemOne record are clearly documented and that specific times are recorded. All recordings should be timely and accurate in accordance with the NMC (2018) Code.**
- **The Head of Healthcare should ensure that a falls risk assessment is promptly completed by the healthcare team, if the patient is known to be at risk of falls and should be recorded in SystemOne and be readily accessible for all professionals.**

The Investigation Process

7. The PPO investigator has investigated non-clinical issues, including Mr Smith's location, the security arrangements for his hospital escorts, liaison with his identified next of kin and whether compassionate release was considered.
8. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at HMP Risley.
9. The PPO investigator and clinical reviewer jointly interviewed three members of staff on 23 October and 6 November 2020. All the interviews were conducted by telephone because of the restrictions imposed in response to the COVID-19 pandemic.
10. Mr Smith had no family or friends listed as a next of kin. His next of kin was identified as his community Probation Officer. However, by the time of his death, she had left the Probation Service and could not be traced.
11. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies in the clinical review and this has been amended accordingly. The PPO found one inaccuracy, and this has also been amended. The prison's action plan has been annexed to this report.

Previous deaths at HMP Risley

12. Mr Smith was the 13th prisoner to die at HMP Risley in the last two years. Of the previous 12 deaths, six were from natural causes.
13. We have previously made a recommendation at Risley about the need to complete Falls Risk Assessments promptly.

Key Events

14. On 13 May 1993, Mr Trevor Smith was sentenced to life imprisonment for murder. He received a tariff of 20 years. He was sent to HMP Leeds. In August 2012, he transferred to HMP Risley.
15. On 11 March 2014, Mr Smith was referred under the 2 Week Wait rule to Urology (the branch of medicine concerned with the male and female urinary tract) specialists following a repeat ultrasound scan which identified a tumour in his bladder.
16. Following elective surgery on the 13 April, Mr Smith was diagnosed with cancer of the bladder. He also had surgery to remove part of his bladder. Mr Smith was subsequently reviewed through Urology clinics post operation.
17. In March 2018, at a urology appointment Mr Smith had a CT scan. On 24 April, A prison GP reviewed the results and noted that Mr Smith might have lung cancer. On 17 August, Mr Smith was told that he had secondary lung cancer. No treatment was advised as the cancer was not advanced enough. This was kept under review through regular follow up appointments.

2020

18. On 5 March 2020, Mr Smith saw a prison GP. He complained of a chesty cough and was concerned his cancer had progressed. The prison GP requested a referral back to the hospital Oncology department for review. Mr Smith was seen by a Consultant Oncologist by telephone on 16 April 2020. The consultant arranged for radiotherapy treatment for Mr Smith's bladder cancer.
19. Mr Smith attended hospital for three radiotherapy treatments on the 23 and 28 April, and 5 May 20. On 10 June, a telephone consultation with a Consultant Oncologist was cancelled by the hospital. Another appointment was not scheduled. In June, Mr Smith moved onto the COVID-19 shielding unit at HMP Risley.
20. On 16 July, Mr Smith saw a prison GP. He complained of feeling tired all the time. The prison GP assessed this could be cancer related fatigue, prescribed medication and requested a set of blood tests.
21. In early August, Mr Smith's health began to deteriorate. Staff were concerned about his self-care. A nurse referred him to Adult Social Care to be assessed and he was given a personal alarm pendant for emergencies. A falls risk assessment (FRA) was also requested and a referral was made to St Rocco's hospice in Warrington.
22. On 7 August, Mr Smith saw a prison GP. The prison GP assessed that Mr Smith was chronically unwell and suffering with respiratory distress. He was sent to Warrington Hospital and admitted as an inpatient. On 11 August, a nurse contacted the hospital. She was told that Mr Smith was being treated for community acquired pneumonia. She was told that the Palliative Care Team (PCT) had been asked to review him but was not offering support at this time.

23. On 19 August, Mr Smith was discharged from hospital. On his return to the prison he was seen by a nurse. She helped Mr Smith to change and wash but he declined further assessment.
24. On 20 August, a prison GP reviewed Mr Smith's hospital discharge and discussed his diagnosis and a Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order with him, which meant that if his heart or breathing stopped he would not be resuscitated. Mr Smith agreed to have a DNACPR order in place. On 21 August, a nurse, spoke with the PCT from Warrington Hospital to discuss palliative care and end of life care provision at HMP Risley. The nurse told them that the prison could not provide end of life care. The PCT asked that Mr Smith be prescribed oramorph for pain relief.
25. On 24 August, a prison GP prescribed Oramorph for Mr Smith which he was permitted to have in-possession. In the night of 24-25 August Mr Smith took more oramorph than the prescribed amount.
26. In the early hours of 25 August, healthcare staff were called and attended Mr Smith's cell. Two nurses assessed him. They noted he had taken more oramorph than he should have. They assessed him and found no cause for concern. They advised wing staff to contact them if needed.
27. Later in the night healthcare staff were called back to Mr Smith's cell because he had fallen and could not get back up. He had no reported injuries and was conscious and alert. Again, they advised wing staff to contact them if needed. They saw Mr Smith for a third time at around 6.15am and noted he was asleep in his bed.
28. At around 10.30am, wing staff reported that Mr Smith was unwell and a nurse assessed him. She then liaised with a prison GP. They agreed Mr Smith was suffering from possible opioid toxicity and called an emergency ambulance.
29. Mr Smith was treated by hospital staff at Warrington Hospital. They assessed that he had suffered an oramorph overdose and discharged him with instructions that he should not have the drug in-possession. On return to the prison Mr Smith was seen by a prison GP. Mr Smith refused further assessment.
30. On 26 August, around 9.50am, healthcare staff assisted Mr Smith to change and wash himself. As they helped him Mr Smith punched one member of staff in the face and tried to punch another.
31. That afternoon, Mr Smith went to St Rocco's hospice for a planned outpatient assessment. He was escorted by two officers. However, on his arrival, hospice staff were concerned about his health and he was admitted as an inpatient.
32. On the same day, an application for Mr Smith's early release on compassionate grounds was started by staff at HMP Risley. The application was not completed by the time Mr Smith died.
33. On 27 August, the hospice began palliative pain relief through a syringe driver and advised the prison that Mr Smith was too unwell to be discharged.
34. At 4.25pm, Mr Smith died at St Rocco's hospice.

Post-mortem report

35. The Coroner concluded in the post-mortem that Mr Smith died of carcinomatosis (a condition where cancer is widely spread through the body) caused by metastatic small cell carcinoma of the bladder. He also had ischaemic heart disease which did not cause but contributed to his death.

Lisa Burrell
Assistant Ombudsman

July 2021

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