

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Martin, a prisoner at HMP Oakwood, on 29 October 2019

**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.

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 Martin died of a heart attack on 29 October 2019 at HMP Oakwood. He was 62 years old. I offer my condolences to Mr Martin's family and friends.

The clinical reviewer was satisfied that the care Mr Martin received was broadly satisfactory and equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer found that healthcare staff did not create care plans to manage Mr Martin's conditions, there was a delay in receiving his post-surgery medication, and some of his hospital appointments were cancelled due to a lack of escort staff.

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**

**August 2020**

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# Summary

## Events

1. On 4 July 2019, Mr Stephen Martin was sentenced to 18 months in prison for fraud. On 9 July, Mr Martin transferred to Oakwood.
2. Mr Martin had several chronic health conditions, including asthma, high blood pressure, various heart conditions, high cholesterol, peripheral arterial disease (which restricts blood supply to the leg muscles), an abdominal aortic aneurysm (a swelling in the main blood vessel that runs from the heart), and an aneurysm in the femoral artery.
3. Mr Martin saw healthcare staff regularly to monitor and treat his medical conditions. Prison GPs prescribed appropriate medications and he was sent to hospital regularly for cardiovascular disease appointments. However, two of his hospital appointments were cancelled because there were not enough prison staff available to escort him to hospital.
4. On 21 August, he was admitted to hospital and had surgery to remove a blood clot in an artery in his leg. He returned to prison on 5 September. A follow-up hospital appointment on 16 October was cancelled because there were not enough prison staff to escort him. It was rearranged for 13 November.
5. At 8.50am on 29 October, Mr Martin's cellmate found him unresponsive on the cell floor. He shouted for assistance. An officer responded and called a medical emergency code. The officer was joined almost immediately by other officers. The control room staff called an ambulance. Staff began cardiopulmonary resuscitation (CPR). Healthcare staff arrived and continued with CPR. A defibrillator was attached to Mr Martin's chest but no shockable rhythm was detected.
6. At 9.04am, paramedics arrived. At 9.38am, a paramedic confirmed that Mr Martin had died.
7. A post-mortem examination gave Mr Martin's cause of death as a heart attack caused by ischaemic heart disease.

## Findings

8. The clinical reviewer concluded that, overall, the level of clinical care Mr Martin received at Oakwood was equivalent to that which he could have expected to receive in the community. Mr Martin had significant health problems and healthcare staff monitored his conditions appropriately.
9. However, there were no documented care plans at Oakwood relating to Mr Martin's care, and there was a delay of 11 days before he received his post-surgery medication prescribed by his hospital consultant (although he did receive it for the six weeks before his death).
10. Three of Mr Martin's hospital appointments were cancelled due to a lack of prison escorts before and after he had surgery. While the cancellations were outside the direct control of healthcare staff, we consider that this aspect of Mr Martin's

healthcare in prison, was not equivalent to that he could have expected in the community.

11. We cannot say if the cancellations contributed to Mr Martin's death. However, the cancellation of appointments may have a significant impact in other cases.

## **Recommendations**

- The Head of Healthcare should ensure that staff create and document care plans for all prisoners with chronic and/or life limiting conditions.
- The Head of Healthcare should ensure that there is no delay in prisoners receiving prescribed medication.
- The Director and Head of Healthcare should ensure that sufficient staffing resources are allocated to hospital escorts to meet the health needs of the population, that hospital appointments are cancelled only as a last resort and at no detriment to a prisoner's health and that staff clearly record the reasons for such cancellations.

## 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 her.
13. The investigator visited Oakwood on 6 November 2019. She obtained copies of relevant extracts from Mr Martin's prison and medical records.
14. The investigator interviewed four members of staff and a prisoner at Oakwood on 6 and 27 November 2019.
15. NHS England commissioned an independent clinical reviewer to review Mr Martin's clinical care at the prison. They jointly interviewed healthcare staff.
16. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination. We have sent him a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Martin's next of kin, to explain the investigation and to ask if they had any matters the family wanted the investigation to consider. They did not raise any issues but requested a copy of the report.
18. Mr Martin's family received a copy of the initial report. They pointed out a typing error. This report has been amended accordingly. Mr Martin's family also pointed out a typing error in Annex 1 - the clinical review which has been amended.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Background Information

### HMP Oakwood

20. 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

21. The last inspection of HMP Oakwood was in February and March 2018. Inspectors reported that health services had improved considerably since their previous 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.
22. However, inspectors found that there were often delays in arranging external hospital appointments because of the high demand and insufficient escort staff. They said that too many cancellations occurred, leading to delays in prisoners attending necessary medical consultations.

### Independent Monitoring Board

23. 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.

### Previous deaths at HMP Oakwood

24. Mr Martin was the 12<sup>th</sup> prisoner to die at Oakwood since October 2017. Of the previous deaths, 10 were from natural causes and one was a drug-related death. There have been four deaths since Mr Martin's, all from natural causes.
25. We have previously made recommendations about the lack of care plans and medication delays in our reports into deaths at Oakwood in July and November 2019.

## Key Events

26. On 4 July 2019, Mr Stephen Martin was sentenced to 18 months in prison for the fraudulent evasion of VAT. It was his first time in prison. He was sent to HMP Dovegate and on 9 July, he transferred to Oakwood.
27. At his initial health screen, staff noted that Mr Martin had several chronic health conditions, including asthma, high blood pressure, acute coronary syndrome (a number of conditions that result in a reduced blood flow to the heart), a previous heart attack, high cholesterol, peripheral arterial disease (PVD, in which a build-up of fatty deposits in the arteries restricts blood supply to the leg muscles), an abdominal aortic aneurysm (AAA, a swelling in the main blood vessel that runs from the heart), and an aneurysm in the femoral artery (a swelling in the artery in the groin). In 2011, he had had surgery to remove plaque (fatty deposits) causing a blockage in his femoral artery.
28. Healthcare staff saw Mr Martin frequently to monitor and treat his medical conditions. Prison GPs prescribed appropriate medications and he was sent to hospital regularly for cardiovascular disease appointments.
29. On 24 July, Mr Martin told a prison GP that he had pain in both legs. On 31 July, she made a referral to the vascular team at a hospital and asked the prison nurses to monitor his blood pressure for any readings above 145/85mmHg (which was monitored as requested until 20 September). On 14 August, a prison GP noted that a lump in Mr Martin's left leg had increased. She contacted the hospital again because she considered that an urgent referral was needed.
30. The hospital made an appointment for 16 August, but prison staff asked for an alternative date because they did not have any escorting staff available. Mr Martin's appointment was cancelled. Hospital staff rearranged the appointment for 19 August but again, there were no escorts available and Mr Martin could not attend his appointment.
31. The appointment was rebooked for 21 August, and he attended. After examination, hospital specialists suspected a thrombosed aneurysm (an aneurysm blocked by a blood clot). They admitted him to hospital for further tests.
32. On 29 August, Mr Martin had surgery to insert a stent in an attempt to keep the artery in his leg open and restore normal blood flow. A follow-up appointment was planned for four weeks' time.
33. Mr Martin returned to Oakwood on 5 September with a 28-day supply of medication. A medical technical officer requested a prescription for Mr Martin. However, he did not receive his medication for eleven days despite attending the medication hatch for it.
34. The following day (6 September), Mr Martin reported pain at his surgery site. When the stitches were removed six days later, the wound was found to be infected and Mr Martin was prescribed antibiotics.

35. After 20 September, there were no further entries in Mr Martin's medical record to indicate that healthcare staff continued to monitor his blood pressure.
36. On 24 and 29 September, Mr Martin told a nurse that he still had pain in his leg. The hospital scheduled an appointment for Mr Martin's post-surgery follow up on 16 October. However, on 8 October, the prison cancelled the appointment due to the unavailability of escorts. The hospital rescheduled the appointment for 13 November.
37. Mr Martin shared a cell. His cellmate said that Mr Martin slept on the bottom bunk. He said that on the night of 27 October, they had watched a film and Mr Martin got out of his bunk, made a cup of coffee and ate two oranges. He asked his cellmate to turn the television off.

### **Events on 29 October 2019**

38. His cellmate told the investigator that the following morning, he woke up, left the cell and went to the gym at 7.45am. Mr Martin was sleeping. At around 8.50am, he returned to the cell and found Mr Martin lying face down on the floor. After checking him, he ran out of the cell and called a Prison Custody Officer (PCO) for help.
39. The PCO entered the cell and saw Mr Martin on the floor. She checked for a pulse, but did not find one. She went out of the cell and radioed a "code blue" medical emergency (indicating a life-threatening incident involving breathing difficulties). Communications room staff called an ambulance immediately.
40. Two nurses and prison staff responded to the emergency call. A nurse noted that there was a little blood on the floor beside Mr Martin. She checked for a pulse but there was none. Prison officers carried Mr Martin out of the cell onto the landing and immediately began CPR. The nurses then helped with the resuscitation attempt. Staff used the defibrillator, which did not detect a shockable heart rhythm.
41. The ambulance arrived at 9.04am. The paramedics reached the landing area and continued with emergency treatment. At 9.38am, a paramedic confirmed that Mr Martin had died.

### **Contact with Mr Martin's family**

42. On 29 October, the prison appointed a PCO as the prison's family liaison officer (FLO). Mr Martin had named his next of kin. The FLO contacted the prison FLO at HMP Altcourse to visit her to inform her of his death as that was the nearest prison to her address. As Mr Martin's wife was in prison, the FLO also arranged for prison staff to inform her of Mr Martin's death.

### **Support for prisoners and staff**

43. After Mr Martin'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. The staff care team also offered support.
44. The prison posted notices informing other prisoners of Mr Martin'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 Martin's death.

### **Post-mortem report**

45. The post-mortem report gave Mr Martin's cause of death as acute cardiac failure caused by ischaemic heart disease (a build-up of fatty deposits in the arteries).

# Findings

## Clinical care

46. The clinical reviewer concluded that the clinical care Mr Martin received at Oakwood, was broadly satisfactory and equivalent to that which he could have expected to receive in the community. She said that the emergency response was timely and well delivered.
47. The clinical reviewer did, however, identify some concerns.

## Care plans

48. Prison Service Order (PSO) 3050, *Continuity of Healthcare*, emphasises the importance of continuity in clinical interventions and treatment.
49. Mr Martin did not have any care plans in place for his chronic health conditions at Oakwood. The clinical reviewer also noted that when Mr Martin returned from hospital, healthcare staff did not create a wound care plan to record how to care for his surgery wounds.
50. After 20 September, staff failed to record Mr Martin's blood pressure checks. A record of his blood pressure could have enabled staff to better assess any improvements or deterioration in his condition. We make the following recommendation:

**The Head of Healthcare at HMP Oakwood should ensure that healthcare staff create and document care plans for all prisoners with chronic and/or life limiting conditions.**

## Delays receiving medication

51. Prescription requests at Oakwood are made on the afternoon or evening when a prisoner arrives into prison. The next day, arrangements are put in place for prescribing and dispensing of medication.
52. When Mr Martin returned to Oakwood on 5 September following his operation, he did not receive his medication for 11 days. The Head of Healthcare investigated the reason why and concluded that the oversight was due one pharmacy team member who at that time was receiving supervision and support. The Head of Healthcare said that the medicines operating procedure had been updated and a system was now in place to identify medication which requires urgent processing.
53. Although we note that Mr Martin did receive his medication in the six weeks before his death, this is the second time we have identified a delay in a prisoner receiving medication at Oakwood following his return from hospital. We repeat the following recommendation:

**The Head of Healthcare must ensure that there is no delay in prisoners receiving prescribed medication.**

54. The clinical reviewer has made number of additional recommendations which we do not repeat in this report but which the Head of Healthcare at Oakwood will wish to address.

### Cancelled hospital appointments

55. Mr Martin's medical records show that three hospital appointment were cancelled by the prison on 16 and 19 August and 16 October, due to a lack of prison staff to provide escorts.
56. A nurse told the investigator that the number of escort staff per day was limited to eight prison officers, which usually translated to four hospital appointments. She was responsible for triaging the list of prisoners with hospital appointments to decide a clinical rationale for the allocation of escorts. She said that other prisoners were a higher clinical priority than Mr Martin on the days his appointments were cancelled.
57. The Head of Healthcare told the investigator that NHS funding had been sought for the prison to have its own scanner, to reduce the number of hospital trips for scans.
58. We are particularly concerned that there were two cancelled appointments in August after a prison GP considered that Mr Martin needed an urgent referral to hospital. Although the hospital booked Mr Martin an appointment on 16 August, two days after the prison GP's referral, both this appointment and a rearranged appointment on 19 August were cancelled by the prison and as a result Mr Martin was not seen until 21 August. We do not consider that this aspect of Mr Martin's healthcare in prison was equivalent to that he could have expected in the community.
59. The clinical reviewer was satisfied that the nurse's decisions about which hospital appointments should be cancelled showed appropriately rationalised clinical judgement. We also recognise that the limit on the number of hospital escorts each day is not in the direct control of healthcare staff. We would expect, however, that senior healthcare staff would tell prison managers if they considered that more escorts were required for clinical reasons on any particular day and would not simply accept the limit as a 'given'.
60. The clinical reviewer could not say if that the cancellation of Mr Martin's appointments impacted on the clinical care he received or contributed to his death, but it may have done. Such cancellations could also have a significant impact in other cases.
61. We make the following recommendation:

**The Director and Head of Healthcare should ensure that sufficient staffing resources are allocated to hospital escorts to meet the health needs of the population, that hospital appointments are cancelled only as a last resort and at no detriment to a prisoner's health and that staff clearly record the reasons for such cancellations.**



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