Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gerald Smith, a prisoner at HMP The Verne, on 24 December 2021

A report by the Prisons and Probation Ombudsman

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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

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 Gerald Smith died in hospital, on 24 December 2021, of bone cancer, while a prisoner at HMP The Verne. Mr Smith was 65 years old. I offer my condolences to Smith's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Smith received at HMP The Verne was equivalent, if not better, to that he could have expected to receive in the community. He made no recommendations.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at HMP The Verne.

7. The PPO investigator has investigated non-clinical issues, including Mr Smith's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. The investigator issued notices to staff and prisoners at HMP The Verne, informing them of the investigation and asking anyone with relevant information to contact her. A prisoner spoke to the investigator over the phone and said that Mr Smith had felt frustrated with healthcare's original diagnosis of his symptoms. The prisoner's concerns were passed to the clinical reviewer. The clinical reviewer said that he had no concerns regarding Mr Smith's management either at first presentation or his subsequent care.

9. The PPO family liaison officer wrote to Mr Smith's next of kin to explain the investigation.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP The Verne

11. Mr Smith was the 11th prisoner to die at The Verne since December 2019. Of these deaths, all were from natural causes. Since Mr Smith's death, there has been one further death and the cause of this death is currently unknown. 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

12. On 21 August 2017, Mr Gerald Smith was remanded to HMP Manchester. On 18 September, he was sentenced to ten years imprisonment for offences of aggravated bodily harm, rape and indecent assault. On 18 September 2018, Mr Smith was transferred to HMP The Verne.

13. Between 1 June 2020 and 18 June 2020, Mr Smith attended healthcare five times with pain which moved between his chest, lower abdomen and back, as well as constipation. Healthcare initially thought his symptoms were caused by injury from exercise.

14. On 22 June 2020, Mr Smith was taken to A&E. He was diagnosed with bone marrow cancer and stayed in hospital for 11 days. After Mr Smith returned to The Verne, he went to hospital twice a week for chemotherapy.

15. On 1 July 2021, the hospital consultant emailed the prison to say that Mr Smith's cancer was not responding to treatment and that he had three to six months left to live. The prison GP discussed the prognosis with Mr Smith and Mr Smith asked to be considered for early release on compassionate grounds,

16. On 28 September 2021, an application for Mr Smith's early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of Her Majesty's Prison and Probation Service (HMPPS). The application was refused on the grounds of life expectancy being more than 3 months, physical capacity, and the lack of release plan. The PPCS asked The Verne to provide updates on Mr Smith's condition.

17. On 8 November, Mr Smith was taken to A&E with a suspected chest infection. He was admitted to hospital and remained there. Healthcare staff wrote in the escort risk assessment that there were no medical objections to the use of restraints and restraints were authorised. Prison staff escorted Mr Smith to hospital using a single escort chain. On 9 November, the Duty Governor had a consultation with healthcare, where they discussed Mr Smith's end of life care. Based on this information, the Duty Governor did not authorise restraints to be used while Mr Smith was an inpatient in hospital, and they were removed. The Head of Healthcare will want to make sure that healthcare staff who are filling out escort risk assessments appreciate what constitutes a medical objection to restraints, including end of life care.

18. On 12 November, The Verne submitted another early release on compassionate grounds application because of Mr Smith's deteriorating health. The application was rejected because the PPCS concluded that Mr Smith's risk of reoffending was still present.

19. On 24 December, the hospital told The Verne that Mr Smith was in his final hours. The Verne requested that the PPCS reconsidered the ERCG decision. Mr Smith died later on that night, at 8.20pm.

Post-mortem report

20. The Coroner concluded that Mr Smith died of Bronchopneumonia caused by bone marrow cancer.

Tallulah Frankland **August 2022**
Assistant Ombudsman

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