Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Arron Smith a prisoner at HMP Gartree on 19 December 2016

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*

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Arron Smith died on 19 December 2016 in hospital from hypoxic brain injury and cardiac arrest resulting from Methylenedioxymethamphetamine (MDMA) ingestion on 17 December 2016. He was 23 years old. I offer my condolences to Mr Smith's family and friends.

Although the prison had some intelligence that Mr Smith was part of a gang involved in the drug culture at HMP Gartree, he did not have a history of substance misuse. His death was sudden and shocking and is a tragic example of how young lives can be unpredictably ended by substance misuse. Staff responded appropriately when he alerted them and three ambulance crews worked hard to save his life.

Mr Smith's death emphasises the need for Gartree to review and develop more robust drug supply and demand reduction strategies. The prison should also have started the process for contacting Mr Smith's family as soon as he was taken to hospital.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2017**

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Summary

Events

1. On 21 February 2013, Mr Arron Smith received a life sentence for murder with a minimum time to serve of 21 years and 167 days. On 3 February 2015, he was transferred to HMP Gartree. Mr Smith had no history of substance misuse or mental illness and was physically fit and well. He was a popular prisoner at Gartree and held several trusted jobs. Mr Smith was seen as a clean-living young man who regularly went to the gym.

2. During 2016, the security department at Gartree received several intelligence reports linking Mr Smith to a gang of prisoners. Some of the gang members were linked to drug culture in the prison. There is nothing on Mr Smith's record to indicate that he took drugs in prison before 17 December 2016.

3. On 17 December, the day after his 23rd birthday, Mr Smith celebrated with other prisoners on the third floor of his wing. Witnesses said he drank "hooch" and took MDMA (a psychostimulant drug). Mr Smith was locked in his cell for the night at about 5.40pm and was described by the friend who put him to bed as "intoxicated".

4. At about 8.05pm, Mr Smith rang his cell bell and told an officer that he had taken something and felt dreadful. The officer radioed for the emergency response nurse. The nurse examined Mr Smith and requested an ambulance when he told her he had chest pains and numbness in his arms.

5. Two ambulance technicians arrived just before 9.00pm. Initially they thought Mr Smith did not need to go to hospital, but his condition deteriorated rapidly and he stopped breathing. The ambulance technicians requested a paramedic to help move Mr Smith to the ambulance and maintain his airway.

6. A second ambulance arrived at 9.23pm, without the requested paramedic, so a third ambulance was called. A third crew member, including a paramedic, arrived at 9.50pm. The ambulance left the prison with Mr Smith at 10.16pm.

7. Mr Smith suffered a cardiac arrest on the way to hospital, where he was put on life support. Life support was removed on 19 December after tests showed his brain was unresponsive. The post-mortem found that Mr Smith died from hypoxic brain injury and cardiac arrest due to MDMA ingestion.

Findings

8. The nurse requested an ambulance as soon as Mr Smith told her he had chest pain and numbness in his arms. This is in line with Public Health England (PHE) guidance for staff to "treat what they see" when dealing with prisoners under the influence of illicit substances.

9. The nurse told the investigator that she had not seen a prisoner drinking such a large amount of water after taking drugs before. This is a common symptom of MDMA use.

10. Mr Smith ingested MDMA in the period between the end of his visit at 4.00pm and 5.40pm when he was locked in his cell on 17 December. A thorough police investigation found no evidence that he had taken MDMA under duress and they were unable to determine who gave it to him.

11. Mr Smith's death emphasises the need for HMP Gartree to review and develop their drug supply and demand reduction strategy. It is disappointing they were not able to provide us with a copy of their policy document during the investigation, despite numerous requests.

12. Prison Rule 22 stipulates that the prison should contact the next of kin at once if a seriously ill prisoner is taken to hospital. Mr Smith was seriously ill when he left Gartree at 10.16pm. The prison did not start the process for contacting Mr Smith's family until after 2.00am and the family were told just before 4.00am. We consider the process for telling them should have started sooner.

Recommendations

- **The Head of Healthcare should review the current guidance to staff on responding to prisoners under the influence of illicit substances and ensure that all staff are aware of the PHE guidance and toolkit.**
- **The Governor should review and develop the drug supply and demand reduction strategy as a matter of urgency.**
- **The Governor should ensure that families are informed as soon as possible when a seriously ill prisoner is taken to hospital.**

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Gartree, informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator visited Gartree on 17 January 2016. She obtained copies of relevant extracts from Mr Smith's prison and medical records. She did not speak to any staff or prisoners at the request of Leicestershire police.

15. NHS England commissioned a clinical reviewer to review Mr Smith's clinical care at the prison.

16. Leicestershire police provided copies of all the statements given to them by staff and prisoners and other evidence gathered in their investigation of Mr Smith's death. The investigator subsequently interviewed five members of staff.

17. We informed HM Coroner for Leicester City and South Leicestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Smith's mother to explain the investigation. Mr Smith's mother asked for details of what happened after Mr Smith pressed his cell bell on 17 December and whether he had received appropriate and timely treatment. Mr Smith's mother asked some further questions via her solicitor at initial report stage, which we have addressed in separate correspondence.

Background Information

HMP Gartree

19. HMP Gartree is a category B prison in Leicestershire and holds up to 708 men sentenced to life imprisonment and other indeterminate sentences. Leicestershire Partnership Trust is responsible for delivering primary physical and mental healthcare in the prison.

HM Inspectorate of Prisons

20. The most recent inspection of Gartree was in March 2014. Inspectors found a mostly safe and decent prison but there were insufficient activities for its population. Drugs, hooch and mobile phones were too easily available and supply reduction processes were weak. Supply reduction was discussed at security and reducing reoffending meetings and there was good information sharing between departments. However, there was no detailed supply reduction strategy or action plan.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to November 2015, the IMB noted that access to drugs and associated violence was less than other prisons, but raised concern that both were higher than they had ever been at Gartree.

Previous deaths at HMP Gartree

22. Mr Smith's was the fifth death at Gartree in 2016. Three of the other four were from natural causes and one was self-inflicted. There are no similarities between the circumstances of these deaths and Mr Smith's death.

Methylenedioxymethamphetamine (MDMA)

23. MDMA is a psychostimulant drug. After oral administration peak blood levels are reached within one to three hours. MDMA has a range of effects that can lead to acute toxic reactions including hyperthermia (overheating), raised heart rate, cardiac arrhythmias and raised blood pressure leading to stroke. The acute effects of MDMA are not necessarily dose-related.

Key Events

Events leading to 17 December 2016

24. In August 2012, Mr Arron Smith was remanded into custody charged with murder. On 21 February 2013, he was sentenced to life imprisonment with a minimum time to serve of 21 years and 167 days. Mr Smith served his sentence at HMP Doncaster before moving to HMP Gartree on 3 February 2015.

25. Mr Smith did not have a history of substance misuse and used the gym regularly. He gained enhanced status under the Incentives and Earned Privileges (IEP) scheme and held trusted jobs including prison barber and servery orderly. Apart from some very minor physical ailments, Mr Smith was healthy and fit and had no mental health issues.

26. Mr Smith was a popular and well liked prisoner at Gartree and got on well with prisoners and staff. Both staff and his fellow prisoners knew him as a clean-living person with a big personality who liked his food and liked going to the gym. Mr Smith lived on the first floor of C Wing in cell number 11 (C1/11).

27. During 2016, the security department at Gartree received several pieces of intelligence linking Mr Smith with a gang of prisoners suspected of using and supplying drugs and mobile telephones. Mr Smith was suspected of assaulting other prisoners in conjunction with this gang.

Saturday 17 December 2016 before 8.00pm

28. A prisoner who lived on the second floor of C Wing said he saw Mr Smith in the morning. He knew Mr Smith's friends were coming to visit him because it had been his birthday the day before. Mr Smith asked him if he was going to make him a pizza for his birthday and he said he would.

29. Between 2.00pm and 4.00pm, Mr Smith received a visit from three friends. The investigator watched a CCTV recording of the visit. There was no evidence that any substance was passed to Mr Smith. He and his friends sat at a table near to supervising officers. Mr Smith appeared relaxed and well.

30. An officer saw Mr Smith return to C Wing from his visit at about 4.00pm. He asked how the visit had gone and Mr Smith said, "Great thanks". He said he expected Mr Smith to go to his cell and get changed for his servery orderly duties. However, at dinner time he found out that Mr Smith had told a colleague he had had a bad visit and could not work that afternoon. He said Mr Smith had seemed fine when he saw him after the visit.

31. A prisoner who lived on the same floor as Mr Smith and was also a servery worker, saw Mr Smith come back from his visit and go upstairs. He went up to the third floor and heard music.

32. The prisoner drank "hooch" during the afternoon but would not say where he got it. He also took MDMA that afternoon but could not remember when and would not say where he had got it. He said it was a sugary substance and he had swallowed some of it wrapped in a Rizla paper (known as bombing).

33. A prisoner said Mr Smith came to his cell on the third floor at about 4.20pm. He said he was in his cell playing music and there were a lot of people around. He said he had asked another prisoner to make Mr Smith a cheesecake for his birthday. This prisoner brought the cheesecake up to his cell and cut it up. Mr Smith stayed outside the cell for about five minutes before leaving.

34. A prisoner said there were five or six prisoners in the other prisoner's cell and about 30 on the landing wishing Mr Smith happy birthday. The prisoners were drinking alcohol. He left the cheesecake and went back to his cell, opposite Mr Smith's on the first floor.

35. Another prisoner said he saw Mr Smith outside another prisoner's cell at about 5.00pm and he appeared to be very happy. He said he did not see anyone taking drugs or drinking. Another prisoner said he chatted to Mr Smith for about five minutes. He said it was obvious Mr Smith had had a drink because he was like himself but "exaggerated". Mr Smith was dancing and having a good time. A prisoner, who lived in cell C1/10 next door to Mr Smith, said he saw Mr Smith celebrating his birthday on the third landing. He said he seemed "a bit altered but in a good mood". Mr Smith told him he had taken some MDMA.

36. At about 5.30pm, a prisoner said he saw Mr Smith on the first landing and described him as having a "love rush". He presumed Mr Smith had been drinking alcohol in Mr Hussain's cell.

37. A prisoner said he saw Mr Smith at about 5.40pm and he was red in the face and smelled of alcohol. He said he did not know where the alcohol came from, he did not have any in his cell and he had not been drinking. Another prisoner also saw Mr Smith come down from the third landing shortly before they were all locked in their cells for the night. He said Mr Smith appeared fine. Another prisoner told Mr Smith to go into his cell before an officer saw him, because he did not want him to get into trouble for being intoxicated. He checked Mr Smith had food and water and put him to bed.

38. At about 6.30pm, the prisoner who lived next door to Mr Smith in cell 12 heard Mr Smith breathing heavily and possibly being sick. He asked him if he was okay and Mr Smith said "it's burning". He said he did not press his cell bell because he did not want to get Mr Smith into trouble.

17 December between 8.00 – 9.00pm

39. At about 8.05pm, Officer A responded to Mr Smith's cell bell. He said Mr Smith was standing at his sink filling a two-litre bottle with water. The cell floor was wet and Mr Smith was drinking lots of water. Mr Smith said he had "taken something" and sounded panicked. He radioed the emergency response nurse and the Custodial Manager (CM) (the night orderly officer in charge of running the prison). The CM sent two assistant night orderly officers to C Wing. Officer A tried to calm Mr Smith down and told him the nurse was on her way.

40. One night assistant night orderly officer said he heard Mr Smith tell Officer A that he had chest pains and had had a drink and taken MDMA. He said the officer called for a nurse immediately. A prisoner said he heard "panicking screaming noises" like Mr Smith was having a "bad trip like a Mamba [a psychoactive

substance] attack or acid trip". He heard Mr Smith tell an officer that he had taken MDMA.

41. A nurse arrived at about 8.10pm and went into Mr Smith's cell with two officers (night protocol at Gartree is that three officers must be present to open a cell). She said Mr Smith was anxious, frightened and pacing about his cell. Mr Smith was saturated in water and continually drinking from a large bottle. She said she had not seen someone drinking so much water before. Mr Smith said he felt "dreadful" and had taken "Spice".

42. The nurse completed some basic observations. Mr Smith's heart rate and oxygen levels were fine but his temperature was quite low. His breathing was fast and he said he had chest pain and numbness in his arms. She telephoned the control room and asked them to call a paramedic 'blue light' ambulance. She said she always called an ambulance if a person had chest pain, whether they had taken a substance or not. She asked for a paramedic ambulance because she wanted a paramedic and not a first responder. She told the control room a prisoner had chest and arm pain.

43. The control room log shows that the ambulance was requested at 8.25pm, although the ambulance service records say it was 8.22pm.

44. The nurse told Officer A to keep an eye on Mr Smith and went to healthcare to get her medical bag and look at Mr Smith's medical records. As soon as she got there she received another call to return immediately to C Wing. She took the emergency bag and a defibrillator with her. When she got to the wing Officer A said he had also found another prisoner behaving strangely in his cell, talking to the walls. He said the prisoner was frothing at the mouth and had glazed eyes. She said the prisoner's observations were normal and she was satisfied he was not in immediate need of medical attention.

45. An officer left C Wing to be ready to meet the ambulance at the gate. An officer and the nurse remained on C Wing and checked both Mr Smith and the other prisoner alternately while they waited for the ambulance to arrive. The officer said Mr Smith was standing in his cell and looked like he had taken something. The nurse said each time she saw Mr Smith he was walking around his cell drinking water. He told her he felt the same as when she first examined him. The last time she checked him was very shortly before the ambulance crew arrived and Mr Smith was still walking around his cell.

46. The ambulance arrived at Gartree at 8.58pm. The officer escorted the crew to C Wing on foot. He said it took no more than five minutes to get to C Wing.

17 December between 9.00pm and 11.00pm

47. The CM went to Mr Smith's cell once the ambulance crew had arrived shortly after 9.00pm. Mr Smith was sitting on the bed drinking water. The ambulance crew examined him and one of them told the CM that Mr Smith was fine and his baseline observations were normal. They would not need to take Mr Smith to hospital and he should be checked every four hours. To be on the safe side they would complete an ECG. The CM said the other member of the ambulance crew then called out that Mr Smith had stopped breathing. The ambulance crew and

officers moved Mr Smith to the landing. He said Mr Smith looked unconscious, was doubly incontinent and was making snoring sounds.

48. The nurse was outside the cell when officers opened it to let the ambulance crew in and her view was obstructed. She could not see Mr Smith's legs, so thought he must have sat down. She remembered the ambulance crew saying that everything seemed to be OK and they would do an ECG before leaving. Then suddenly they said Mr Smith had lost his airway and asked for help to bring him out on to the landing so they had more room to work on him. She gave them a nasal airway from her kit. Mr Smith was making gargling noises indicating he was struggling to breathe. As Mr Smith was moved to the landing she noticed he had been doubly incontinent.

49. The CM said it was obvious Mr Smith was very unwell, so he left C Wing to prepare the necessary paperwork for escorting him to hospital. He telephoned the on-call manager and they agreed that Mr Smith would be escorted by two officers, double cuffed (hand cuffed and hand cuffed to an officer) with an escort chain to be used as appropriate.

50. The ambulance technicians called for another ambulance crew with a paramedic to help carry Mr Smith to the ambulance because they were unable to leave him to retrieve the necessary equipment to move him. They specifically asked for a crew with a paramedic because Mr Smith's airway was not secure and they thought they needed paramedic help to manage it.

51. A second ambulance received a call to attend Gartree at 9.19pm asking for an airway bag, suction machine and carry chair. It arrived at 9.23pm. (One of the crew was incorrectly recorded as a paramedic.) An officer let the ambulance through several gates and it parked outside C Wing. One of the first ambulance crew called for a third ambulance once they realised the second crew did not contain a paramedic. EMAS records show the third ambulance was called at 9.27pm.

52. Mr Smith was expelling a significant amount of bloody fluid from his mouth, nose and eyes. The ambulance crew used the prison's suction machine and a suction machine from the second ambulance to try to clear Mr Smith's airway but at about 9.32pm, Mr Smith's breathing started to slow and the ambulance technicians used a bag valve mask (BVM) to help him breathe.

53. Both ambulance crews and officers moved Mr Smith to the second ambulance. The CM went ahead of them to open the gates. On the way, Mr Smith went into respiratory arrest (stopped breathing due to lung failure) and continued to expel lots of fluid. The ambulance crew gave Mr Smith naloxone hydrochloride (a drug that reverses the effects of opiates) because they were not sure what Mr Smith had taken. They called ambulance control to repeat they needed a paramedic and were told a third ambulance, with a paramedic, was outside the prison main gate and could not get in. EMAS records showed the third ambulance arrived at Gartree at 9.50pm.

54. An officer said it was possible the third ambulance waited at the gate for a minute or two because he was not aware that one had been called. The second ambulance drove to the main gate by which time the third ambulance had come

through the gate. All three ambulance crews then worked on Mr Smith in the back of the second ambulance.

55. The CM began briefing an officer and a Supervising Officer (SO), the escort officers. He said he told them to ignore the original risk assessment and not to apply handcuffs or the escort chain while Mr Smith was unconscious and in case the ambulance crew needed to give Mr Smith an electric shock. He said it was obvious Mr Smith was in a very bad way and he realised he might need an electric shock, so for both reasons handcuffs were not appropriate.

56. During the briefing one of the ambulance crew opened the door of the ambulance and told him, once they had stabilised Mr Smith, they would need to leave immediately. The CM, the gate officer and the nurse all estimated the three ambulance crews worked on Mr Smith for about 15 minutes in the sterile area. The CM told the gate officer to open both prison gates at the same time so that as soon as the ambulance was ready it could leave as soon as possible. One escort officer said that the CM gave a very quick briefing to him. They left as soon as one of the crew opened the back of the ambulance and told them they were ready.

57. The ambulance left Gartree at 10.16pm. During the journey, Mr Smith went into cardiac arrest and was given cardiopulmonary resuscitation. The ambulance arrived at hospital at 10.55pm. Mr Smith was taken to the intensive care unit.

58. The crew from the first ambulance remained to check on the prisoner on C Wing and the CM began organising cleaners for the landing outside Mr Smith's cell.

59. The CM said the SO telephoned from the hospital about 11.00pm and said that Mr Smith's breathing had been stabilised but brain death was likely. The control room log records that the SO telephoned the prison at 10.50pm and a message was passed to the CM that Mr Smith might not live and asking for next of kin to be contacted.

60. The on-call manager arrived at the prison about midnight and they discussed the situation. At 1.26am, an escort officer telephoned and told them that Mr Smith would be in hospital for the next 24-48 hours on life support and was unlikely to live. They decided to start the process for contacting Mr Smith's next of kin. The CM asked a SO to come in to the prison to act as family liaison officer, and she arrived at about 1.45am. At 2.15am, the on-call manager contacted Mr Smith's local police and asked them to visit Mr Smith's mother to tell her that he was in hospital.

Contact with Mr Smith's family

61. At 3.55am on 18 December, the SO spoke to Mr Smith's mother on the telephone. She and the Governor went to the hospital to meet Mr Smith's family, as they arrived at about 7.00am. The prison Imam also went to the hospital at the request of Mr Smith's family.

62. Mr Smith died on 19 December with his family present.

63. The prison held a memorial service for Mr Smith on 5 January 2017 which was attended by Mr Smith's mother and aunt. The prison contributed towards the costs of Mr Smith's funeral in line with national guidance.

Support for prisoners and staff

64. The prison posted notices informing other prisoners of Mr Smith's death and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm in case they had been adversely affected by Mr Smith's death. The prison staff care team spoke to all the staff involved and offered support.

Post-mortem report

65. The post-mortem examination concluded that Mr Smith died from hypoxic brain injury and cardiac arrest resulting from Methylenedioxymethamphetamine (MDMA) ingestion. The pathologist said the ratio of MDMA to its metabolite suggested Mr Smith had taken it a short time before he was admitted to hospital. He said in his opinion cardiac arrhythmia caused my MDMA was the most likely cause of cardiac arrest in Mr Smith's case. The post-mortem revealed no evidence of psychoactive substances (Spice) but found alcohol at a level consistent with Mr Smith having drunk some before he died.

Findings

The response to finding Mr Smith unwell on 17 December

66. The Public Health England (PHE) guidance to healthcare staff for treating prisoners presenting with symptoms of drug toxicity is to, "address the presenting symptoms rather than the specific drug suspected to have been used i.e. treat what you see". The nurse said Mr Smith told her he had taken Spice and the PHE guidance for acute Spice toxicity is "Symptom-directed supportive care until symptoms, which are usually short-lived, resolve".

67. The nurse called an ambulance after Mr Smith told her he had chest pains and checked Mr Smith regularly while waiting for the ambulance to arrive. He was walking around his cell and talking. We consider that she responded appropriately to Mr Smith's presentation on 17 December.

68. During her interview, the nurse said that she had not seen a person drinking so much water after taking an illicit substance. This is a common symptom in people who have taken MDMA and variants of it. There is an increasing issue with variants of psychoactive substances in prison. We therefore recommend:

    The Head of Healthcare should review the current guidance to staff on responding to prisoners under the influence of illicit substances and ensure that all staff are aware of the PHE guidance and toolkit.

69. The gate officer was expecting the first ambulance and checked the cameras so that he was prepared as soon as it arrived. An officer arrived at the gate as it arrived. At that stage, Mr Smith was not critically unwell, so the crew walked to C Wing by the quickest route, taking about five minutes. When the second ambulance arrived at 9.23pm the situation was critical and the ambulance drove to C Wing with an officer opening the gates ahead of it.

70. There was a small delay letting the third ambulance through the gate because the communications officer was not aware it was coming and the limited number of night staff were deployed elsewhere. The first two ambulance crews were in the process of transferring Mr Smith from C Wing in the second ambulance and the third ambulance had been let in by time the second ambulance arrived at the gate. The CM gave his permission, exceptionally, for both gates to be open at the same time to allow a speedy exit, in line with local policy on emergency situations.

71. We consider that there were no unnecessary delays in allowing all three ambulance crews into and out of Gartree on 17 December.

Drug supply and reduction strategy

72. Mr Smith ingested MDMA in the period between the end of his visit at 4.00pm and 5.40pm when he was locked in his cell on 17 December. A thorough police investigation found no evidence that he had taken MDMA under duress and they were unable to determine who gave it to him. Mr Smith had no history of drug use and there was no intelligence to suggest he took them in prison before 17 December.

73. Although there was no reason for staff to suspect Mr Smith had possession of any drugs, his death emphasises the need for HMP Gartree to review and develop their drug supply and demand reduction strategies.

74. In 2014, Inspectors found supply reduction and demand strategy at Gartree was weak. Supply reduction was discussed at security and reducing reoffending meetings and there was good information sharing between departments. However, there was no detailed supply reduction strategy or action plan and they recommended that Gartree should develop one.

75. During the investigation we were provided with the minutes for the December 2016 and January 2017 meeting of Gartree's Substance Supply and Demand Reduction Committee, which evidenced some work in this area. Disappointingly, Gartree did not provide us with a copy of their strategy document despite several requests. We recommend:

The Governor should review and develop the drug supply and demand reduction strategy as a matter of urgency.

Contacting Mr Smith's family

76. Prison Rule 22(1) 'Notification of illness or death' states:

> '22 – (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

77. Mr Smith was taken to hospital at 10.16pm. It was obvious that he was in a critical condition and at least one of the ambulance crew had told the CM that he was unlikely to survive. The SO telephoned about 11.00pm to tell the prison that Mr Smith might not live and that the hospital had asked for next of kin to be told. It was not until the escort officer telephoned at 1.26am that Mr Smith would be in hospital for 24-48 hours that the on-call manager and the CM decided to contact Mr Smith's next of kin. Mr Smith's mother was eventually told her son was in hospital at nearly 4.00am, some five hours after Mr Smith arrived there.

78. Our investigations seek to learn lessons with the benefit of hindsight. We accept that there was much still to do in the prison after the ambulance left with Mr Smith including escorting the first ambulance crew to see the other prisoner, cleaning the landing of Mr Smith's blood and other bodily fluids and reorganising the night staff to compensate for the two officers who had gone to the hospital. Nevertheless, five hours is a considerable gap given that it was apparent Mr Smith was seriously ill before he left the prison. Although informing his next of kin earlier would not have meant they would have been able to speak to him before he died, because he did not regain consciousness, this might not be the case in other deaths. We make the following recommendation:

The Governor should ensure that families are informed as soon as possible when a seriously ill prisoner is taken to hospital.

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