

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Rodney Smallman, a prisoner at HMP Risley, on 11 March 2023

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic process failure.
3. Mr Rodney Smallman died of chronic kidney disease in hospital on 11 March 2023, while a prisoner at HMP Risley. He was 81 years old. He also had Type 2 diabetes, heart failure, atrial fibrillation (an irregular and often fast heartbeat), peripheral vascular disease (a blood circulation disorder) and hypertension which contributed to but did not cause his death. We offer our condolences to Mr Smallman's family and friends.
4. The PPO family liaison officer wrote to Mr Smallman's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Smallman's next of kin did not respond.
5. The PPO investigator investigated the non-clinical issues relating to Mr Smallman's care. We did not find any non-clinical issues of concern.
6. NHS England commissioned an independent clinical reviewer to review Mr Smallman's clinical care at Risley. The clinical reviewer concluded that the clinical care that Mr Smallman received at Risley was variable and some areas of his care were not equivalent to that which he could have expected to receive in the community.
7. Annual reviews of Mr Smallman's long-term conditions were not completed within the timescales outlined in NICE guidelines and care plans were not created in a timely fashion. He was not added to the Complex Care Register when he should have been.
8. Mr Smallman developed venous leg ulcers at Risley. There is no evidence that healthcare staff carried out an initial assessment of his leg ulcers or created a management plan to treat them.
9. The clinical reviewer made three recommendations related to Mr Smallman's death:
 - The Head of Healthcare should ensure that prisoners with long-term conditions are reviewed annually in line with NICE guidelines and have appropriate care plans created in a timely manner.
 - The Head of Healthcare should ensure that prisoners with complex care needs are added to the Complex Care Register in a timely manner.
 - The Head of Healthcare should ensure that prisoners who develop leg ulcers have an initial assessment and that a management care plan for their treatment is created.

10. We shared the initial report with the Prison Service. There were no factual inaccuracies. Their action plan has been appended to this report.
11. At an inquest held on 14 July 2023, the Coroner concluded that Mr Smallman died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman

February 2024

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