Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hill, a prisoner at HMP Oakwood, on 31 July 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*

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 Stephen Hill died of Sudden Unexpected Death in Epilepsy on 31 July 2019 at HMP Oakwood. He was 42 years old. I offer my condolences to Mr Hill's family and friends.

I am concerned that Mr Hill's epilepsy medication was not sent with him when he was moved from HMP Stafford to Oakwood on 29 July 2019. I am also concerned that following his arrival at Oakwood, no epilepsy medication was administered to him before he died.

I have made recommendations to both prisons on these serious failings.

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 **June 2020**

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Summary

Events

1. On 29 August 2017, Mr Stephen Hill was sentenced to five years in prison for sexual offences. On 10 November, he was moved to HMP Stafford.

2. Mr Hill had epilepsy and reported regular seizures. He was referred for specialist opinion and seen regularly by prison GPs to review his medication. He was assessed by the mental health team for stress and anxiety, which could lead to seizures, and in 2018, was prescribed antidepressants. In June 2018, Mr Hill missed an appointment with the epilepsy nurse specialist but he continued to receive regular GP reviews and specialist care.

3. On 29 July 2019, Mr Hill was moved to HMP Oakwood. When he arrived, he told a nurse that he had epilepsy. Mr Hill's medication was not sent with him so the nurse made a prescription request on his patient record. The prescription was written the next day but Mr Hill did not get his medication before he died.

4. On 31 July at 1.30am, Mr Hill rang his cell bell and an officer attended. Mr Hill told the officer that he had epilepsy and felt unwell. She called for the night manager who advised Mr Hill to rest and to ring his cell bell again if he felt worse.

5. At 6.59am, an officer responded to a cell bell activation from Mr Hill's cellmate. Mr Hill was lying on his bunk, unresponsive. His cellmate could not rouse him despite tapping him and calling his name.

6. The officer was unable to call a medical emergency code over her radio because the battery was flat but she shouted out the code, and was joined almost immediately by other officers. She used one of their radios to call the code and control room staff called an ambulance. The officers began cardiopulmonary resuscitation (CPR). A defibrillator was attached to Mr Hill's chest but no shockable rhythm was detected.

7. Healthcare staff arrived quickly. They continued CPR and gave Mr Hill oxygen. At 7.20am, the first paramedics arrived, followed shortly after by a second team. At 7.45am, a paramedic declared that Mr Hill had died.

8. A post-mortem examination concluded that Mr Hill died of Sudden Unexpected Death in Epilepsy.

Findings

9. When Mr Hill was moved from Stafford to Oakwood, his epilepsy medication was not sent with him. The clinical reviewer considered that this aspect of his care was not equivalent to that he could have expected to receive in the community.

10. When Mr Hill arrived at Oakwood, a nurse completed a prescription request for his epilepsy medication but he did not get it before his death. The clinical reviewer considered that Mr Hill's care at Oakwood was not equivalent to that he could have expected to receive in the community.

11. We are concerned that the officer who found Mr Hill unresponsive could not radio a medical emergency code because her radio battery was flat. The officer summoned help quickly and used another officer's radio to call the code, which resulted in a minimal delay. However, it is important that officers have a working radio in an emergency situation so that the correct procedures are followed and all relevant staff are notified immediately.

Recommendations

- The Head of Healthcare at HMP Stafford should ensure that when prisoners are released or transferred, their prescribed medication goes with them.
- The Head of Healthcare at HMP Oakwood should ensure that there is no delay in prisoners receiving medication prescribed as urgent.
- The Director at HMP Oakwood should ensure that arrangements are in place to enable officers to replace or recharge radio batteries before their shift ends, including at night.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact him. No one responded

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

14. NHS England commissioned an independent clinical reviewer to review Mr Hill's clinical care at the prison.

15. We informed HM Coroner for South Staffordshire District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. One of the Ombudsman's family liaison officers contacted Mr Hill's next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hill's friend asked if he was given the correct medication when he was moved to Oakwood.

17. We sent a copy of the initial report to Mr Hill's next of kin. She did not make any comments.

18. We shared the initial report with HM Prison and Probation Service. They did not find any factual inaccuracies. Their action plan is annexed to this report.

Background Information

HMP Oakwood

19. 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.

HM Inspectorate of Prisons

20. The last inspection of HMP Oakwood was in February and March 2018. Inspectors reported that health services had improved considerably since their last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans. However, there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 March 2019, the IMB reported that the introduction of pharmacy technicians had resulted in an improvement in the management of medication. There had been a reduction in the number of missed healthcare appointments and the ongoing use of prison based paramedics continued to provide benefits. The Board expressed concern that some prisoners attending visits were unable to collect medication on their return as they had missed their appointment.

Previous deaths at HMP Oakwood

22. Mr Hill was the 12th prisoner to die at Oakwood since July 2017. Of the previous deaths, 10 were from natural causes and one was drug-related. There are no similarities between our findings in the investigation into Mr Hill's death and the other deaths.

HMP Stafford

23. HMP Stafford is a medium security prison in Staffordshire for adult sex offenders. It can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call doctors outside these hours.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Stafford was in February 2016. Inspectors found that the range of primary care services was appropriate and access to nurses and GPs was good. However, hospital appointments were regularly cancelled or rescheduled because there were not enough escort staff.

Governance of healthcare was reasonable overall, with effective working between healthcare providers and the prison.

Independent Monitoring Board

25. In its latest annual report for the year to 30 April 2019, the IMB reported that the healthcare service was generally working well. Waiting times in most areas were acceptable and in line with the community. The Board recognised the ageing prison population and the increased need for social care. Despite the best efforts of staff, the Board highlighted its concern about the suitability of HMP Stafford for elderly prisoners.

26. During the reporting period, Care UK introduced 24/7 cover which, whilst there were initial teething problems, had proved to be beneficial, especially to those prisoners needing medical provision at night. However, the Board remained concerned about the supervision of medication, with older and vulnerable prisoners being bullied for medication.

Previous deaths at HMP Stafford

27. There were 11 deaths from natural causes at HMP Stafford between July 2017 and July 2019. There are no similarities between our findings in the investigation of Mr Hill's death and the other deaths.

Key Events

28. On 29 August 2017, Mr Stephen Hill was sentenced to five years in prison for sexual offences.

29. Mr Hill had epilepsy (diagnosed aged 14) and high cholesterol. A prison GP reviewed his medication which included simvastatin (used to lower cholesterol) and topiramate (used to treat epilepsy). No other medical conditions were identified.

30. On 3 September, at his epilepsy review, Mr Hill told a nurse that he had three or four seizures a week. He said that a brain injury in the past might be causing these. The nurse referred him to a GP and on 7 September, a GP increased his medication.

31. Despite reviews, examinations and changes to the dosage of his medication, Mr Hill continued to suffer regular seizures. On 22 September, he told a nurse that enclosed spaces (as experienced in prison) made his seizures worse.

32. On 9 November, a prison GP recorded that Mr Hill's seizures were less frequent following the most recent increase in his medication.

HMP Stafford

33. On 10 November, Mr Hill was moved to HMP Stafford. He continued to have seizures and was regularly reviewed by prison GPs who amended and increased his medication. In December, Mr Hill was referred to a neurologist and assessed by the mental health team for stress and anxiety, which often triggered his seizures. His epilepsy medication was increased at the suggestion of the consultant neurologist, and he was prescribed antidepressants.

34. On 24 June 2018, Mr Hill missed an appointment with the epilepsy nurse specialist as there were no prison escort staff to accompany him. However, he continued to receive regular GP reviews and support from the mental health team. In early 2019, Mr Hill's medication was increased following a hospital outpatient appointment and he was seen by the Long-Term Conditions Nurse.

HMP Oakwood

35. On 29 July, Mr Hill was moved to HMP Oakwood. He told a nurse that he had epilepsy that was controlled by medication, but still had occasional seizures. He also said that he had lots of headaches (that made him dizzy), anger issues and a history of anxiety. The nurse described Mr Hill as well presented but anxious.

36. When he arrived at Oakwood, Mr Hill did not have any medication with him. The nurse entered an electronic prescription request onto his patient record for the attention of a GP or Advanced Nurse Practitioner (ANP).

37. On 30 July at 9.28am, a Development ANP reviewed Mr Hill's medical history, current medication and prescribing history. The nurse completed, printed and signed a prescription for Mr Hill and marked it as urgent. The prescription went on a pile, with others, ready to go to the pharmacy. The nurse also sent an electronic 'task' to a GP, about the need for a neurology referral for Mr Hill.

38. On 31 July at 1.30am, Mr Hill rang his cell bell. An officer got to the cell two minutes later. Mr Hill was standing by the cell door and he told the officer that he was epileptic and felt unwell. The officer radioed the night manager, who was already on the house block and who got there very quickly. Mr Hill was sitting on the floor of his cell. He told the night manager that he was epileptic and felt that "something" might be coming on. He explained that he had seizures that were brought on by stress and that he felt stressed following his recent move to Oakwood.

39. The cell light was on and the night manager did not consider that Mr Hill was displaying symptoms indicating that he needed urgent help. He advised Mr Hill to move onto his bed once he felt better and to ring his cell bell again if he started to feel worse. Mr Hill agreed.

40. At 5.10am, two officers began the morning roll check to confirm that all prisoners were present. The officers did not specifically recall checking Mr Hill's cell but were confident that they would have raised the alarm had they noticed anything untoward.

41. At 6.59am, an officer responded to a cell bell activation from Mr Hill's cell. She arrived almost immediately. Mr Hill was lying on his bunk with his head towards the door. His cellmate was standing over him. Mr Hill was unresponsive and his cellmate could not rouse him despite tapping him and calling his name.

42. The officer's radio did not work as the battery was flat, so she shouted out "Code Blue" (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Two First Line Managers (FLMs) attended immediately and they entered Mr Hill's cell. The officer radioed the Code Blue using an FLM's radio and control room staff called an ambulance.

43. Mr Hill remained unresponsive, his face was blue and his eyes bulging and red. The officers put him onto the floor and began cardiopulmonary resuscitation (CPR). A defibrillator was attached to his chest but no shockable rhythm was detected.

44. Healthcare staff arrived quickly and Mr Hill was moved onto the landing. They took over CPR and gave Mr Hill oxygen. At 7.20am, the first paramedics arrived and took over from healthcare staff. A second team of paramedics arrived approximately five minutes later. At 7.45am, a paramedic declared that Mr Hill had died.

Contact with Mr Hill's family

45. On 31 July at 9.30am, the prison appointed a family liaison officer (FLO). Mr Hill had named a friend as his next of kin and at 10.10am, together with a prison manager, the FLO went to his friend's home.

46. Mr Hill's friend was not at home and the officers spoke to her partner. They left their contact details and returned to Oakwood.

47. Mr Hill's friend telephoned the prison later that afternoon and spoke to the FLO who told her that Mr Hill had died and offered his condolences. The FLO explained what would happen next including funeral arrangements and the return

of Mr Hill's property. He asked Mr Hill's friend if she knew of any living relatives and she said she did not.

48. The FLO spoke to Mr Hill's friend again the next day and she asked him to make the funeral arrangements. The FLO kept in contact and arranged the return of Mr Hill's property. He told Mr Hill's friend that she could call him at any time.

49. Mr Hill's funeral was held on 2 September and the prison paid in line with Prison Service instructions.

Support for prisoners and staff

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

51. The prison posted notices informing other prisoners of Mr Hill'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 Hill's death.

Post-mortem report

52. A post-mortem examination found no evidence of any significant physical natural disease that would have contributed to Mr Hill's immediate cause of death. Toxicology tests showed low/therapeutic concentrations of topiramate (anti-epileptic drug) and sertraline (antidepressant).

53. The pathologist noted that Mr Hill had a history of epilepsy and in the absence of any other explanation, concluded that he died from Sudden Unexpected Death in Epilepsy (SUDEP). SUDEP is believed to be caused by neurologically precipitated fatal cardiac arrhythmias (abnormal heartbeat caused by an abnormality in the brain). It can cause death at any time and may or may not occur during a seizure.

Findings

Clinical care

HMP Stafford

54. Discipline staff at Stafford notify the healthcare team in advance of prisoners being transferred or released. When Mr Hill was moved to Oakwood his medication should have gone with him. Because he was assessed as not suitable to have medication in his possession, it should have been carried by the escort staff.

55. Because Mr Hill transferred on a Monday, the pharmacy team would normally have prepared his medication on the Friday before (26 July). However, because the pharmacy team was very busy and short of staff, this was not done. They did not prepare his medication or have it taken to the reception area ready for his transfer.

56. During the early hours of 29 July, a member of the healthcare staff completed Mr Hill's escort record and sent an electronic task to Hotel One (the emergency response nurse coming on duty later that morning) reminding the nurse about Mr Hill's medication.

57. However, on the morning of 29 July, three members of healthcare staff reported sick and Hotel One was therefore needed to provide cover and did not access the task until after Mr Hill had left the prison.

58. There is no requirement or expectation for a prisoner transferring out of Stafford to be seen by a member of the healthcare team and, as a result, no one realised that Mr Hill left without his medication.

59. The clinical reviewer was satisfied that the management of Mr Hill's epilepsy at Stafford was of a good standard. There were examples of good practice including regular GP reviews and specialist referrals. Mr Hill received extensive support from the mental health team, bereavement counselling and access to emotional awareness groups.

60. However, because Mr Hill's medication did not go with him when he transferred to Oakwood the clinical reviewer did not consider that the care he received was equivalent to that he could have expected to receive in the community. We make the following recommendation:

    The Head of Healthcare at HMP Stafford should ensure that when prisoners are released or transferred, their prescribed medication goes with them.

HMP Oakwood

61. At his initial health screen at Oakwood, Mr Hill told a nurse that he had epilepsy. The nurse identified that he did not have any medication with him so sent a 'task', requesting its prescription, on his electronic patient record.

62. The next morning a nurse actioned the task, reviewed Mr Hill's medical history and completed the prescription for his medication. The prescription, which was marked as urgent, was put in a pile ready to go to the on-site pharmacy

63. When a prescription is marked as urgent the expectation is that the patient will receive his medication on the day that the prescription is requested. Under normal circumstances the request would be made on the afternoon/evening of day one, after a prisoner transfers, for prescribing and dispensing on day two (at the very latest).

64. There is an agreement that for this to happen the prescription must get to the pharmacy before 2.00pm. The pharmacy closes at 4.00pm. Unfortunately, it appears that despite Mr Hill's prescription being marked as urgent it either did not get to the pharmacy in time or, if it did, it was not dispensed.

65. As a result, Mr Hill did not receive any medication after his transfer to Oakwood. In total he missed three doses, one on the afternoon of his arrival and two the next day (morning and afternoon).

66. For this reason, the clinical reviewer did not consider that the care Mr Hill received at Oakwood was equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare at HMP Oakwood should ensure that there is no delay in prisoners receiving medication prescribed as urgent.

67. The clinical reviewer has made additional recommendations which we bring to the attention of the Heads of Healthcare but do not repeat in this report.

Emergency response

68. When an officer found that Mr Hill was unresponsive, she was unable to call a medical emergency code over her radio because the battery was flat. She shouted out the code instead, and other staff in the vicinity responded quickly. She then used another officer's radio to call the code. Healthcare staff responded and the control room called an ambulance.

69. While we accept that there was minimal delay in calling the code over the radio and an ambulance being called, we are nevertheless concerned that the officer was unable to use her radio when she found Mr Hill. The prison told the investigator that radios are fully charged when they are collected but sometimes the batteries, particularly older ones, can run out of charge before the end of the shift. We make the following recommendation:

The Director at HMP Oakwood should ensure that arrangements are in place to enable officers to replace or recharge radio batteries before their shift ends, including at night.

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