

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Ms Susan Smith a prisoner at HMP Drake Hall on 21 December 2017

A report by the Prisons and Probation Ombudsman

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*



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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.

Ms Susan Smith died of a brain haemorrhage in hospital on 21 December 2017, while a prisoner at HMP Drake Hall. She was 48 years old. I offer my condolences to Ms Smith's family and friends.

A year before Ms Smith went into prison, a scan had revealed shadows on her brain and during her imprisonment she had recurrent seizures, as well as symptoms of confusion and loss of memory. The investigation found several deficiencies in her care. Owing to various oversights, Ms Smith did not receive appropriate continuity of care at key stages, including when she arrived at Foston Hall, after a subsequent admission to hospital and on transfer to Drake Hall. These delays denied her the opportunity of early diagnosis and specialist treatment.

We are concerned about the management of Ms Smith during the night of 17/18 December, when she became acutely unwell. Staff should have given more weight to her cellmate's description of her symptoms and consulted the out of hours medical service at the outset. We are also concerned that they did not follow the correct procedures for medical emergencies.

Ms Smith's clinical care was the below the standard that she could have expected to receive in the community and the outcome might have been different if she had been referred to a specialist sooner. I hope that all concerned will learn lessons from these sad events.

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

Sue McAllister CB
Prisons and Probation Ombudsman

January 2019

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Summary

Events

1. On 10 October 2017, Ms Susan Smith was sentenced to nine months in prison and sent to HMP Foston Hall. At reception health screens, she disclosed that hospital scans taken a year before had shown shadows on her brain. A week later, Ms Smith started having persistent seizures. She also became confused and acutely forgetful. On 15 November, a prison GP referred her urgently to a neurologist.
2. Ms Smith was transferred to HMP Drake Hall on 27 November, before she received an appointment for the specialist. Her symptoms continued. A prison GP assessed her on 14 December and made another urgent neurology referral.
3. During the evening of 17 December, Ms Smith's cellmate reported on three occasions that she was unwell with symptoms of a stroke. Prison officers felt that she was stable, but monitored her periodically. The third time, they called an ambulance as they saw her fitting. Ms Smith refused to go to hospital and signed a disclaimer.
4. In the early hours of 18 December, Ms Smith had another seizure and became unconscious. Staff called an ambulance and conducted CPR until it arrived. Ms Smith was taken to hospital and admitted to the Critical Care Unit. She died on 21 December.

Findings

5. The investigation identified a number of serious shortcomings in Ms Smith's clinical care at Foston Hall and Drake Hall. We agree with the clinical reviewer's conclusion that her care was not equivalent to that which she would have expected to receive in the community and that there might have been a better outcome if she had seen a neurologist.
6. After Ms Smith arrived at Foston Hall, reception healthcare staff took no action to investigate her history of shadows on her brain, or to obtain the relevant hospital records. When she was later admitted to hospital, there was a delay in following up the advice in the discharge letter to refer her to a neurologist if her symptoms persisted.
7. Ms Smith was transferred to Drake Hall while waiting for an appointment under the NHS pathway for suspected cancer. There was no evidence of a medical assessment of her fitness for transfer (despite her having two seizures the day before), no handover between the prisons and no provision to follow up the expected neurology appointment.
8. Within Ms Smith's first few days at Drake Hall, requests for urgent GP appointments were not actioned and two weeks elapsed before she saw a GP.
9. During the evening of 17 December, officers went to see Ms Smith quickly and kept an eye on her when she was reported to be unwell. However, despite the seriousness of her symptoms and the absence of healthcare staff at night, they

did not consult the out of hours service about her condition and how best to monitor her.

10. When staff observed Ms Smith fitting that night, they did not follow the set emergency procedures for prisoners with these symptoms. They failed to call a radio emergency and the supervising officer attended each time before an ambulance was called. During one of the episodes, they waited for nine minutes before calling an ambulance. A member of staff admitted that if a prisoner has seizures staff routinely wait to see if it subsides.
11. Ms Smith's cellmate and other women on Ms Smith's unit were very upset and angry about the handling of Ms Smith's seizures on 17/18 December and feel that more should have been done and sooner. While there is no evidence to corroborate specific complaints of incivility and insensitivity, we believe that staff should have given more credence to prisoners' concerns about Ms Smith's health.

Recommendations

- The Head of Healthcare at Foston Hall should ensure that the reception health screen triggers appropriate reviews and referrals when a newly-arrived prisoner discloses an existing medical condition and that the relevant community records are obtained.
- The Governor and Head of Healthcare at Foston Hall should ensure that healthcare staff are informed when a prisoner returns from hospital, the prisoner is assessed, if appropriate and actions recommended in hospital discharge reports are implemented promptly.
- The Governor of HMP Foston Hall should ensure that the transfer process includes input from healthcare staff.
- The Head of Healthcare should ensure that requests for priority GP appointments are followed up promptly.
- The Governor and Head of Healthcare should ensure that night staff obtain advice from the out of hours service when a prisoner is seriously unwell.
- The Governor should ensure that all staff understand their responsibilities during medical emergencies and adhere to the instructions in PSI 03/2013 and local guidance, including using the appropriate emergency code and calling an ambulance without delay when they discover an apparent emergency.
- The Governor should review with prison managers the events of 17/18 December, to inform learning and future management of similar incidents.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Drake Hall informing them of the investigation and asking anyone with relevant information to contact her. No one responded, but the prison submitted formal complaints from two prisoners to be considered as part of the investigation.
13. The investigator obtained copies of relevant extracts from Ms Smith's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Ms Smith's clinical care at the prison. On 7 February 2018, the clinical reviewer and investigator jointly interviewed two members of healthcare staff at HMP Foston Hall and two at Drake Hall. On 1 March, the investigator returned to Drake Hall, where she interviewed two prison officers and Ms Smith's cellmate. Three telephone interviews were also completed.
15. Our investigation was suspended between 26 March and 10 September, while waiting for the cause of death and then the clinical review report. This report was delayed as a result.
16. We informed HM Coroner for Staffordshire South of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. The investigator wrote to Ms Smith's mother, her next of kin, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not respond to our letter.
18. The initial report was shared with the Prison Service. The Prison Service pointed out two factual inaccuracies and a typographical error and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Drake Hall

19. Drake Hall is a closed prison which holds just over 300 sentenced women. Accommodation consists of 15 house units with mainly single rooms. Each house unit has a small kitchen, a laundry room and a television lounge. There is also a 25-room open unit outside the prison perimeter.
20. Care UK provides healthcare services from 7.15am to 6.30pm on weekdays and 7.30am to 5.00pm on weekends. Staffordshire Doctors Urgent Care provides medical advice out of hours.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Drake Hall was in July 2016. Inspectors found that healthcare provision was a major weakness and a number of areas required improvement. Although there was a range of appropriate primary care clinics, there were delays in accessing services as waiting times were unacceptably lengthy. There was also a high level of non-attendance.

Independent Monitoring Board

22. 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 October 2017, the IMB reported that many of the women had complex health needs. Overall, they were satisfied with the standard of healthcare at the prison. Waiting times for treatment had improved and the prison had put in place new procedures to address the high level of non-attendance for medical appointments.

HMP Foston Hall

23. HMP Foston Hall is a closed women's prison serving courts in the Midlands. It holds up to 344 prisoners, including unconvicted and unsentenced women, young adult women under 21 years old and sentenced women.
24. Care UK provides primary healthcare services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. Three primary care nurses and a healthcare assistant are on duty during the day, reducing to one nurse and a healthcare assistant from 8.00pm to 7.15am.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Foston Hall was in June 2016. Inspectors reported that women received a suitable initial health screen and their needs were followed up. Healthcare was generally decent and responsive and those with long-term conditions received suitable clinical care.

Independent Monitoring Board

26. In its latest annual report, for the year to November 2017, the IMB at Foston Hall reported several concerns about healthcare provision, including recurrent

concerns from prisoners about treatment, medication, problems with the appointment system and accessing healthcare, as well as dissatisfaction with the complaints system. These difficulties had been largely caused by staff shortages, but the Board had seen evidence that the healthcare provider had made efforts to address the shortfalls.

Previous deaths at HMP Drake Hall

27. There have been two previous deaths at Drake Hall since this office began investigating deaths in custody in 2004 - one from natural causes in 2014 and a self-inflicted death in 2016. There has been a further death from natural causes since Ms Smith died. We have made previous recommendations about continuity of care and medical emergencies (after the self-inflicted death).

Key Events

28. On 10 October 2017, Ms Susan Smith was sentenced to nine months imprisonment and sent to HMP Foston Hall. She had breached a Suspended Sentence Order for theft by failing to attend an appointment with her probation officer. It was not her first time in prison.
29. At an initial health screen, a nurse recorded that Ms Smith had a history of substance misuse and referred her to the doctor and substance misuse service. Ms Smith received methadone and medication for alcohol detoxification and staff monitored her closely. The prison received a summary of her community GP's medical records on 12 October.
30. Ms Smith had a secondary health assessment on 12 October. She told a healthcare assistant that an MRI scan at New Cross Hospital, Wolverhampton, had revealed two shadows on her brain, but she had not attended subsequent appointments. There is no evidence that the prison followed up this information.
31. On 17 October, Ms Smith was drowsy, unsteady on her feet and her speech was slurred. Given her clinical observations and reduced consciousness, a prison GP suspected that she might have taken an opioid drug and sent her to hospital. She was discharged the next day, without receiving any treatment. No discharge summary was recorded.
32. During the evening of 21 October, Ms Smith appeared to have a seizure. She was drooling, vacant, confused and had a headache. A nurse examined her and an ambulance was called, but later stood down as she became stable. The nurse telephoned the NHS helpline and the out of hours GP service, but they did not return her call. She then spoke to an ambulance service call handler, who declined to send an ambulance at that time and advised her to speak to a GP.
33. In spite of this, an ambulance arrived at 9.30pm and the crew were concerned about the combination of brain lesions and seizures. After initial reluctance, Ms Smith was persuaded to go to hospital. She returned to Foston Hall on 24 October. The hospital discharge letter indicated that they had treated her headache with painkillers and advised prison healthcare staff to refer her to the neurology department if it persisted.
34. On 31 October, a prison GP assessed Ms Smith. She was confused and had become increasingly forgetful. She could not remember family members' names, events such as when she was arrested, or how long she had been in prison. The GP requested the previous hospital CT and MRI reports and planned to review Ms Smith in two weeks to explore her memory problems.
35. At around 4.00pm on 2 November, staff called a nurse to examine Ms Smith, who had been found slumped in a chair in her cell. She had been unconscious for around two minutes and was clammy, sweaty and disorientated to time and place. An hour later, she had another seizure. The nurse noted that Ms Smith should see a GP the next day. There is no evidence that this happened.
36. On 15 November, a prison GP reviewed Ms Smith. He noted two seizures since the last review and pain at her right temple. She was still struggling with memory

problems and needed a chaperone and a list of where she had to be each day. The GP suspected a brain tumour and referred her urgently to a neurology specialist, under the NHS pathway that requires patients with suspected cancer to be seen by a specialist within two weeks.

37. On 26 November, Ms Smith had two seizures. She was disorientated, unable to coordinate her movements and did not know her name, location, year, or the date. Healthcare staff monitored her.
38. On 27 November, Ms Smith was transferred to HMP Drake Hall. Prison records show that she was signed as fit for transfer, but there was no entry in the medical records to indicate that she had been medically assessed. No handover took place between the healthcare teams.
39. At a reception health assessment, Ms Smith told a nurse that she had a shadow on the brain which was being investigated. The nurse placed her on the GP's waiting list and noted the doctor should ask an administrator if they wished to see her sooner. She also referred Ms Smith to the prison's brain injury link worker. On 28 November, a nurse assigned Ms Smith as a high priority to see the GP, but this does not appear to have triggered an appointment.
40. The prison's brain injury link worker saw Ms Smith on 30 November and subsequently held several sessions with her. She noted that she was incoherent and confused.
41. On 1 December, the Head of Healthcare (and a nurse prescriber) noted that in the medical records that she could not request medication, as Ms Smith did not know what medication she was on and it was unclear whether previous prescriptions had stopped or ended accidentally. The Head of Healthcare also flagged that the GP might want to see her sooner than the routine waiting list. Several subsequent healthcare entries suggested that Ms Smith appeared to be vulnerable. Although she had served a previous sentence at Drake Hall, she needed help to find her way around the prison and relied on the other women to help her to attend appointments, obtain medication and fill in forms.
42. On 14 December, a prison GP and the brain injury link worker held a joint review with Ms Smith in which they discussed the decline in her memory and cognitive function. The GP described Ms Smith as looking vacant. After carrying out a mini mental state examination, he requested memory screen blood tests and referred her urgently to a neurologist as he suspected that she might have a tumour.
43. At 8.21pm on 17 December, Ms Smith's cellmate pressed their cell bell and told two officers that she thought Ms Smith was having a stroke. (At interview, she said that Ms Smith had repeatedly complained of a bad headache during the evening.) The officers said that by the time they arrived the symptoms had stopped and they saw no obvious signs of a stroke. One of the officers had smelt vomit and noticed a clear wet patch at the pillow end of Ms Smith's cell. They offered Ms Smith some water and the opportunity to go somewhere cooler, but she did not want to leave the cell. As they left, her cellmate and some of the other women insisted that Ms Smith needed to go to hospital. At around 8.55pm,

the officers reported back to a supervising officer (SO), who was in charge of the operational running of the prison.

44. At 8.58pm, Ms Smith's cellmate rang the cell bell again. Two officers went to the cell. Her cellmate told them that Ms Smith was still unwell. She repeated that the symptoms appeared to be those of a stroke and asked them to get an ambulance. The officers asked Ms Smith her name, age, date of birth, if she knew where she was and similar questions and she answered clearly. The officers were satisfied that she was lucid and detected no stroke symptoms. They reassured her cellmate that she was all right and did not need an ambulance. At around 9.30pm, they reported back to the SO, who asked staff to monitor Ms Smith.
45. At 10.31pm, Ms Smith's cellmate rang the general alarm. Two officers attended and saw Ms Smith on her bed, apparently having a seizure. The SO arrived shortly afterwards. In a statement and at interview, the SO said that as nine minutes had passed since the alarm, she radioed the control room to call an ambulance.
46. Paramedics arrived at 10.50pm and examined Ms Smith. They explained their concerns about her condition and that she should go to hospital, as she was at a high risk of having another seizure. She persistently refused and signed a disclaimer. The paramedics left at around 11.50pm and staff checked Ms Smith hourly. The last time was around 1.20am.
47. At around 1.40am, Ms Smith's cellmate rang the general alarm again as Ms Smith was having another seizure. An officer arrived first (and radioed to say that she was bleeding), closely followed by two more officers. The SO heard the radio call. She went to the cell and then requested an ambulance. The control room made the call at 1.42am. Officers described Ms Smith as fitting, with bubbles of blood and saliva through her nose and incontinence of urine and faeces. She then became motionless and unresponsive and they could not detect a pulse, or breathing. They used a defibrillator, which advised cardiopulmonary resuscitation (CPR). The SO began CPR and they took turns to conduct rescue breaths and compressions.
48. An ambulance arrived at 2.00am and the crew continued CPR. At 2.57am, they took Ms Smith to the Royal Stoke University Hospital, where she was placed on life support in the Critical Care Unit. Two prison officers escorted her, without the use of restraints. At 4.15am, after a request for Ms Smith's medical records, the Head of Healthcare telephoned the ward sister and gave a verbal handover. A prison GP telephoned the hospital twice later in the day.
49. Prison managers visited Ms Smith in hospital and spoke to the doctor and nurse responsible for her care. On 19 December, the escort was reduced to one officer. Ms Smith died at 4.16pm on 21 December.

Contact with Ms Smith's family

50. The prison assigned an officer as the family liaison officer (FLO). At 9.30am on 18 December, she informed Ms Smith's mother of her condition and admission to hospital. She also offered to arrange transport to the hospital if no one was

available to take her. Shortly afterwards, the FLO and two prison managers went to the hospital.

51. Ms Smith's mother and several other family members spent long periods with Ms Smith in the following days. The FLO and a prison chaplain met them at the hospital to provide support and answer questions. After her death, they also spent several hours at the hospital with them.
52. On 22 December, the FLO and the Governor of Drake Hall visited Ms Smith's family at their home. They offered condolences, explained the processes to be followed, invited them to a memorial service at the prison and offered transport if they needed it. The FLO continued to support Ms Smith's family and made further visits with prison managers. In line with national policy, the prison contributed to the costs of the funeral, which was held on 2 March.

Support for prisoners and staff

53. After Ms Smith's death, the Governor held a brief, informal debrief with the staff involved in the emergency response to offer support. The staff care team also offered support.
54. The prison posted notices informing other prisoners of Ms Smith's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Ms Smith's death.

Post-mortem report

55. The report of the post-mortem examination concluded that the cause of Ms Smith's death was, 1a: cerebral haemorrhage and infarction [a type of stroke], 1b: cerebral vascular malformation [abnormal blood vessels in the brain].
56. The pathologist explained that the vascular malformation might have caused the bleed in the brain which triggered the repeated and prolonged seizures on 17 and 18 December.

Findings

Clinical care

57. The investigation identified several shortcomings in the management of Ms Smith's health throughout her relatively short period of imprisonment. The clinical reviewer considered that there might have been a different outcome if staff had referred her sooner to a neurologist. We agree with the clinical reviewer that in view of the delays in referring Ms Smith to a specialist, the standard of her clinical care at both Foston Hall and Drake Hall was below that which she could have expected to receive in the community.

Reception health assessments at HMP Foston Hall

58. At a general health assessment on 12 October, two days after her arrival at Foston Hall, Ms Smith told a nurse that a brain scan carried out a year before had revealed two shadows on her brain. There is no evidence that healthcare staff took steps to follow up this disclosure of a potentially serious medical condition by obtaining the relevant hospital records, or referring Ms Smith to the prison GP for a more detailed assessment. We make the following recommendation:

The Head of Healthcare at Foston Hall should ensure that the reception health screen triggers appropriate reviews and referrals when a newly-arrived prisoner discloses an existing medical condition and that the relevant community records are obtained.

Continuity of care following Ms Smith's discharge from hospital

59. Ms Smith was twice admitted to hospital in October 2017, following suspected seizures. On the second occasion, the hospital discharge letter advised the prison healthcare staff to refer her to a neurologist if the symptoms persisted. Ms Smith was not reviewed by a prison GP until a week after her return to the prison, which delayed the opportunity for a referral. We agree with the clinical reviewer that this should have taken place sooner. We make the following recommendation:

The Governor and Head of Healthcare at Foston Hall should ensure that healthcare staff are informed when a prisoner returns from hospital, the prisoner is assessed, if appropriate and actions recommended in hospital discharge reports are implemented promptly.

Transfer to HMP Drake Hall and continuity of care

60. On 27 November, Ms Smith was transferred to Drake Hall. The Prison Service discharge form noted that she was fit to transfer, but there was no evidence in the medical record of an assessment to support this. At that time, she was awaiting an appointment following an urgent referral for a suspected tumour and she had suffered two seizures the day before her transfer.
61. We consider that Ms Smith should have been placed on medical hold pending her neurology appointment. At the very least, there should have been a handover between the medical teams at both prisons, as well as monitoring after

her arrival to ensure that the appointment was kept. In response to these deficiencies, highlighted after Ms Smith's death, Care UK has issued a local operating policy setting out the procedures for prisoners with outstanding urgent referrals, or the need for urgent care. The policy includes instructions to place such prisoners on medical hold, or give a full handover to the receiving prison if a transfer is beyond the control of the healthcare department. In view of the steps already taken to address these issues, we make no further comment on the oversights by healthcare staff. However, we are not satisfied that prison staff properly consulted healthcare before authorising the transfer. We make the following recommendation:

The Governor of HMP Foston Hall should ensure that the transfer process includes input from healthcare staff.

Referral to the prison doctor at Drake Hall

62. During the reception procedures on 27 November, a nurse at Drake Hall placed Ms Smith on the waiting list to see a prison GP, but noted that an administrator would arrange an urgent appointment, if appropriate. The next day, another nurse placed Ms Smith as a high priority to see the GP. On 1 December, the Head of Healthcare, who is also a nurse prescriber also flagged that the GP should see Ms Smith as a priority to resolve medication problems. Ms Smith did not see a GP until 14 December. We consider that this was an inordinate delay for a priority appointment. We make the following recommendation:

The Head of Healthcare should ensure that requests for priority GP appointments are followed up promptly.

Monitoring of seizures on 17 December

63. During the evening of 17 December, Ms Smith was reported to be unwell three times in two hours. Her cellmate thought she showed symptoms of a stroke and told them a little of Ms Smith's history, but officers thought otherwise. No medical advice was sought on the first two occasions, but the supervising officer told staff to monitor her. She explained that she did not consider it necessary to seek further medical advice, as staff had observed no symptoms of a stroke such as slurred speech, loss of movement in the arms and facial drooping. After the third episode, staff called an ambulance.
64. Against the advice of the paramedics, Ms Smith declined to go to hospital and, as in the community, it was her right to do so. The paramedics told staff that Ms Smith was at risk of having a stroke.
65. We consider that it would have been prudent to seek advice from the out of hours service after the first two episodes and also after Ms Smith's refusal to attend hospital. Although the officers had made some rudimentary observations and concluded Ms Smith had not had a stroke, a clinician would have had a deeper understanding of symptoms and would have given substantive advice on the frequency of monitoring and signs to observe. In addition, given that Ms Smith's problems were related to her brain, a doctor would also have been able to assess her mental capacity to take her decisions on her health. We make the following recommendation:

The Governor and Head of Healthcare should ensure that night staff obtain advice from the out of hours service when a prisoner is seriously unwell.

Emergency response

66. Prison Service Instruction (PSI) 3/2013 sets out how a prison should respond to a medical emergency. It requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called automatically in a life-threatening medical emergency. There should be no requirement for staff to check with managers before calling an ambulance. The PSI notes that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.
67. Drake Hall's local policy is consistent with national guidance and is clear that a code blue should be called in the event of a seizure. However, staff did not use an emergency code in response to any of the emergency alarms on the night of 17/18 December and, on the two occasions that staff witnessed the seizures, the SO attended before an ambulance was called. During the episode at 10.30pm, staff waited nine minutes before calling an ambulance.
68. At interview, the SO explained that the emergency codes were used only during the day, to help healthcare staff decide what equipment they should take to an emergency. She also said that at night she did not always call an ambulance for seizures, the practice was to wait for a while to see if they abated.
69. We are concerned that staff did not follow the expected emergency procedures. At night, when there are no healthcare staff on duty in the prison, it is particularly important for staff to call the emergency services immediately. Staff should not have waited for a manager before taking appropriate action and the delay of nine minutes before calling an ambulance was unacceptable. We make the following recommendation:

The Governor should ensure that all staff understand their responsibilities during medical emergencies and adhere to the instructions in PSI 03/2013 and local guidance, including using the appropriate emergency code and calling an ambulance without delay when they discover an apparent emergency.

Prisoners' concerns about the handling of the incidents on 17 December

70. Ms Smith's cellmate expressed grave concerns about the handling of Ms Smith's seizures on 17/18 December and two prisoners submitted formal complaints, which the prison asked the investigator to take into account as part of the investigation. They believed that staff should have called an ambulance earlier in the evening when Ms Smith was first reported to be unwell. The concerns raised covered uncaring attitudes, swearing and uncivil comments by two of the prison officers, including one of them suggesting that they did not care if Ms Smith died and threats of disciplinary action. The officers said that several prisoners were around and were very vocal in their protests. As well as dealing with Ms Smith, they had to manage the unrest and agitation, but they denied the specific comments attributed.

71. Ms Smith's cellmate said that as well as explaining the symptoms she had observed, she had told the officers about Ms Smith's history of bleeding from her ears and nose, her collapse at Foston Hall and that she was waiting for a 'fast track' appointment at hospital for brain problems. Ms Smith's cellmate became anxious, upset and agitated and told the officers that she was frightened that something would happen to Ms Smith. Staff gave her the opportunity to move to a different cell, but she declined as she strongly felt Ms Smith should not be left alone. Ms Smith's cellmate said she was angry and that although her own medication had made her drowsy, she sat up and watched Ms Smith. She had also asked another prisoner to use the prisoner telephone to ask a relative to request an ambulance.
72. Ms Smith's cellmate also alleged that staff had tried to prevent her from speaking to the paramedics. However, she insisted on doing so and the other women supported her. The paramedics then asked to speak to her and she told them about some of Ms Smith's history and symptoms. She said the paramedics was unaware of this information until she spoke to them.
73. There is no way of resolving the conflicting accounts of officers' actions on the night of the emergency. However, the weight of evidence suggests that staff should have given more credence to Ms Smith's cellmate's concerns, unless there were good reasons to doubt them. We make the following recommendation:

The Governor should review with prison managers the events of 17/18 December, to inform learning and future management of similar incidents.

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