

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jonathan Mather a prisoner at HMP & YOI Stoke Heath on 14 May 2017

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*



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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.

Mr Jonathan Mather died on 14 May 2017 of ischaemic heart disease at HMP & YOI Stoke Heath. He was 37 years old. We offer our condolences to Mr Mather's family and friends.

Mr Mather did not present with any symptoms that indicated he was suffering from heart disease. We are satisfied that his death could not have been predicted or prevented and that his clinical care at Stoke Heath was equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

February 2018

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Summary

Events

1. Mr Jonathan Mather was sent to prison in July 2015. He was moved to HMP & YOI Stoke Heath in April 2016.
2. When Mr Mather arrived at Stoke Heath, a nurse noted his history of stomach ulcers and alcohol abuse. Before entering prison, Mr Mather had become dependent on prescription pain killers and was diagnosed with post traumatic stress disorder.
3. Prison GPs prescribed Mr Mather appropriate medication which was not kept in his possession.
4. On 26 May 2016, Mr Mather had a routine electrocardiogram (ECG) with normal results.
5. On 8 May 2017, Mr Mather moved to the Clive Unit (a small unit for category D prisoners which is outside the main prison) and registered with a community GP. Mr Mather was authorised to keep his prescribed medication in his possession.
6. At 6.50am on 14 May, a prisoner found Mr Mather unresponsive in his bed and staff called an emergency ambulance. A nurse examined Mr Mather and determined that he was dead. She did not attempt cardiopulmonary resuscitation. The paramedics arrived and at 7.14am recorded that Mr Mather had died.
7. The post mortem indicated that the cause of death was ischaemic heart disease, coronary atherosclerosis and myocardial hypertrophy.

Findings

8. Mr Mather did not present with any symptoms that indicated he was suffering from heart disease. The clinical reviewer considered that his death could not have been predicted or prevented.
9. We agree with the clinical reviewer that the care provided to Mr Mather was equivalent to that which he could have expected to receive in the community. We make no recommendations.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP and YOI Stoke Heath informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Mather's prison and medical records. Our investigation was suspended until we received the cause of death and resumed in September.
12. NHS England commissioned a clinical reviewer to review Mr Mather's clinical care at the prison.
13. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation who gave us a copy of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Mather's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Mather's mother raised concerns about his access to prescribed medication and asked about GP support provided to prisoners located in the Clive Unit.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Stoke Heath

16. HMP & YOI Stoke Heath is a medium security prison in Shropshire holding up to 782 adult and young adult men. It has a small unit (Clive Unit) for category D prisoners which is outside the main prison. Primary care services are provided by Shropshire Community Health NHS Trust and secondary mental health services by South Staffordshire NHS Foundation Trust.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stoke Heath was in April 2015. Inspectors reported that the Clive Unit was a good environment for the few who lived there. Health services in the main prison were not sufficiently good but there were clear plans for improvement. There was good access to primary care services, including the GP, and an appropriate range of clinics.

Independent Monitoring Board

18. 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 30 April 2017, the IMB reported that the healthcare in the main prison was fully staffed for part of the year but unfortunately this had not been maintained and attempts at recruitment were in progress. Despite staff shortages a full range of medical services had been provided.

Previous deaths at HMP Stoke Heath

19. Mr Mather was the second prisoner to die of natural causes at Stoke Heath since January 2015. There has been one death since. There were no significant similarities between Mr Mather's death and the other deaths at Stoke Heath.

Key Events

20. On 20 July 2015, Mr Jonathan Mather was remanded in custody for public order offences and sent to HMP Dovegate. On 8 April 2016, he was sentenced to five years and six months in prison. On 29 April 2016, he was moved to HMP & YOI Stoke Heath.
21. At an initial health screen at Stoke Heath, a nurse noted that Mr Mather had a history of duodenal ulcers and had abused alcohol in the community. Mr Mather had become dependent on prescription pain killers and was diagnosed with post traumatic stress disorder (PTSD – a chronic anxiety based condition that manifests itself with recurrent intrusive thoughts and “flashbacks” related to episodes of trauma) after his discharge from the armed services. Mr Mather was a heavy smoker and declined help to stop. Prison GPs prescribed medication to manage his medical conditions. Mr Mather’s medication was not kept in his possession.
22. On 26 May 2016, Mr Mather had a routine electrocardiogram (ECG) with normal results. There is nothing else of significance in his medical records until May 2017.
23. Also on 26 May 2016, Mr Mather was recategorised to category D. This is the lowest security category and is for prisoners who can be reasonably trusted not to try to escape.
24. On 8 May 2017, Mr Mather moved to the Clive Unit. This is a two storey unit outside the main prison for category D prisoners to prepare them for release from custody. Prisoners are allowed to leave the unit between the hours of 6am and 9pm and they sleep in two dormitories on the first floor. There is no GP service in the Clive Unit and prisoners are required to register with a GP in the community. Before his move to the Clive Unit prison GPs prescribed Mr Mather his medication, which he kept in his possession.
25. On 12 May, an occupational therapist, visited Mr Mather in the Clive Unit. She noted that he was in a bright mood, well presented and appeared to be physically well. Mr Mather said he had registered with a community GP who had seen him about his stomach ulcers and had prescribed medication.

Events of 14 May

26. At 6.50am on 14 May, a prisoner telephoned a prison officer and told him Mr Mather was unresponsive in his bed. The officer radioed an emergency code blue (indicating that a prisoner is unconscious or having difficulties breathing) and the control room called an emergency ambulance. The officer arrived at the Clive Unit a few minutes later with another prison officer and a nurse.
27. The nurse examined Mr Mather and noted that he was cold to the touch, his limbs were stiff and there were no signs of life. The nurse decided that Mr Mather was clearly dead and to preserve his dignity she did not attempt cardiopulmonary resuscitation (CPR). Paramedics arrived at 7.05am and supported the nurse’s decision not to perform CPR. At 7.14am, the paramedics recorded that Mr Mather had died.

Contact with Mr Mather's family

28. At 8.25am on 14 May 2017, the prison appointed a prison manager as the family liaison officer. At 10.50am, the family liaison officer arrived at the home of Mr Mather's mother and told her Mr Mather had died.
29. On 19 May, the family liaison officer and a prison governor visited the home of Mr Mather's mother again and offered support. The family liaison officer remained in contact with Mr Mather's mother until Mr Mather's funeral on 31 May. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

30. Following Mr Mather's death, a prison governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
31. The prison posted notices informing other prisoners of Mr Mather'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 Mr Mather's death.

Post-mortem report

32. The coroner concluded that the cause of death was ischaemic heart disease (blockage to the blood vessels of the heart), coronary atherosclerosis (fatty deposits blocking the blood vessels) and myocardial hypertrophy (enlarged heart). The results of the toxicology tests did not indicate the presence of illicit substances or medication above the prescribed amount.

Findings

Clinical care

33. The clinical reviewer noted that there was no evidence in Mr Mather's medical record that he was suffering from ischaemic heart disease. Mr Mather had a routine ECG in May 2016 which was normal and he did not present with any symptoms indicative of heart disease.
34. Mr Mather had a history of alcohol abuse and dependence on prescription pain killers. However, results of the toxicology tests did not indicate that illicit or prescribed substances contributed to his death.
35. The clinical reviewer concluded that Mr Mather's death could not have been predicted or prevented and that the standard of care he received at Stoke Heath was equivalent to that which he could have expected to receive in the community.

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