

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Maddock, a prisoner at HMP Rye Hill, on 7 December 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 Maddock died from acute pancreatitis on 7 December 2019, at HMP Rye Hill. He was 59 years old. I offer my condolences to Mr Maddock's family and friends.

The investigation found that the officer who unlocked Mr Maddock's cell on the morning of 7 December, failed to do a welfare check and therefore did not identify that Mr Maddock was dead on his cell floor. It took another half an hour before other prisoners alerted staff.

Although this failure did not affect the outcome for Mr Maddock, as it appears he had been dead for some time, it is essential that unlock procedures are carried out correctly so that any welfare needs are identified and addressed as soon as possible.

Mr Maddock had rigor mortis when he was found, which indicates that he had been dead for at least two hours. He was almost certainly dead when the 7.15am roll check was carried out, and possibly also at the 6.00am roll check. I am very concerned that the officers carrying out these checks failed to identify that Mr Maddock was dead.

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**

**May 2020**

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# Summary

## Events

1. On 9 April 2015, Mr Stephen Maddock was sentenced to 16 years imprisonment for sexual offences. He was moved to HMP Rye Hill on 27 September 2019.
2. Mr Maddock had diabetes and hypertension (high blood pressure) for which he received medication. He was also clinically obese.
3. On the evening of 6 December, Mr Maddock failed to collect his dinner. When an officer went to check on him, he told him that he was feeling nauseous. The officer told him to use his cell bell if he needed help after the cells were locked for the night. Mr Maddock did not use his cell bell overnight.
4. On 7 December 2019 at 6.00am, an officer carried out a roll check (count of prisoners) on Mr Maddock's wing. He reported no concerns. Another officer carried out a roll check at 7.15am, and again reported no concerns.
5. At 8.00am, an officer unlocked Mr Maddock's cell. About half an hour later, prisoners called for staff after they had found Mr Maddock on his cell floor. He had rigor mortis, which indicated that he had been dead for some time (rigor mortis normally sets in two to six hours after death). Staff did not try to resuscitate him. Ambulance paramedics pronounced him dead at 8.50am.
6. The post-mortem examination found that Mr Maddock died from acute pancreatitis (inflamed pancreas). Fatty liver cirrhosis (scarring of the liver causing it to stop working properly) was listed as a contributory factor.

## Findings

7. The clinical reviewer was satisfied that overall, the healthcare Mr Maddock received at Rye Hill was of a standard equivalent to that he could have expected to receive in the community. She made no recommendations.
8. When unlocking a prisoner's cell, the officer is supposed to get a response from the prisoner to satisfy themselves that they are alive and well. This did not happen, which meant that no one realised that Mr Maddock was dead for another half an hour. Following Mr Maddock's death, the Director of Rye Hill reissued a notice to staff reminding them of the unlock procedures. The officer who unlocked Mr Maddock's cell was dismissed following a disciplinary investigation.
9. The fact that Mr Maddock had rigor mortis when he was discovered at around 8.30am, indicates that he was almost certainly dead when the 7.15am roll check was carried out, and possibly also at the 6.00am roll check. We are concerned that neither roll check was carried out correctly despite two notices having been issued to staff in 2019 reminding them of the correct procedures.

## Recommendations

- The Director of Rye Hill should ensure that all staff understand what is expected of them when conducting roll checks and that all staff adhere to these expectations.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Rye Hill informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of the relevant extracts from Mr Maddock's medical and prison records.
12. NHS England commissioned an independent clinical reviewer to review Mr Maddock's clinical care at the prison.
13. We informed HM Coroner for Northamptonshire of the investigation. The coroner provided us with the results of the post-mortem. We have sent the coroner a copy of this report.
14. Mr Maddock was estranged from his family and his nominated next of kin was his Offender Manager (probation officer). The PPO investigator contacted him and he provided details for Mr Maddock's sister and daughter. His sister became his next of kin. One of the Ombudsman's family liaison officers contacted her, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.
15. The initial report was shared with the Prison Service. The Prison Service pointed out a name correction and two date inaccuracies in the clinical review. This report has been amended accordingly.

# Background Information

## HM Prison Rye Hill

16. HMP Rye Hill is run by G4S and holds over 600 men convicted of sex offences. G4S Forensic and Medical Services provide primary, physical and mental health services. The prison does not have an inpatient facility.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Rye Hill was in September 2019. Inspectors noted that the prison held a complex mix of serious sex offenders. At the previous inspection in 2015, inspectors said that the quality of healthcare services was the weakest area of the prison. In 2019, they found improvements in most healthcare areas previously identified as underperforming, and that strong leadership had driven improvements in primary care services.
18. They said that long term conditions were found to be reasonably well managed, and that appointment times to see doctors were reasonable. Social care provision was found to be good.
19. Inspectors found that there were still healthcare staff shortages but these were better managed than before with well-integrated agency staff. However, there were still some gaps in the mandatory training of healthcare staff, and IT problems impacted disproportionately on healthcare delivery.

## Independent Monitoring Board

20. 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 healthcare provision remained under pressure in some respects, but was continuing to improve. They also expressed concerns about whether there was sufficient resourcing to cater for an ageing prison population.

## Previous deaths at HMP Rye Hill

21. Mr Maddock was the 12th prisoner to die at Rye Hill since December 2017. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation of Mr Maddock's death and the other deaths.

## Key Events

22. On 8 April 2015, Mr Stephen Maddock was convicted of sexual offences. The next day, he was sentenced to 16 years imprisonment. He was sent to HMP Exeter.
23. On 28 May, he was moved to HMP Isle of Wight, where he remained for the next four years. Mr Maddock had difficulty accessing offender treatment programmes because of his limited literacy. On 27 September 2019, he was moved to HMP Rye Hill to enrol on the treatment programmes there.
24. Mr Maddock had several health issues and was clinically obese. At Rye Hill he received medication for hypertension (high blood pressure) and diabetes, as well as medication which controlled his depression and which had been prescribed for many years. Mr Maddock had mild learning difficulties and there was a care plan in place for this and his other conditions. He was diagnosed with subclinical hyperthyroidism in January 2019, but he refused to attend an endocrinology appointment in June 2019. He had a history of refusing to attend medical appointments.

### Events of 6–7 December

25. On the evening of 6 December, an officer was told by a colleague that Mr Maddock had not collected his food. He went to his cell to check on him and asked if he would like his meal. Mr Maddock said that he did not, as he was feeling nauseous. The officer suggested that he might have a stomach bug and that if he needed to be seen by a nurse after the cells were locked, he should use his cell bell to get help. The cell bell record shows that Mr Maddock did not activate his cell bell overnight.
26. At 6.00am on 7 December, an officer carried out a roll check (count of prisoners) on Mr Maddock's wing. He reported no concerns. At 7.15am, another officer carried out another roll check. Again, he reported no concerns.
27. At 8.00am, an officer unlocked Mr Maddock's cell. However, she did not check on Mr Maddock. At 8.32am, prisoners alerted the officer that Mr Maddock was lying on his cell floor. She called a code blue on her radio (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties, which alerts healthcare staff and prompts the control room to call an ambulance).
28. Another officer who was elsewhere on the wing, attended at 8.34am, in response to shouts from prisoners and the officer who had originally unlocked the cell. Healthcare staff arrived a few minutes later. Neither the officers nor healthcare staff attempted resuscitation as there were signs of rigor mortis (stiffness of the limbs that normally sets in around two to six hours after death).
29. At 8.50am, Mr Maddock was pronounced dead by paramedics.

### **Contact with next of kin**

30. Mr Maddock was estranged from his family and said he had no friends outside prison. He did not have any visitors or make phone calls. His Offender Manager was listed as his next of kin.
31. The prison contributed towards Mr Maddock's funeral in line with national guidance.

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

32. After Mr Maddock's death, the Duty Director debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
33. The prison posted notices informing other prisoners of Mr Maddock's death, and offering support.

### **Post-mortem report**

34. A post-mortem examination showed that Mr Maddock died from acute pancreatitis (inflamed pancreas). Fatty liver cirrhosis (scarring of the liver causing it to stop working properly) was listed as a contributory factor.

# Findings

## Clinical care

35. Mr Maddock had hypertension, diabetes and obesity. The clinical reviewer found that Rye Hill managed these conditions appropriately. Mr Maddock also had a mild learning difficulty, but the clinical reviewer agreed that he had mental capacity. She was satisfied that the care Mr Maddock received was equivalent to that which he could have expected to receive in the community
36. The clinical reviewer made no recommendations.

## Unlock procedures

37. Mr Maddock was dead when he was discovered on the floor of his cell at 8.32am. He had rigor mortis, which meant that he had been dead for some time. An officer unlocked Mr Maddock's cell at 8.00am, but failed to notice that he was dead on the floor.
38. Prison Service Instruction 75/2011, *Residential Services*, states:

“Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight, apparently from natural causes, but staff unlocking them have not noticed that the prisoner had died. This is not acceptable.

“The appropriate arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”
39. When the officer unlocked Mr Maddock's cell, she should have checked his welfare and obtained a response from him. She failed to do so. Rye Hill carried out a disciplinary investigation and the officer was dismissed. The Director of Rye Hill also reissued a notice to staff on 9 December, setting out the correct unlock procedures. As action has been taken, we make no recommendation.

## Roll checks

40. Given that Mr Maddock had rigor mortis when he was found dead in his cell at 8.32am, it is almost certain that he was already dead at the 7.15am roll check, and quite possibly at the 6.00am check.
41. Rye Hill issued two notices to staff in 2019, reminding them of the roll check procedures, one dated 25 January, and the other, 16 August. Both these emphasise that heads must be counted, and not empty spaces. To do this, the officer has to look through the cell's observation panel.
42. The PPO investigator watched the wing CCTV but the quality of the video means that it is not possible to take a definitive view on the extent of the roll checks into

Mr Maddock's cell. However, while the matter is more ambiguous in the case of the officer who carried out the earlier roll check, the likelihood is that Mr Maddock was dead on the floor when another officer carried out his roll check at 7.15am, and he has been issued with a final written warning by Rye Hill.

43. We are concerned that despite Rye Hill issuing notices in January and August 2019, reminding staff about the correct roll check procedures, it is apparent from this case that officers are not properly looking into cells to check that the occupant is there and that there are no immediate issues that need attention. We consider that more needs to be done to ensure that roll checks are carried out properly and we make the following recommendation:

**The Director of Rye Hill should ensure that all staff understand what is expected of them when conducting roll checks and that all staff adhere to these expectations.**

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