Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jesse-Jon Spence a prisoner at HMP Oakwood on 21 April 2018

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.

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 Jesse-Jon Spence died of heart failure and heart disease on 21 April 2018 at HMP Oakwood. He was 38 years old. I offer my condolences to his family and friends.

Mr Spence was known to have a history of substance misuse and mental health issues, but had no physical health problems. The healthcare that he received was equivalent to that which he could have expected to receive in the community, and healthcare staff appropriately decided not to resuscitate him as there were no signs of life.

However, I am concerned that a prison officer did not follow the correct guidance when unlocking prisoners, and did not check on the Mr Spence's welfare.

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 2019**

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Summary

Events

1. On 10 July 2017, Mr Jesse-Jon Spence was sentenced to two years in prison for assault. He was initially sent to HMP Hewell and was transferred to HMP Oakwood on 2 November.

2. Mr Spence had a history of substance misuse and mental health issues, but he had no physical health concerns. The majority of his medical records were about managing his depression and anxiety, and attending appointments with the specialist drugs worker.

3. At approximately 5.10am on 21 April 2018, an officer completed a roll check on the houseblock, where Mr Spence was located but noted nothing unusual when looking in Mr Spence's cell.

4. At 8.00am, another officer started a roll check and unlocked Mr Spence's cell, but did not complete a welfare check before moving on to unlock the next cell.

5. At approximately 9.55am, a nurse told an officer that Mr Spence had not attended the medication hatch that morning. The officer went to Mr Spence's cell, and found him lying on the floor.

6. A medical emergency code blue was called, and healthcare and prison staff responded and checked on Mr Spence. Staff could not move him, and stated that there were no obvious signs of life. As rigor mortis had set in, staff decided not to attempt to resuscitate him. Paramedics pronounced him dead at 10.25am.

Findings

7. We are satisfied that the clinical care that Mr Spence received at HMP Oakwood was equivalent to that which he could have expected to receive in the community.

8. However, we are concerned that an officer did not check on Mr Spence's wellbeing during unlock in line with national instructions. It is likely that this caused a delay in staff being aware of his death. Oakwood have already re-issued guidance aimed at making sure that this does not occur again.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded, and was interviewed during the investigation.

10. The investigator obtained copies of relevant extracts from Mr Spence's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Spence's clinical care at the prison. They jointly interviewed seven members of staff and two prisoners at HMP Oakwood on 18 June 2018.

12. We informed HM Coroner for South Staffordshire District of the investigation. He gave us the results of the post-mortem examination and the toxicology report. We have sent the Coroner a copy of this report.

13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

14. The initial report was also shared with Mr Spence's mother. She noted that the date of her son's funeral was incorrect. This has been amended in the report.

Background Information

HMP Oakwood

15. HMP Oakwood is managed by G4S and is one of the largest prisons in England and Wales, providing places for around 2,100 male prisoners. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs.

16. Oakwood is made up of several houseblocks which are subdivided into wings. Mr Spence was located on Elm House, a drug free unit.

HM Inspectorate of Prisons

17. The last inspection of HMP Oakwood was conducted in January and February 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good and the range of services was appropriate.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board made up 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 March 2018, the IMB reported that mental health and substance misuse caseloads are high because of staff vacancies.

Previous deaths at HMP Oakwood

19. Mr Spence was the sixteenth prisoner to die at Oakwood since April 2015, and the fifteenth to die from natural causes. There are no similarities between these cases and the circumstances of Mr Spence's death.

Key Events

20. On 10 July 2017, Mr Jesse-Jon Spence was sentenced to two years in prison for assault by actual bodily harm, and was sent to HMP Hewell. He was transferred to HMP Oakwood on 2 November 2017.

21. When he arrived, a nurse completed Mr Spence's initial health screen. She noted that he was communicative, co-operative and cheerful. She recorded that he had tried to take an overdose a few years ago and that he had a history of depression and substance misuse. He had no physical health concerns.

22. The nurse appropriately referred Mr Spence to the inreach mental health team, who gave him group therapy, and to the substance misuse team whom he saw on a regular basis. The majority of his medical records were for mental health and substance misuse appointments.

23. On 8 February 2018, a prison GP saw Mr Spence as he had symptoms of anxiety. He prescribed him an antidepressant and propranolol (a beta blocker generally used for heart conditions, but in this instance, prescribed for anxiety).

24. The substance misuse and mental health team continued to monitor Mr Spence, and they were planning for his release in May 2018.

25. At approximately 5.10am on 21 April, an officer began a roll check on Elm House, where Mr Spence lived. She told the investigator that when checking prisoners, she specifically checked if prisoners were breathing and if there was anything unusual. She said that she could not remember anything about Mr Spence and therefore assumed that he must have been asleep.

26. At 7.45am, an officer started her shift, and began a roll check at 8.00am. She unlocked Mr Spence's cell but did not complete a welfare check before she moved on to unlock the next cell.

27. At approximately 9.55am, an officer who worked in Elm House, was contacted by the medication hatch because Mr Spence had not collected his medication that day. She told the investigator that she made her way to Mr Spence's cell, where she described his cell door as slightly ajar.

28. The officer explained that as she went into the cell, she called out Mr Spence's name but received no response and saw Mr Spence lying on the floor. She said that when she touched Mr Spence, he was cold and had no pulse.

29. At 9.58am, the officer stepped out of Mr Spence's cell and called a medical emergency code blue (used to indicate breathing difficulties and triggers members of the healthcare team to attend and the control room to call an emergency ambulance).

30. An officer and a nurse responded to the code blue. The nurse said that she arrived at Mr Spence's cell within approximately one minute of hearing the call. She found him lying on the floor of his cell, with no obvious signs of life. She said that he had rigor mortis, so was unable to insert an airway. She said that as there were no signs of life, she decided, in agreement with discipline and

healthcare staff, not to start CPR because it would have been futile and undignified for Mr Spence.

31. At 10.18am, the ambulance arrived at the prison and paramedics were escorted to Elm House, where they confirmed Mr Spence's death at 10.25am.

Contact with Mr Spence's family

32. On 21 April, after Mr Spence's death was confirmed. A senior manager was appointed as the prison's family liaison officer (FLO). Mr Spence had given the details of a law firm as his next of kin. The FLO looked through Mr Spence's pin phone account to see if she could identify any numbers, however he had made no calls since arriving at Oakwood.

33. The FLO contacted Mr Spence's law firm, but the named lawyer was not available until 23 April.

34. Mr Spence had three numbers on his telephone contacts list, and the FLO tried unsuccessfully to contact them all to ascertain their relationship with Mr Spence.

35. On the afternoon of 21 April, a prisoner told the FLO that he knew the Spence family, and provided contact details for Mr Spence's mother. As she was the victim of his offence, the prison gave her contact details to the police who broke the news of Mr Spence's death to her. She told the police that she was content for the prison to contact her.

36. The prison did so, and offered emotional support.

37. Mr Spence's funeral was held on 16 May. Two members of prison staff attended. The prison contributed towards Mr Spence's funeral costs in line with national instructions.

Support for prisoners and staff

38. After Mr Spence's death, a safer custody manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

39. The prison posted notices informing other prisoners of Mr Spence's death, and offering support.

Post-mortem report

40. The post-mortem investigation concluded that the cause of Mr Spence's death was acute left ventricular heart failure and hypertensive and ischaemic heart disease. The toxicology confirmed that he had low, therapeutic levels of mirtazapine and paracetamol, which had been prescribed to him, and no illicit substances in his system.

Findings

Clinical care

41. The clinical reviewer found that the clinical care that Mr Spence received at Oakwood was equivalent to that which he could have expected to receive in the community.

42. Healthcare staff saw him regularly to manage his mental health and substance misuse problems. He had access to primary care services, when required.

43. There is nothing in Mr Spence's medical records to suggest that staff could have foreseen his death. No one whom we interviewed, including prisoners, saw anything to indicate that Mr Spence was unwell.

Unlock

44. Prison Service Instruction (PSI) 74/2011 states that:

> "Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example, by obtaining a response during the unlock process."

45. The officer who unlocked Mr Spence did not seek a response from him and continued to unlock other prisoners. She told the investigator that she had 'no explanation, none whatsoever' for not completing a welfare check.

46. Although we cannot say whether completing a welfare check would have resulted in a different outcome for Mr Spence, in other circumstances, it may make a difference.

47. The Head of Safer Custody told us that Oakwood had issued a warning to the officer who failed to check on Mr Spence's wellbeing and re-issued local guidance on unlocking procedures to all officers. We do not therefore make a recommendation.

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