

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Smith, a prisoner at HMP Whatton, on 18 June 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

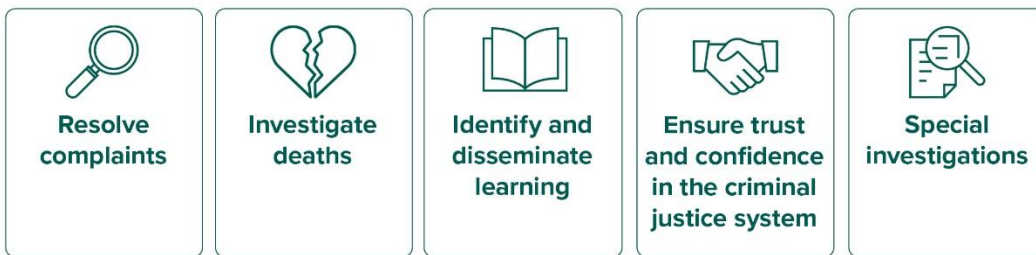
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100

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. 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 David Smith collapsed and died of heart disease on 18 June 2024, at HMP Whatton. He was 54 years old. We offer our condolences to Mr Smith's family and friends.
4. Mr Smith had diabetes and high blood pressure. Healthcare staff prescribed medication for both conditions and monitored Mr Smith regularly.
5. The clinical reviewer concluded that the clinical care Mr Smith received at Whatton was equivalent to that which he could have expected to receive in the community. However, the clinical reviewer highlighted that during the resuscitation attempt, nurses could not locate the suction equipment in the emergency bag. Suction equipment is in the emergency bag as standard, and nurses should have known how to locate it. In addition, it became apparent after Mr Smith's death that he had not collected his medication for around 11 weeks.

Recommendations

- The Head of Healthcare should ensure that all clinical staff are fully conversant with the contents of the emergency resuscitation bag and arrange an onsite reflective training session by an advanced resuscitation practitioner.
- The Head of Healthcare should ensure that the monthly audit of checking that patients have requested and or collected their in-possession medications, as prescribed, is firmly embedded into the quality schedule. This will also include the pharmacy team identifying and reporting any medication that has not been collected.

The Investigation Process

6. HMPPS notified us of Mr Smith's death on 19 June 2024.
7. NHS England commissioned an independent clinical reviewer to review Mr Smith's clinical care at Whatton.
8. The PPO investigator investigated the non-clinical issues relating to Mr Smith's care.
9. The investigator interviewed four members of staff at Whatton on 14 August and three members of staff by video call on 21 and 22 August. The clinical reviewer accompanied her for all healthcare interviews. The investigator also had telephone contact with five prisoners on 9 July and 29 August. They raised concerns about the speed and quality of the emergency response when Mr Smith collapsed on 18 June. These issues have been addressed in this report and in the clinical review.
10. The Ombudsman's office contacted Mr Smith's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of the report.
11. We shared our initial report with HMPPS and the prison's healthcare provider, Practice Plus Group. They found no factual inaccuracies.
12. We sent a copy of our initial report to Mr Smith's sister. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Whatton

13. Mr Smith was the 15th prisoner to die at Whatton since June 2021. Of the previous deaths, 13 were from natural causes and one was self-inflicted. 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.

Key Events

14. On 22 September 2022, Mr David Smith was sentenced to 90 months imprisonment for rape. He was moved to HMP Whatton on 1 November 2023.
15. Mr Smith had diabetes and high blood pressure. Healthcare staff prescribed medication for both conditions and monitored Mr Smith regularly. Mr Smith was assessed as suitable to keep his medication in his cell.
16. In February 2024, a GP noted that Mr Smith's blood pressure was almost in the target range. However, she increased his diabetes medication to improve his blood sugar levels and encouraged him to lose some weight. The next month, a nurse prescribed weight loss medication.
17. In April, a nurse recorded that Mr Smith had lost 2kg, but his blood pressure remained high. She increased one of his blood pressure medications. The next month, a nurse noted that Mr Smith's blood pressure was almost within target range and that he was attending the gym.
18. On 13 June, a nurse saw Mr Smith after he reported diarrhoea and vomiting. He also said he had pain down both sides of his abdomen. She took Mr Smith's observations, which showed that his blood pressure was high, and his pulse was fast but regular. She noted that Mr Smith had no signs of breathlessness, had a normal skin colour and was not clammy. She advised Mr Smith to stay in his cell until his symptoms cleared. When interviewed, she said that Mr Smith showed no symptoms of acute heart disease.

Events of 18 June

19. On 18 June, a nurse reviewed Mr Smith. He told her that his diarrhoea and vomiting had stopped. He did not mention chest pain.
20. Mr Smith went to work that afternoon. At 2.10pm, Mr Smith passed an officer on his way to the workshop. She did not know Mr Smith, but he seemed to be struggling to walk so she asked him if he was okay. Mr Smith told her that he had a respiratory illness and had already seen healthcare staff earlier that day. Mr Smith continued to Workshop 13.
21. At 3.07pm, Mr Smith collapsed in Workshop 13. The workshop instructor activated the general alarm to alert staff. The control room operator called over the radio network that the alarm had been activated in Workshop 10. (Workshops 10 to 13 are on the same wiring loop and Workshop 10 is the first workshop listed on the control room monitor.)
22. Officer A responded to the general alarm and headed towards Workshop 10. When he got there, he saw that the alarm light was not activated outside Workshop 10, so he proceeded to Workshop 13, where he saw the alarm light. He entered Workshop 13 and saw that Mr Smith was unconscious and unresponsive. At 3.12pm, he called a Code Blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). He switched on his Body Worn Video Camera

(BWVC). This is the only footage of the incident as there is no CCTV inside the workshop or in the workshop corridor.

23. Two nurses arrived with the emergency resuscitation bag and started CPR. On the Body Worn Video Camera (BWVC) footage, a nurse can be heard asking for suction (to remove secretions in Mr Smith's airway) and that she could not find the suction equipment. We were told that suction equipment is in the emergency bag as standard.
24. An air ambulance arrived at Whatton at approximately 3.22pm. Officer A said control room staff told him that the air ambulance would be landing on the sports field, so he and another officer headed there to escort the ambulance paramedics back to the workshop. After a few minutes, he contacted the control room for an update on where to meet the air ambulance as he could hear the helicopter but could not see it. The control room told him that the air ambulance had landed outside the prison and to make his way to the gate to meet the ambulance paramedics.
25. Officer A got to the gate at 3.30pm and escorted the air ambulance doctor and paramedics to Workshop 13. The air ambulance crew arrived at Workshop 13 at 3.33pm.
26. The air ambulance doctor and paramedics continued resuscitation attempts but they were unsuccessful. At 4.02pm, the doctor pronounced that Mr Smith had died.
27. After Mr Smith's death, healthcare staff realised that Mr Smith had not collected his medication for around 11 weeks. Nurse A told us that she now performed random checks on prisoners given in-possession medication to check they were collecting it and taking it as prescribed.

Post-mortem report

28. The post-mortem report concluded that Mr Smith died of ischaemic heart disease caused by coronary artery atherosclerosis and old myocardial infarction. Diabetes mellitus, hypertension (high blood pressure), hypercholesterolaemia (high cholesterol in the blood) and chronic kidney disease were listed as contributory factors.

Findings

Clinical care

29. The clinical reviewer concluded that the clinical care Mr Smith received at Whatton was equivalent to that which he could have expected to receive in the community. However, she highlighted some concerns with the emergency response. During the resuscitation attempt nurses asked for suction but could not locate the suction equipment in the emergency bag. (A manual lightweight suction device should always be in the emergency bag.)
30. Nurse A said that she had attended an immediate life support training session after Mr Smith's death and considered that all the nurses involved should have this opportunity to reflect on skills and knowledge in this area. We recommend:

The Head of Healthcare should ensure that all clinical staff are fully conversant with the contents of the emergency resuscitation bag and arrange an onsite reflective training session by an advanced resuscitation practitioner.

31. It became apparent after Mr Smith's death that he had not collected his medication for around 11 weeks. Nurse A stated at interview that she now performed random checks on patients that have medication in possession by monitoring the collection process and cross checking with any hospital discharge letters. We recommend:

The Head of Healthcare should ensure that the monthly audit of checking that patients have requested and or collected their in-possession medications, as prescribed, is firmly embedded into the quality schedule. This will also include the pharmacy team identifying and reporting any medication that has not been collected.

Emergency response

General Alarm

32. Although the general alarm was activated in Workshop 13 when Mr Smith collapsed, the control room operator told staff to go to Workshop 10. We were told this was because Workshops 10 to 13 are on the same wiring loop and when any of those alarms are activated, Workshop 10 will appear first on the list. The delay was minimal in this case as the first officer to respond saw that the alarm light was not on outside Workshop 10 so proceeded to Workshop 13.
33. The prison has told the PPO investigator that work is planned to amend the wiring issue.

Governor to note

Air Ambulance

34. Officer A was originally told that the air ambulance was landing on the prison's sports field, so he headed there to meet it. When he got there and realised the helicopter was not there, he contacted the control room, who said that it had landed outside the prison and to go to the gate instead. This caused a short delay in meeting the air ambulance paramedics and escorting them to Workshop 13.
35. The prison told us that an air ambulance would not be permitted to land inside the prison grounds and would always have to land outside the perimeter. Control room staff were clearly unaware of this when they told Officer A to go to the sports field. We bring this to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman

January 2025

Inquest

At the inquest, held on 8 October 2025, the Coroner concluded that Mr Smith died from natural causes.

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