

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Cameron West a prisoner at HMP Oakwood on 3 June 2018

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 I oversee can improve their work in the future.

Mr Cameron West died on 3 June 2018 of epilepsy, which was influenced by illicit substance misuse, while a prisoner at HMP Oakwood. Mr West was 26 years old. I offer my condolences to Mr West's family and friends.

I am satisfied that the clinical care Mr West received was equivalent to that he could have expected in the community. He had a history of epilepsy and was not always compliant with his medication.

Although the post-mortem report found that Mr West had used illicit drugs before his death, I am satisfied that staff had no suspicions that he was using illicit substances. There was no record of any substance misuse by Mr West while he was at Oakwood.

I consider that the prison's decision to inform Mr West's family of his death by telephone was appropriate in the circumstances of this case.

I have made no recommendations.

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

January 2020

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Summary

Events

1. In February 2018, Mr Cameron West was sentenced to two years' imprisonment for sexual offences. He was transferred to HMP Oakwood on 16 April.
2. At his reception health screen, a nurse noted Mr West's long history of epilepsy. Mr West also had a history of substance misuse and drug-induced mental illness.
3. During the morning of 6 May, Mr West had an epileptic attack and was treated by healthcare staff. At midday he had another epileptic attack. Healthcare staff administered drugs to treat his seizure and gave him oxygen. An ambulance took Mr West to hospital where he was treated further.
4. Following his return to Oakwood, a nurse noted that Mr West was not compliant with his epilepsy medication. She explained to him the importance of taking it. Mr West was reviewed by the mental health team and added to their caseload.
5. On the morning of 3 June, staff saw Mr West walking about on the wing. At approximately 11.40am, an officer triggered an emergency when he discovered Mr West unresponsive in his cell. Other officers and healthcare staff arrived promptly and started life support procedures. An ambulance arrived shortly afterwards and took Mr West to hospital.
6. At 1.05pm, the hospital pronounced Mr West dead.

Findings

Clinical Care

7. We agree with the clinical reviewer that the care Mr West received at Oakwood was equivalent to that he could have expected in the community. The prison was aware of his epilepsy and encouraged him to take his medication.

Illicit substance misuse

8. The post-mortem found that Mr West's death was influenced by the use of psychoactive substances (PS). The prison had no intelligence recorded that Mr West was, or had been, using illicit substances at Oakwood and there is no indication that staff suspected he was taking anything.

Emergency response

9. We are satisfied that the emergency response was triggered immediately and that all staff acted promptly and effectively.

Family contact

10. We recognise that the prison informed Mr West's family of his death by telephone, rather than in person, but are satisfied that this was appropriate in the circumstances.

Recommendations

- We make no recommendations in this case.

The Investigation Process

11. 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. No one responded.
12. The investigator obtained copies of relevant extracts from Mr West's prison and medical records.
13. A second investigator then assumed responsibility for the investigation and obtained additional information from the prison.
14. NHS England commissioned an independent clinical reviewer to review Mr West's clinical care at the prison.
15. We informed HM Coroner for Staffordshire South of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr West's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr West's family had no questions but asked to be sent a copy of our report.
17. Mr West's family received a copy of the initial report. They did not make any comments.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

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 most recent inspection of HMP Oakwood was conducted 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 that staff created appropriate care plans.

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 March 2018, the IMB reported that there had been an increased number of deaths at Oakwood, but that this reflected the ageing population. The Board also reported that a Learning from Experience Group had been set up to review recommendations from clinical reviews, PPO investigations and Coroners. The group highlighted themes and shared learning. The Board had some concerns about the number of staff vacancies in the healthcare department.

Previous deaths at HMP Oakwood

22. Mr West was the seventeenth prisoner to die of natural causes at Oakwood since January 2016. We have previously made recommendations about failings in the emergency response but note that the emergency response in this case was prompt and efficient.

Psychoactive Substances (PS)

23. Psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.
24. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the

dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

26. Mr Cameron West had spent significant periods of his adult life in prison. In October 2017, he was remanded in custody to HMP Birmingham. On 12 February 2018, Mr West was sentenced to two years' imprisonment for sexual offences. He was returned straight to Birmingham.
27. In 2009, Mr West had been stabbed five times in his abdomen. He had emergency surgery to repair his aorta (the main blood vessel leading from the heart) and his intestines. In 2010, Mr West had been struck by a bus and sustained brain trauma. Following this accident, Mr West was diagnosed with epilepsy. He had also suffered a serious fall from a significant height onto concrete. In 2016 he was diagnosed with hepatitis C (a blood born viral infection).
28. Mr West had a history of mental health issues and had been diagnosed with drug-induced psychosis. Mr West also had a history of substance misuse, including PS.
29. On 16 April, Mr West was transferred to HMP Oakwood. He was initially located in the Vulnerable Prisoner Unit but immediately requested a transfer to a standard wing. Mr West was relocated to a standard cell within a few days.
30. A nurse reviewed Mr West at a health screen on his reception at Oakwood. She recorded his history of epilepsy, hepatitis C and his diagnosis of psychosis. The nurse noted that Mr West should have an epilepsy care plan. She also documented that Mr West was prescribed lamotrigine (to treat epilepsy) and olanzapine (to treat his psychosis). The nurse recorded that Mr West was fit for work and to live in a standard cell.
31. On the morning on 6 May, a First Line Manager (FLM) called a code blue emergency after Mr West's cell mate discovered him having a fit. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing. It triggers the immediate attendance of healthcare staff and alerts the control room to call for an ambulance.) A nurse responded to the call and noted that Mr West was experiencing a seizure when she arrived. She recorded that Mr West recovered without assistance and was helped onto his bed by officers. The nurse examined Mr West and noted that his airway was clear and his observations were fine. She asked officers to monitor him closely for the next few hours and seek help if they had any concerns.
32. At midday, the nurse responded to another code blue emergency after Mr West was observed having another seizure. She noted that Mr West was on the floor of his cell and that an officer said he had been in seizure for approximately five minutes. The nurse examined Mr West and recorded that his forehead was swollen, he had a cut above his eye and was bleeding from his mouth, having bitten his tongue. She observed that Mr West's pupils were dilated and non-reactive and that he had a GCS score of 6. (The Glasgow Coma Scale (GCS) defines a person's level of consciousness.) The nurse observed that Mr West started to seize again after a few minutes, his jaw locked and his respiratory rate dropped. She administered oxygen and diazepam (used to treat seizures). The

nurse noted that the ambulance then arrived and took Mr West to hospital. The nurse recorded that Mr West was known to be non-compliant with his medication.

33. On 15 May, the nurse reviewed Mr West. She noted that Mr West was still not compliant with his medication and she explained to him the importance of complying with it.
34. The next day, a member of the mental health team assessed Mr West. She noted that Mr West was not taking his anti-epilepsy drugs. She added Mr West to the mental health caseload and ensured he was allocated a caseworker. She also noted that he had a history of substance misuse, including heroin, cocaine and PS.
35. On the morning of 3 June, an officer unlocked Mr West's cell. He reported that he observed movement from both Mr West and his cell mate. Sometime between 9.00am and 9.30am, an officer reported seeing Mr West walking about on the wing.

Emergency response

36. At approximately 11.40am, a prisoner beckoned an officer over to Mr West's cell. When the officer arrived, Mr West was on the top bunk of the cell and two prisoners were shaking him. He reported that Mr West was lying still and that the mattress was covered in a liquid. The officer called a code blue emergency on his radio and then tried to place Mr West in the recovery position on the top bunk. Shortly afterwards, two officers and a FLM arrived. An officer escorted the other prisoners out of the cell and stood outside to ensure no one entered. The FLM reported that healthcare arrived at this point.
37. Two nurses responded to the code blue emergency. One of the nurses assessed Mr West and reported that he was unresponsive. The other nurse asked officers to lower Mr West to the floor so she could start cardiopulmonary resuscitation (CPR). She asked an officer to start chest compressions while she attached a breathing tube to deliver breaths. The other nurse requested a defibrillator, and noted that when it was first attached, it advised that no shock should be administered. She asked officers to clear the wing so that they could move Mr West onto the landing. CPR was continued by rotation by those staff present until the ambulance arrived.
38. A prison paramedic recorded that he responded to the emergency call and arrived at 11.45am. He noted that Mr West was unresponsive, his pupils were fixed and dilated, and he had a GCS of 3. He observed that there were no evident injuries. He worked alongside the other healthcare staff and administered adrenaline to Mr West to try to stimulate his heart.
39. At 11.54am, the ambulance arrived at the prison. At 11.59am, ambulance staff reached Mr West and took over life support duties from prison healthcare staff. The ambulance crew recorded that they performed three shocks with the defibrillator before taking Mr West to New Cross Hospital in Wolverhampton.
40. The hospital confirmed Mr West's death at 1.05pm.

Post-mortem report

41. The post-mortem concluded that Mr West's death was caused by epilepsy which was influenced by PS usage. Toxicology tests revealed two different types of PS in Mr West's blood. The pathologist documented that one of the substances had been implicated as being a contributory factor in several deaths in the past. Toxicology also revealed lamotrigine in Mr West's blood at the lower end of the therapeutic range.
42. The post-mortem recognised that Mr West had developed epilepsy following a traumatic event experienced many years earlier when he was hit by a bus.

Contact with Mr West's family

43. Mr West's next of kin was his mother. On 3 June, following Mr West's death, the prison appointed a family liaison officer (FLO). A prison manager explained to the FLO that Mr West had been sharing a cell with his cousin. They discussed their concerns that his mother would find out about his death indirectly from other prisoners, so decided to inform her themselves by telephone instead of journeying to her home to inform her in person.
44. At 2.15pm, the FLO telephoned Mr West's mother to inform her of her son's death. Mr West's mother said that she wanted to see her son, so the FLO agreed to collect her from her home and take her to the hospital. On their way, the FLO also picked up Mr West's mother's sister, at her request.
45. Mr West's funeral was held on 3 July. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

46. After Mr West'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.
47. The prison posted notices informing other prisoners of Mr West'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 West's death.

Findings

Clinical Care

48. We agree with the clinical reviewer that the care Mr West received at Oakwood was equivalent to that he could have expected in the community. Healthcare staff were aware of Mr West's epilepsy, and he was prescribed medication to treat this. When it became clear that he was not complying with his medication, nursing staff and the mental health team explained the importance of taking the medication to him.

Management of illicit substance misuse

49. The post-mortem report concluded that Mr West had PS in his system at the time of his death. It also recorded that PS contributed to the epilepsy attack which caused his death. Staff were aware that Mr West had a history of substance misuse, including PS, but there is no record of any suspicion that he had taken PS during his time at Oakwood.
50. We are satisfied that the prison had no reason to suspect PS use on the part of Mr West. There were no reports or suspicions of Mr West taking PS during his time at Oakwood. His electronic prison record contains no mention of any relevant events. There were no intelligence reports about suspicions of Mr West taking illicit substances. His electronic medical records contain no mention of any suspicions of drug use, and he was never treated for PS use during his time at Oakwood.

Emergency response

51. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system in place. A code blue call should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance.
52. As soon as Mr West was discovered unresponsive, a code blue emergency was called and both prison and healthcare staff attended promptly. Staff appropriately started CPR without delay and attached a defibrillator. Oakwood employ a qualified paramedic, who also attended promptly, and administered adrenaline to try to address Mr West's cardiac arrest.
53. We are satisfied that prison staff acted promptly and did all they could to save Mr West's life.

Family contact

54. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

55. We are satisfied that the prison conducted its family contact appropriately. While we recognise that the PSI requires prisons to inform families of a prisoner's death in person, we accept that the prison assessed the particular circumstances in this instance and made an appropriate judgement call to inform his mother by telephone. We also recognise that this decision was carefully considered and appropriately documented.
56. We also note that the prison made additional efforts to ensure that they assisted Mr West's mother and her sister to reach the hospital as soon as possible. We would like to commend the FLO for making this extra effort to assist Mr West's family.

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