

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Smith on 22 January 2023, following his release from HMP Ranby

A report by the Prisons and Probation Ombudsman

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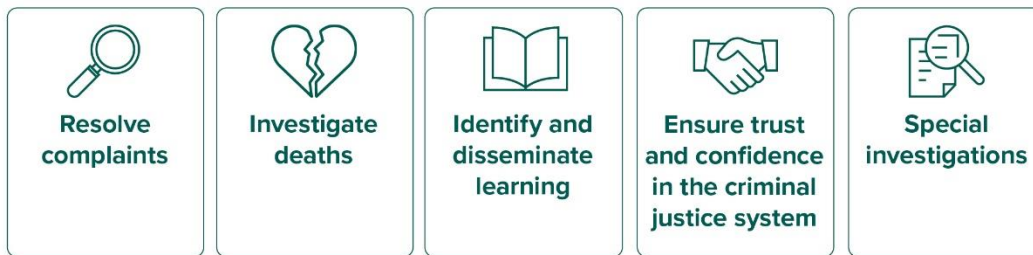
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OUR VISION

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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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. Since 6 September 2021, the PPO has been investigating post-release deaths that occur within 14 days of the person's release from prison.
3. 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 failure.
4. Mr David Smith died of combined drug toxicity on 22 January 2023, five days after his release from HMP Ranby. He was 37 years old. We offer our condolences to those who knew him.
5. We did not find any issues of concern related to the pre or post-sentence planning process. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Smith's death on 26 January 2023.
7. The PPO investigator obtained copies of relevant extracts from Mr Smith's prison and probation records.
8. We informed HM Coroner for Nottingham of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
9. We contacted Mr Smith's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Ranby

11. HMP Ranby is a Category C adult male training and resettlement prison. Nottinghamshire Healthcare NHS Foundation Trust provides physical health, mental health and substance misuse services.

Probation Service

12. The Probation Service work with all individuals subject to custodial and community sentences. During a person's imprisonment, they oversee their sentence plan to assist in rehabilitation, as well as prepare reports to advise the Parole Board and have links with local partnerships to whom, where appropriate, they refer people for resettlement services. Post-release, the Probation Service supervise people throughout their licence period and post-sentence supervision.

Key Events

13. On 5 October 2022, Mr David Smith was convicted of obstructing a police constable in execution of duty and was sentenced to 30 weeks in prison. He was sent to HMP Nottingham.
14. Mr Smith had a long history of substance misuse and had been on methadone (a medicine used to treat heroin dependency) detoxification programmes during previous prison sentences, most recently in May 2020. However, when he arrived at Nottingham, Mr Smith told the reception nurse that he had no issues with drugs or alcohol, and that he had not used drugs before.
15. On 24 October, Mr Smith was sent to HMP Ranby.

Pre-release planning

16. On 25 November, Mr Smith had a video link meeting with his Community Offender Manager (COM) and his Prison Offender Manager (POM), during which they discussed licence conditions and accommodation. Mr Smith said he would like to live in Bolsover and wanted to stay away from Chesterfield due to known associates in that area. Mr Smith's COM told him that he would like Mr Smith to engage with the Derbyshire Drug and Alcohol Action Team (DAAT) on release, who would monitor Mr Smith's alcohol use and keep the COM informed of any issues.
17. During this meeting, Mr Smith said he had not used drugs for approximately two years. He also said he was previously diagnosed with psychosis and was prescribed a depot injection (slow-release medication) but he had also not taken any medication for his mental health for approximately two years. Mr Smith was not engaging with the mental health team in prison, because he thought he did not need to. Mr Smith did not engage with the prison substance misuse team while at Ranby.
18. That day, Mr Smith's COM submitted a Duty To Refer (DTR, the Homelessness Reduction Act 2017 introduced a duty on specified public authorities to refer service users who they think may be homeless or threatened with homelessness to local authority homelessness teams) to Bolsover Council. He also completed a Nacro referral (a partnership agency who deal with housing support and resettlement and who provide a worker dedicated to help find accommodation).
19. On 15 December, the COM completed an ARBOR referral (a housing partner that Chesterfield probation office work with who accept high risk offenders). There is no evidence documented that ARBOR responded to the COM's referral.
20. On 1 January 2023, a case worker from Nacro met with Mr Smith in prison for his initial assessment and they discussed what accommodation support Mr Smith needed on release. The case worker then sent an action plan to the COM and that was approved by the COM on 4 January.
21. On 17 January, the COM also referred Mr Smith to P3 (a housing and mental health organisation). There is no evidence documented that P3 responded to the COM's referral. At the point of release, Mr Smith had no confirmed accommodation.

22. Mr Smith was subject to two additional licence conditions on release:
- Attend appointments as directed, to address his dependency on, or propensity to misuse, a controlled drug.
 - To comply with any requirements specified by his supervising officer for the purpose of ensuring that he address his alcohol, drug, violence and offending behaviour problems.

Post-release planning

23. On 17 January, Mr Smith was released from Ranby and attended the Chesterfield probation office for his initial appointment with his COM. During this appointment the COM called Bolsover Council with Mr Smith and spoke to the homeless team. They were able to provide Mr Smith with accommodation that night under SWEP (Severe Weather Emergency Protocol) due to the drop in temperature at the time. Mr Smith was offered a B&B until the weather improved.
24. That day, Mr Smith was seen by a member of DAAT, who gave him an appointment on 23 January for his initial assessment.
25. On 20 January, the COM spoke to Pathways (an organisation within Bolsover Council who deal with homelessness) who had assessed Mr Smith earlier that morning and they were able to get him an assessment with Hope House (a charity who support those who are homeless or at risk of homelessness), that afternoon.
26. That day, Hope House accepted Mr Smith and he was able to move into their hostel the next day.
27. On 21 January, Mr Smith moved into Hope House hostel and was seen coming in and out of the hostel throughout the day.
28. According to the police report, at around 9.15pm, during the evening checks, a member of hostel staff knocked on Mr Smith's door but got no response. A colleague told her that Mr Smith was not in, so she did not go into Mr Smith's room to check on him. (According to CCTV, Mr Smith went back into his room at 6.58pm that evening and did not leave again.) The CEO of Hope House told us that staff always did a headcount at around 9.00pm, the hostel curfew time, and that they should either see or hear the resident to check whether they were in or out. She said that the incident report did not mention that staff did not get a response from Mr Smith that evening and that the staff member who carried out the check had since left so she could not check with them.

Circumstances of Mr Smith's death

29. At 2.14pm on 22 January, while completing the daily checks, the hostel manager found Mr Smith lying face down on the floor in his room and there was a needle on the table. He took a colleague into the room and called for an ambulance. The colleague attempted to wake Mr Smith by touching him but due to his colour, how cold he was and how stiff he appeared, they realised he was dead.
30. The paramedics arrived and pronounced Mr Smith deceased at 2.28pm.

Post-mortem report

31. The post-mortem report concluded that Mr Smith died of combined drug toxicity. The toxicology report confirmed Mr Smith used cocaine and heroin just before his death.
32. At the inquest held on 15 December 2023, the Coroner concluded that Mr Smith's death was drug related.

Findings

Substance misuse

33. Due to Mr Smith being abstinent from drugs for approximately two years, he did not engage with the substance misuse team in prison, and therefore he was not released with a naloxone kit. (Naloxone is a medicine that can rapidly reverse the effects of opioid overdose.)
34. Mr Smith's COM referred him to the community substance misuse team in a timely manner, prior to his release so they could monitor Mr Smith appropriately and inform the COM of any issues. Unfortunately, Mr Smith died before having his initial assessment with the substance misuse team.
35. Mr Smith's COM also made appropriate accommodation referrals which resulted in Mr Smith being given a hostel place.
36. The police report said that hostel staff failed to get a response from Mr Smith during the evening check on 21 January. However, the CEO of Hope House said there was no record of this in the incident report. Whether or not a response was obtained from Mr Smith at 9.15pm is unlikely to have affected the outcome. The actions of the hostel staff, which is run by a charitable organisation, are outside our remit.
37. We make no recommendations.

Adrian Usher
Prisons and Probation Ombudsman

May 2024

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