Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Vincent Smith, a prisoner at HMP Durham, on 27 August 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 Vincent Smith died on 27 August 2021, of a heart attack following a bleed on the brain, while a prisoner at HMP Durham. Mr Smith was 46 years old. I offer my condolences to Mr Smith's family and friends.

4. The clinical reviewer concluded that the care Mr Smith received at HMP Durham was of the required standard and equivalent to that which he could have expected to receive in the community. She made a recommendation about reviewing the process for logging and following up tasks on SystmOne (electronic medical record) and record keeping. We repeat the recommendation about this below.

5. We did not find any non-clinical issues of concern.

## Recommendation

- The Head of Healthcare should:
    - review the process for logging tasks requiring actions in the wing nurse ledger on SystmOne which should be followed up by healthcare clinicians; and,
    - ensure that record keeping is comprehensive for the wider multi-disciplinary team and the plan of care and treatment is documented.

# The Investigation Process

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

7. The investigator obtained copies of relevant extracts from Mr Smith's prison and medical records. The investigator and clinical reviewer interviewed six members of staff at HMP Durham on 4 October.

8. The Ombudsman's family liaison officer contacted Mr Smith's next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns but asked for a copy of this report.

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

10. We sent a copy of our initial report to Mr Smith's mother. She did not respond.

# Background Information

## Previous deaths at HMP Durham

11. Mr Smith was the 13th prisoner to die at Durham since August 2019. Of the previous deaths, five were self-inflicted, six were from natural causes and one was drug related.

12. There were no significant similarities between the findings in our investigation into Mr Smith's death and our findings from the investigations into the previous deaths.

# Key Events

13. On 26 June 2021, Mr Vincent Smith was remanded to HMP Durham for harassment, assault, indecent exposure and sexual assault.

14. Mr Smith was homeless prior to arriving at HMP Durham and had been previously diagnosed with kidney disease, although the date of his diagnosis was unknown. He also had several mental health conditions including bipolar disorder. He was not prescribed any medication during his time at Durham.

15. On his arrival at Durham, staff started suicide and self-harm prevention procedures (known as ACCT) because Mr Smith came into custody with a Suicide and Self-harm (SASH) warning form and was displaying what prison staff described as 'bizarre' behaviour.

16. On 9 July, an officer went to Mr Smith's cell for a welfare check and spoke with wing staff about Mr Smith collecting his own food. He had gone into the servery but was unhappy with the menu choices, so threw his plate and bowl at the wall. The officer recorded that Mr Smith leaving his cell was an improvement in his behaviour, despite his outburst, as staff had struggled to get him to leave his cell. When she tried to speak to Mr Smith about his behaviour, he told her to shut up. He also said that he was feeling sick but did not give any more information about feeling unwell. She reminded Mr Smith that he could access healthcare staff for any health issues. Mr Smith did not respond, and she left his cell.

17. On 12 July, staff ended the ACCT procedures. An officer told us that ACCT procedures were stopped because Mr Smith was less volatile with staff and was not swearing at people as frequently as when he arrived in prison custody.

18. On 3 August, a prison GP asked for precautionary blood pressure readings for Mr Smith via the task system following blood pressure checks in early July. These were to be taken a week apart and were scheduled for 4 August and 11 August. Healthcare staff did not take any blood pressure readings as they should have done.

19. At around 5.40am on 21 August, an officer was conducting the night roll checks. He saw Mr Smith on his cell floor. He told us that Mr Smith appeared to be sleeping on the floor, which some prisoners do, but his snoring stood out to him as a possible concern. He contacted the nurse on duty to get a medical opinion.

20. The nurse attended Mr Smith's cell. She noted that there could be an obstruction to his breathing due to the noises he was making. More staff were asked to assist before entering his cell as it was not clear if it was an emergency at that point. More staff arrived and entered the cell. The nurse said that when they moved Mr Smith, they could see green-coloured vomit and he was unresponsive.

21. At 5.41am, staff radioed a code blue medical emergency (indicating a prisoner is unconscious or is having difficulty breathing). An ambulance was called immediately and was considered a 'category 2' incident, which is less urgent. The nurse told us that Mr Smith was breathing on his own and his pulse was stable.

22. At 6.03am, staff updated the ambulance service and told them that Mr Smith's oxygen levels were dropping and that he was at risk of a cardiac arrest. The ambulance service updated the incident to a 'category 1', and an ambulance arrived at the prison at 6.20am.

23. Mr Smith was transferred to University Hospital of North Durham by emergency ambulance. He was escorted by two officers and was restrained using an escort chain. The restraints were removed when they arrived at the hospital.

24. Once at the hospital, Mr Smith had a CT scan, which showed that he had a bleed on the brain. Hospital staff transferred him to the Royal Victoria Infirmary Newcastle, where he had surgery to ease the pressure on his brain. Mr Smith was sedated and kept under observation.

25. On 27 August, it was confirmed that Mr Smith had died in hospital.

## Post-mortem report

26. The pathologist gave Mr Smith's cause of death as cardiorespiratory arrest (heart attack) caused by a bleed on the brain.

27. It was confirmed when Mr Smith arrived in hospital that no illegal drugs were detected in his system.

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **May 2022**

## Inquest

The inquest, heard on 23 March 2023, concluded that Mr Smith died from natural causes.

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