Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Smith, a prisoner at HMP Liverpool, on 24 March 2024

A report by the Prisons and Probation Ombudsman

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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

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. 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.

3. Mr Stephen Smith died on 24 March 2024 of respiratory failure (when the lungs cannot give oxygen or remove carbon dioxide from the blood) which was caused by laryngotracheobronchitis (also known as croup, a viral infection) due to an infected branchial cyst (swelling in the neck) and chronic obstructive pulmonary disease (COPD – a group of lung conditions which cause breathing difficulties). He was 58 years old. We offer our condolences to Mr Smith's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Smith received at Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found that there was a delay in calling a code blue when Mr Smith's cellmate informed an officer that Mr Smith was not breathing partly because the officer who responded was not carrying a radio. It is unlikely that this delay had an impact on the outcome for Mr Smith.

6. We found that during night state on wings where there is more than one officer, it is not mandatory for all staff to carry a radio.

7. We found that staff were not wearing body worn video cameras although they were available, so there was no footage of the incident. This is not in line with the national policy.

Recommendations

- The Governor should ensure that all staff carry a radio during night state.

- The Governor should ensure that there is a robust audit process to ensure that all staff draw body worn video cameras and use them according to the national policy.

The Investigation Process

8. HMPPS notified us of Mr Stephen Smith's death on 24 March 2024.

9. NHS England commissioned an independent clinical reviewer, to review Mr Smith's clinical care at HMP Liverpool.

10. The PPO investigator investigated the non-clinical issues relating to Mr Smith's care.

11. She obtained and reviewed copies of relevant extracts from Mr Smith's prison and medical records. There was no body worn video camera (BWVC) footage of the emergency response. Due to a technical error, the prison was also unable to provide the investigator with a copy of the CCTV.

12. The investigator and clinical reviewer interviewed a member of staff via MS Teams on 11 June. The investigator also contacted the Head of Safer Custody for further information on internal prison processes.

13. The Ombudsman's office wrote to Mr Smith's next of kin, his brother-in-law, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our communication.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Liverpool

15. Mr Smith was the 15th prisoner to die at Liverpool since 24 March 2021. Of the previous deaths, eight were from natural causes, one was due to drugs, four were self-inflicted and one was unascertained. There are no similarities between the findings in our investigation into Mr Smith's death and the findings from our investigations into the previous deaths. Since Mr Smith's death and up to the end of September 2024, three prisoners had died of natural causes at Liverpool.

Key Events

16. On 20 March 2024, Mr Stephen Smith was sentenced to 5 years and 8 months imprisonment for a drug related offence. He was taken to HMP Liverpool.

17. A nurse assessed Mr Smith on his arrival. His observations were normal and he raised no health concerns. Mr Smith had a history of asthma and Chronic Obstructive Pulmonary Disease (COPD) for which he was prescribed medication. This continued in prison.

18. On 21 March, Mr Smith had a key worker session with a member of staff who explained the regime to Mr Smith. On 22 March, a GP saw Mr Smith, noticed a lump on his neck, and referred him for non-urgent blood tests. The GP had no other concerns about Mr Smith's health and Mr Smith did not tell staff that he felt unwell while at Liverpool.

19. On 24 March at 3.16am, Mr Smith's cellmate rang their emergency cell bell. A minute later, an officer responded and spoke to the cellmate who said that Mr Smith was having trouble breathing. The officer explained during interview that Mr Smith was in the bathroom at the time and that she could not see him as a wall blocked the view.

20. The officer was not carrying a radio, so she immediately went downstairs and told a second officer that Mr Smith was having breathing difficulties. The second officer radioed a nurse and a Custodial Manager (CM) at 3.18am. He said that Mr Smith was having breathing difficulties and asked for them to come to the cell. The officer returned to Mr Smith's cell door.

21. The officer asked Mr Smith's cellmate whether Mr Smith had taken any drugs. She also asked if he could put Mr Smith in the recovery position. Mr Smith's cellmate said he could not because of the position Mr Smith was in. He told the officer that Mr Smith was asthmatic, which she then shouted to the second officer. She then asked if Mr Smith was breathing. Mr Smith's cellmate returned to the bathroom to check on Mr Smith and returned to say that Mr Smith was not breathing and his lips had gone blue. As the officer considered going into the cell, the nurse and CM arrived.

22. The nurse asked the second officer to get the emergency bag (she said she had not brought it with her as the second officer had not used a medical emergency code, so she had not appreciated the seriousness of the situation). She went into the cell with the CM and assessed Mr Smith. At 3.22am, a member of staff (it is not recorded who) radioed a code blue (an emergency code indicating that a prisoner has stopped or is having difficulty breathing). The second officer returned with the emergency bag. The CM, the nurse and another prison officer did CPR on Mr Smith.

23. The ambulance arrived the prison gate at 3.32am and paramedics got to Mr Smith's cell two minutes later. They took over Mr Smith's care but pronounced him dead at 4.27am.

Post-mortem report

24. The post-mortem report concluded that Mr Smith died of respiratory failure (a condition when the lungs cannot give oxygen or take carbon dioxide from the blood) caused by laryngotracheobronchitis and acute exacerbation of COPD. On 31 March, after our final report was issued, the Coroner shared an amended post-mortem report which now reflected that laryngotracheobronchitis was due to an infected branchial cyst. The clinical review has been amended accordingly.

Non-Clinical Findings

Prison radios

25. The officer was not carrying a radio on the night of 24 March. This delayed her request for help when Mr Smith's cellmate raised the alarm. In interview, she said that during night state, there is only one radio per wing. The Head of Safety confirmed that during night state every wing must have at least one radio. She said that most wings are staffed by one officer overnight and on wings with more than one officer (as in this case), at least one radio must be used. Other officers can decide whether to carry, but it is not mandated. The prison provided no evidence that the impact of this practice had been risk assessed or had any practical benefit for prisoners or staff. The Head of Safety said that there were enough radios for every member of staff to have one. We make the following recommendation:

    The Governor should ensure that all staff carry a radio during night state.

Body Worn Video Cameras (BWVC)

26. Prison Service Instruction (PSI) 04/2017, *Body Worn Video Cameras (BWVC)*, requires prison staff to use BWVCs during any reportable incident.

27. The investigator was informed that no attending staff had drawn a BWVC at the beginning of their shift on the night Mr Smith died, although we were told that the prison had sufficient cameras for all staff. We make the following recommendation:

    The Governor should ensure that there is a robust audit process to ensure that all staff draw body worn video cameras and use them according to the national policy.

Governor to Note

Emergency response

28. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, states that when staff find a prisoner unresponsive, they should immediately alert the control room using a medical emergency code. This is to ensure a timely, appropriate, and effective response to medical emergencies and to maximise the likelihood of a positive outcome for the prisoner. The control room should then automatically call an ambulance.

29. Mr Smith's cellmate told the officer that Mr Smith was having breathing difficulties at 3.17am. Due to not having a radio, the officer went downstairs and told the second officer that Mr Smith was having breathing difficulties. The second office radioed for a nurse and CM to attend, but did not radio a code blue. Staff did not radio a code blue until 3.22am. This delayed staff requesting the ambulance by five minutes but did not delay the nurse and CM getting to the cell. It also meant that the nurse did not take the emergency bag with her. The Governor will want to ensure that staff are aware of how and when to use emergency codes. The officer said she was

considering going into the cell on her own when other staff arrived. We consider that it was reasonable for her to delay entering the cell until further staff arrived.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Inquest

The inquest hearing was held on 2 July 2025. The Coroner concluded that Mr Smith died of natural causes.

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