Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kyle Batsford, a prisoner at HMP Lindholme, on 25 September 2019

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

OGL

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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.

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

Mr Kyle Batsford was found unresponsive in his cell at HMP Lindholme on 23 September. He died in hospital on 25 September 2019 from the effects of psychoactive substances (PS). Mr Batsford was 37 years old. I offer my condolences to his family and friends.

I am satisfied that Lindholme has taken substantive steps to improve its drug strategy. However, given the incidence of PS at the prison, I consider that the strategy should include specific measures to reduce the availability and use of PS, as well as better data collection and information sharing.

Despite these weaknesses, the appropriate action was taken whenever Mr Batsford was found under the influence of PS. He was actively encouraged to engage with the substance misuse service but chose not to until shortly before his death. I am satisfied that Mr Batsford received a good standard of clinical care at Lindholme, equivalent to that he could have expected to receive in the community.

The support Mr Batsford received under the key worker scheme and violence management provisions was inadequate. While staff were sympathetic and began the anti-bullying process, they did not set clear objectives or review the actions required to address his needs. It is unacceptable that a man with such complex issues and vulnerabilities, who had been considered a priority under the key worker scheme, only had one meeting with his key worker during the 12 months he spent at Lindholme.

I am also concerned that there was a delay in requesting an ambulance when Mr Batsford was found unresponsive and that his family was not informed promptly that he was gravely ill in 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.

Sue McAllister CB
Prisons and Probation Ombudsman **March 2021**

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Summary

Events

1. Mr Kyle Batsford was remanded to prison in January 2017. He was later convicted of robbery and assault and sentenced to six years imprisonment. He was often involved in acts of violence against staff and other prisoners. He said that he began to use PS towards the end of 2017, and his use appeared to increase from June 2018.

2. Mr Batsford transferred to HMP Lindholme on 24 September 2018. He continued to use PS. Staff took punitive action and referred him to the substance misuse service, but he persistently refused ongoing support. After setting fire to his cell on 24 May 2019, Mr Batsford had regular meetings with a mental health nurse, in which he discussed using PS and threats from other prisoners.

3. On 10 June, staff started a Challenge, Support and Intervention Plan (CSIP) to support Mr Batsford and address his reports that he was being bullied by other prisoners due to a drug debt. It was suggested that drug dealers tested new batches of drugs on him and that other prisoners watched his reaction as a form of entertainment.

4. Mr Batsford was allocated a key worker and, at their first meeting on 8 August, he agreed to hand in his drug equipment. Shortly afterwards, he asked for substance misuse support and was assessed on 5 September.

5. At 6.58pm on 23 September, prisoners called for help and two prison officers went to Mr Batsford's cell. They found him lying on the floor unconscious and radioed a medical emergency code blue. A nurse and wing staff attempted resuscitation until paramedics arrived. At 8.00pm, Mr Batsford was taken to hospital. He was admitted to the intensive care unit and placed on life support.

6. The next day, the hospital notified Mr Batsford's partner that he was in hospital and the prison appointed a family liaison officer. Family members were permitted to visit him. On 25 September, doctors withdrew his ventilator and he died that day.

Findings

7. There is evidence that Mr Batsford got into debt because of his PS use and that, as a result, he was bullied and used as a 'PS guinea pig' by other prisoners.

8. We are satisfied that when Mr Batsford was found under the influence of PS, staff dealt with him appropriately. He chose not to engage with substance misuse services until shortly before his death.

9. The clinical reviewer concluded that Mr Batsford's clinical care was of a good standard and equivalent to that he could have expected in the community.

10. Lindholme has updated its local drug strategy to address weaknesses identified by HM Chief Inspector of Prisons. The improvements include better governance, clearer lines of responsibility and the introduction of a new process to reduce drugs being trafficked through legally privileged correspondence. However, the strategy

makes no specific reference to PS and there are also concerns that the data on PS is inaccurate as some incidents were not routinely recorded or shared with healthcare staff and the substance misuse service.

11. Lindholme has a wide-ranging Safety Strategy in place. Staff began the process to support Mr Batsford as a victim of bullying, but there is no evidence of specific objectives, or follow-up actions, after initial investigation of the allegations and completion of the CSIP form. As a result, the support he received was less effective than it might have been.

12. We are concerned that Mr Batsford had only one key worker session, particularly as he had been identified as a priority for early allocation when the scheme was introduced. Given his vulnerability and persistent use of PS, staff and managers should have ensured that he had consistent support to help address his problems.

13. It is a requirement for an ambulance to be requested immediately when a medical emergency code is called. There was a delay of five minutes between the code blue and the telephone call to the ambulance service. Although this might not have altered the outcome for Mr Batsford, such a delay may be critical in other life-threatening emergencies.

14. Lindholme did not adhere to the requirement to inform Mr Batsford's next of kin immediately that he was seriously ill. Given the gravity of his condition and the risk that he could die overnight, the prison should have notified his family as a matter of urgency. Only one attempt was made, two and a half hours after he had left the prison. The hospital contacted his family the following morning.

Recommendations

- The Governor should ensure that:
  - the local drug strategy includes specific plans to help reduce the availability of psychoactive substances; and
  - staff record all instances of prisoners found under the influence of illicit substances and pass the information to the healthcare department and the substance misuse service.
- The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated, and victims are effectively supported, in line with the local Safety Strategy.
- The Governor should ensure that the prison meets the standards expected of the key worker scheme. Key workers should be assigned promptly and have regular contact with the prisoners allocated to them; all interactions should be recorded in prisoners' case notes; and managers should check compliance.
- The Governor should ensure that staff in the communications room request an ambulance as soon as an emergency code is called.
- The Governor should ensure that staff comply with the requirement to contact families immediately when a prisoner is seriously ill.

The Investigation Process

15. The initial investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. One prisoner replied.

16. The initial investigator visited Lindholme on 3 October 2019. He obtained copies of relevant extracts from Mr Batsford's prison and medical records.

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

18. Our investigation was suspended for several months while we waited for the cause of Mr Batsford's death and the conclusion of a related police investigation. This delayed the initial report. Another investigator took over and resumed the investigation in July 2020.

19. The second investigator and clinical reviewer conducted interviews with six members of staff at Lindholme on 26 and 27 August. The second investigator also obtained further information from prison functional managers by correspondence and in a further interview in October. These interviews were all carried out by telephone because of the coronavirus pandemic restrictions.

20. We informed HM Coroner for South Yorkshire (East District) of the investigation. She gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.

21. One of the PPO's family liaison officers contacted Mr Batsford's family to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. They asked for information on several issues, including:

    - Mr Batsford's mental health, including any diagnoses, treatment, or problems accessing medication;
    - the impact of the distance from home on his mental health;
    - his motivation for using drugs, whether recreational, or as a form of self-harm; and
    - the support he received for self-harm attempts and whether he had intentionally taken an overdose.

22. We have addressed the issues raised by Mr Batsford's family that fall within our remit. The clinical review report gives detailed information on the medical issues unrelated to Mr Batsford's cause of death.

23. Mr Batsford's partner and his son received a copy of our initial report. His partner made several observations about the investigation and the circumstances leading to Mr Batsford's death. Mr Batsford's son made no comments.

24. The initial report was shared with HM Prison and Probation Service (HMPPS). They accepted our recommendations and found no factual inaccuracies.

Background Information

HMP Lindholme

25. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services, with healthcare staff on duty between 7.30am and 7.30pm every day.

HM Inspectorate of Prisons

26. The most recent full inspection of HMP Lindholme took place in October 2017. Inspectors found that safety had been significantly compromised by the ready availability of drugs. The prison environment and the nature of its population (which included a high proportion of organised gang members) presented challenges in preventing the flow of drugs. Over two-thirds of prisoners said that it was easy to get illicit drugs and, when PS was included in mandatory drug testing data, 41% of tests were positive. Over a quarter of prisoners said that they had developed a drug problem while at Lindholme, which was higher than at similar establishments. Substance misuse services were reasonably good, with prompt psychosocial assessments.

27. Inspectors noted that the number of violent incidents was higher than at similar prisons and victimisation was mostly due to drugs and/or debt. While there had been significant investment and focus on reducing violence, this lacked coordination between all key stakeholders and there was no detailed supply reduction action plan. The substance misuse meeting was infrequent, and attendance was poor, with no representation from the security department.

28. Healthcare staff had dealt with a large number of emergencies related to drug intoxication, which had put a significant strain on health resources.

29. HMIP also conducted a scrutiny visit (a shortened inspection due to the coronavirus pandemic) in October 2020. Inspectors found that staff generally had limited individual contact with prisoners and held themselves apart. Violence had significantly reduced since 2017: there were around 50% fewer assaults in the six months before the pandemic compared with a similar period two years previously. The prison's response to most violent incidents was to place victims and perpetrators on challenge, support and intervention plans (CSIPs), although most plans lacked detail on how the individual should be supported. A third of prisoners said it was easy to access drugs in the prison.

Independent Monitoring Board

30. 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 31 January 2020, the IMB found that substance misuse and the availability of illicit drugs remained a significant problem. The prison had introduced several measures to improve security.

31. The Board noted that the key worker system had been introduced during the reporting year. However, although 80% prisoners surveyed in October 2019 knew

they had a key worker, only half knew their name and only a quarter had spoken to their key worker in the previous seven days. The Board found that significant improvements had been made towards the end of the year.

Previous deaths at HMP Lindholme

32. Mr Batsford was the 14th prisoner to die at Lindholme since September 2017. Three of the previous deaths were from natural causes, four were self-inflicted and six were drug related. There have been two further deaths, both due to natural causes. We have previously made recommendations about the drug strategy, bullying, emergency response procedures and contacting prisoners' next of kin, all of which are repeated in this report.

Psychoactive substances (PS)

33. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

34. The effects of PS are unpredictable, and prisoners do not know what exactly they are using. In the course of our investigations we see numerous examples of apparently fit young men dying as a result of the effects of PS.

Key Events

35. Mr Kyle Batsford was remanded to HMP Leicester on 18 January 2017, charged with robbery and assault. It was not his first time in prison. On 3 July, he was convicted and sentenced to six years imprisonment.

36. During a 16-month period, Mr Batsford transferred to six prisons and was referred to the mental health team each time. He was often involved in incidents of disorder, threats and violence against other prisoners and staff (for which he received additional sentences). In June 2017, a consultant psychiatrist noted that Mr Batsford had been diagnosed with post-traumatic stress disorder (PTSD), adult attention deficit hyperactivity disorder (Adult ADHD) and anti-social personality disorder (ASPD).

37. From October 2017, security intelligence reports suggested that Mr Batsford was using illicit substances, with an apparent increase in incidents from June 2018. On 3 July, he told his key worker that he had started to smoke PS because he was going through a "bad patch", and that it had affected his behaviour. He was particularly frustrated about being a long distance from home.

Transfer to HMP Lindholme

38. Mr Batsford transferred to HMP Lindholme on 24 September 2018. At his initial health screen, he denied using drugs or alcohol and declined a referral to the substance misuse service. Mental health assessments in November indicated a moderate risk of anxiety and depression and Mr Batsford was referred to the chaplaincy for bereavement counselling. The first record of Mr Batsford's PS use at Lindholme was on 13 December.

39. From March to May 2019, Mr Batsford refused to work and was therefore downgraded to the basic regime under the Incentives and Earned Privileges scheme (the process to incentivise and reward good behaviour).

40. Mr Batsford set fire to his cell on 24 May and was managed under ACCT (the Prison Service care-planning system to support prisoners at risk of suicide or self-harm). The next day, he told a mental health nurse that he used PS, was under threat from other prisoners and had a "price on his head", but he refused to see the substance misuse service. She held regular one-to-one sessions with Mr Batsford. She spoke to the safer custody team about his concerns and asked about a move to another wing. She also explored a transfer to HMP Ranby, but this was refused due to Mr Batsford's previous poor behaviour at that prison. The ACCT was closed on 4 June as Mr Batsford was no longer considered to pose a risk himself.

41. On 10 June 2019, Mr Batsford reported bullying due to debt for PS and said he was afraid to leave his cell unless escorted. An officer completed a Challenge, Support and Intervention Plan (CSIP – the process to manage the behaviour of violent prisoners and/or victims) and concluded that Mr Batsford would benefit from a support compact. Mr Batsford initially refused to name the perpetrators. However, he later mentioned the nicknames of two prisoners who had tried to force him to take PS and who he said had slapped and tried to stab him when he refused.

42. On 18 June, Lindholme received a letter from Mr Batsford's partner, who was concerned about his wellbeing and mental health. She said that he had been affected by the distance from home and lack of privileges on the basic regime over several months. The safer custody manager replied that Mr Batsford had been upgraded to standard and a transfer was being considered.

43. In July and August, staff found Mr Batsford under the influence of PS at least five times. He was also seen cleaning other prisoners' cells, which was likely to be payment for PS. After each incident, staff sought medical help if required; took punitive action by demoting him to the basic regime, and/or placing him on a disciplinary charge; and referred him to the substance misuse service, who gave him advice on the dangers of PS and harm minimisation. He repeatedly declined ongoing support.

44. On 29 July, Mr Batsford told his offender supervisor that he had held 'hooch' for other prisoners for £20 but had not been paid as it had been seized by staff. He said he had gained insight and had made good progress with the mental health nurse.

45. On 30 July, Mr Batsford was allocated a key worker. At their first meeting, on 8 August, Mr Batsford said he paid for PS by taking on 'Spice challenges' or selling his milk and other items. He agreed to hand over his 'pipe' and 'foils' (for smoking drugs).

46. At a substance misuse assessment on 12 August, Mr Batsford said that he had been using PS for about ten weeks but had handed his drug paraphernalia to a wing officer that morning.

47. Security reports noted that on 18 and 23 August, several prisoners watched and laughed at Mr Batsford whilst he was under the influence of PS. It was suggested that he was being used to test new batches of PS and for amusement. On 24 August, an improvised weapon was found in his cell. Mr Batsford said he wanted to self-isolate as he feared for his safety, but he would not divulge any names.

48. After a joint mental health and substance misuse meeting on 28 August, Mr Batsford was discharged from the mental health service. He then agreed to substance misuse support and was assessed on 5 September. Mr Batsford said that he did not use illicit substances when he was mentally well but that he lapsed and used drugs to manage periods of low mood.

49. A security report on 7 September, indicated that Mr Batsford had been bullied to hold a weapon and hooch as payment for a PS debt by two (named) prisoners. The author of the entry felt Mr Batsford was genuinely in debt, given the number of times he had recently been found under the influence of PS. She noted that he should be managed under CSIP and that the details should be circulated to the substance misuse service as he was likely to encounter the same problems on other wings and at other prisons.

50. On 21 September, it was noted that Mr Batsford had not recently been found under the influence of PS and he was upgraded from basic to standard regime.

Events of 23 September

51. From 5.35pm on 23 September, several prisoners went in and out of Mr Batsford's cell and others loitered outside. At 6.58pm, towards the end of the association period, prisoners shouted for staff help. Two officers went to Mr Batsford's cell and found him unresponsive. One officer immediately radioed a code blue (an emergency call sign to indicate that a prisoner is unresponsive or has difficulty breathing) and the communications room requested an ambulance. A nurse arrived and started cardiopulmonary resuscitation with the officers.

52. Ambulance paramedics arrived at 7.12pm and gave advanced life support. At 8.00pm, they took Mr Batsford to Doncaster Royal Infirmary, where he was admitted to the intensive care unit and placed on life support. He was escorted by two prison officers and no restraints were used.

53. On 25 September, doctors withdrew Mr Batsford's ventilation support and he died that day.

Contact with Mr Batsford's family

54. On 24 September, the hospital contacted Mr Batsford's partner. She asked for permission to visit and prison managers approved this through the escort officers. The prison appointed a family liaison officer who arranged to meet Mr Batsford's family at the hospital. His family were allowed to visit him throughout and were with him when he died. The family liaison officer provided relevant information and later established contact with Mr Batsford's son.

55. In line with national policy, the prison contributed to the costs of the funeral, which was held on 18 October.

Support for prisoners and staff

56. The Governor held a debrief for all staff involved in the emergency response, to offer support and discuss any issues arising. The prison also posted notices, informing other staff and prisoners of Mr Batsford's death and offering support.

Information from prisoners after the incident

57. A prisoner told staff that Mr Batsford had been pressured to take PS by other prisoners around ten minutes before staff arrived. He had passed out and prisoners had slapped and drawn on him. When he started to regain consciousness, he was offered half an ID card-sized piece of PS paper free of charge (although the prisoner concerned felt he was not in a fit state to make a decision) and he then relapsed into unconsciousness. The prisoner would not give names for fear of reprisals.

58. A prisoner told the investigator that Mr Batsford and other men were often offered PS "as a challenge so they can laugh at the state he got into".

Post-mortem report

59. Toxicology tests showed that Mr Batsford was under the influence of PS when he died. The pathologist found that the PS had caused a heart attack, which had resulted in a lack of oxygen to the brain, and gave the cause of death as hypoxic brain injury caused by drug poisoning.

Findings

60. Mr Batsford died as a result of using PS. There is evidence that he was bullied by other prisoners because he had built up drug debts, and that he may have been bullied into using PS shortly before his death. We have, therefore, considered whether he received appropriate support for his substance misuse and whether the prison did enough to protect him from bullying.

Clinical care

61. When Mr Batsford arrived at Lindholme, there was a significant delay in completing a secondary health screen. This did not affect his clinical care.

62. The mental health team actively supported Mr Batsford in the last few months of his life and his care is described in detail in the clinical review report.

Support for Mr Batsford's substance misuse

63. Mr Batsford had a history of alcohol misuse in the community. He began using drugs in prison and this appears to have escalated at Lindholme. We are satisfied that staff managed known incidents of substance misuse appropriately and that Mr Batsford was offered opportunities to receive psychosocial support to help him address his PS use. He finally agreed to engage with the substance misuse service four weeks before his death but died before formal support was put in place.

64. We agree with the clinical reviewer's conclusion that he received a good standard of care, equivalent to that he could have expected to receive in the community.

Drug strategy at HMP Lindholme

65. Inspections of Lindholme in 2016 and 2017 found that the availability and use of drugs, including PS, was a serious problem linked to debt and violence. Inspectors found that there was no detailed supply reduction plan; drug strategy meetings were infrequent and poorly attended; and there was a lack of coordination across prison departments.

66. Lindholme has tried to address these shortcomings. There is now an up to date local drug strategy document, with clear governance arrangements. Drug strategy meetings and processes such as mandatory drug testing were suspended during the height of the COVID-19 pandemic but were recently reinstated. During the height of the regime restrictions, there was a reduction in drug use and traditional supply routes stopped because of regime changes, but new ways of smuggling had been devised and we were told that drug use has started to increase again. The prison has introduced a unique reference number system to stem the flow of PS through legal and confidential correspondence.

67. HMPPS guidance says that accurate data on the prevalence, use and effects of PS is crucial to managing the problems it causes and prisons should ensure that recording processes are effective to inform healthcare and security policy. However, drug strategy meeting minutes show that healthcare and the substance misuse service are not routinely informed of all incidents of PS use, so records are

inaccurate. We also noted that the formal documents provided for this investigation contained generic passing references to PS, but no clear actions specific to Lindholme. Given the prevalence of PS at the prison, we consider that there should be specific strategies to address its supply and use, as well as better notification and improved data collection to inform policy. We make the following recommendation:

The Governor should ensure that:

- **the local drug strategy includes specific plans to help reduce the availability of psychoactive substances; and**
- **staff record all instances of prisoners found under the influence of illicit substances and pass the information to the healthcare department and the substance misuse service.**

Management of Mr Batsford's wellbeing and safety

Bullying and coercion

68. Lindholme has a comprehensive Safety Strategy, which includes the policy on violence management and the CSIP process. It says that prisoners vulnerable to violence as a victim should have a support plan specific to their needs, which should be regularly reviewed. The document sets out in detail the required actions, responsibilities, timescales and need for review.

69. In line with the policy, a CSIP referral and investigation report was completed for Mr Batsford. However, there was little evidence of follow-up actions. We are concerned that, although staff were supportive and tried to keep Mr Batsford safe, they did not fully comply with the expected process. Clear objectives, regular reviews, consistent recording and information sharing would have enabled more proactive management of the risks. We make the following recommendation:

The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated, and victims are effectively supported, in line with the local Safety Strategy.

Key worker meetings

70. All prisoners in closed prisons must have a key worker to engage with them, identify their needs and provide one to one support through their sentence. Key workers should document meetings in prisoners' electronic case notes and management checks should be made.

71. A prison manager said that someone with Mr Batsford's history should receive wrap around support, primarily from the substance misuse service and a key worker. However, only one personal officer meeting was recorded at Lindholme (in December 2018) and only one key worker session, six weeks before his death.

72. The Head of Offender Management Delivery said that the roll out of the key worker scheme had prioritised early allocation for prisoners, such as Mr Batsford, whose behaviour was causing the most difficulties. She said it was not clear why he did

not have weekly meetings with his key worker, but that as a result of the PPO's investigation the prison had reviewed and adjusted the quality assurance process.

73. We do not know whether earlier or more frequent key worker input would have enabled Mr Batsford to become drug-free. However, we note that the single meeting he had with his key worker was productive, as he was immediately open about his PS use and agreed to hand over drug equipment. This suggests that he may have found regular support from a key worker helpful. We are concerned that such a vulnerable prisoner slipped through the net.

74. We are also concerned that HMPPS has suspended elements of the key worker scheme during the pandemic. We make the following recommendation, to be implemented as soon as possible:

The Governor should ensure that the prison meets the standards expected of the key worker scheme. Key workers should be assigned promptly and have regular contact with the prisoners allocated to them; all interactions should be recorded in prisoners' case notes; and managers should check compliance.

Emergency Response

75. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. It contains mandatory instructions on efficiently communicating the nature of a medical emergency and says that if a medical emergency code is called over the radio, an ambulance must be called immediately.

76. Ambulance service records show that they received a telephone call for an ambulance at 7.03pm, five minutes after the code blue was called at 6.58pm. While this delay might not have adversely affected the outcome for Mr Batsford, such delays may make a crucial difference in other life-threatening emergencies. We make the following recommendation:

The Governor should ensure that staff in the communications room request an ambulance as soon as a medical emergency code is called.

Contacting Mr Batsford's family

77. Prison Rule 22 states that prisons should inform the next of kin immediately if a prisoner becomes seriously ill.

78. The escort officers gave immediate and frequent updates when they arrived at the hospital, informing the prison that Mr Batsford was in intensive care and that he remained unresponsive and might not live until the morning. At 9.55pm, the officers asked the prison to notify his next of kin. At 11.00pm, a nurse repeated this request and the prison gave the next of kin's contact details to the escorts at 11.15pm. At 2.40am, a hospital doctor made a further request for the family to be told. At 6.40am, the escort officers told medical staff that if they contacted Mr Batsford's family, they must inform the prison.

79. By the time the prison's family liaison officer contacted Mr Batsford's partner at around 8.30am on 24 September, medical staff had already notified her that he was

seriously ill in hospital. The family liaison officer noted that a custodial manager had tried to contact Mr Batsford's family at 10.35pm the previous evening but was unable to leave a message.

80. The ambulance had left the prison at around 8.00pm and the family's contact details were up to date. We consider that it was the prison's responsibility to inform Mr Batsford's family urgently that he had been taken to hospital in a serious condition and that the prison should have appointed a family liaison officer and tried to contact the family sooner that evening or, failing that, earlier the following morning. We make the following recommendation:

The Governor should ensure that staff comply with the requirement to contact families immediately when a prisoner is seriously ill.

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