Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shaun Riley, a prisoner at HMP Oakwood, on 7 September 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Shaun Riley died of sudden unexpected death in epilepsy on 7 September 2019 at HMP Oakwood. He was 29 years old. I offer my condolences to his family and friends.

Mr Riley was transferred from HMP Birmingham to HMP Hewell and then to HMP Oakwood in the months before he died.

The clinical reviewer concluded that, overall, the care that Mr Riley received at HMP Oakwood was equivalent to that which he could have expected to receive in the community.

However, I am concerned that that healthcare staff at Hewell and Oakwood did not review or re-request Mr Riley's community medical record from his GP, particularly as he told them that he had a history of epilepsy.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **January 2021**

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Summary

Events

1. On 16 March 2019, Mr Shaun Riley was remanded to HMP Birmingham, charged with drug offences.

2. Mr Riley told healthcare staff at HMP Birmingham that he had a history of blackouts but that he had had tests that showed both normal and abnormal results. He said that he had declined taking medication and had a follow-up appointment at hospital.

3. In line with the prison's security policy, Mr Riley's hospital appointment was cancelled because he knew the date, and he was added to the waiting list for another appointment.

4. Healthcare staff asked for Mr Riley's medical record from his community GP and a healthcare administrator attached a patient summary to his electronic medical record.

5. On 25 March, Mr Riley was sentenced and sent to HMP Hewell. He told healthcare staff that he had a history of seizures, that a scan had shown no issues and that he was not taking any medication.

6. On 2 April, Mr Riley was transferred to HMP Oakwood. Mr Riley told healthcare staff that he had a history of epilepsy but that he did not have seizures often and no medication was needed.

7. On 10 April, Mr Riley received an appointment at a hospital's neurology department for 26 April. Healthcare staff planned to refer Mr Riley to a more local hospital but did not know why he had been referred, despite his patient summary stating that his community GP had referred him due to him suffering from day time "sleep waking". The hospital did not have the original referral, and a prison GP made the decision to take no further action.

8. On 3 September, Mr Riley told a nurse that he had not had a follow-up appointment, and the nurse referred Mr Riley to the prison GP for an appointment.

9. At 12.10pm on 7 September, an officer found Mr Riley in his cell, lying on the floor. He radioed for emergency medical assistance as Mr Riley was not breathing, and started cardio pulmonary resuscitation (CPR).

10. At 12.11pm, an ambulance was called for Mr Riley. Healthcare staff attended the incident and continued CPR.

11. At 12.31pm, paramedics arrived but their attempts to resuscitate Mr Riley were unsuccessful. At 12.52pm, paramedics confirmed that Mr Riley had died.

Findings

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

13. She concluded that it was reasonable that the prison GP at HMP Oakwood did not re-refer Mr Riley for a neurology appointment as despite efforts to find out, it was not clear why he was being referred. However, we are concerned that healthcare staff at Oakwood, and at Hewell, failed to either review Mr Riley's community GP patient summary or to re-request it if they had been unable to find it. Had they done so, they would have known why Mr Riley had been referred to the neurology department.

14. We are also concerned that healthcare staff at Hewell and Oakwood failed to request Mr Riley's community medical records when he told them that he had a history of epilepsy.

Recommendation

- The Heads of Healthcare at HMP Hewell and HMP Oakwood should ensure that, when prisoners are transferred from other prisons, healthcare staff review or request community GP summaries for them if they report medical conditions.

The Investigation Process

15. 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.

16. The investigator visited HMP Oakwood on 7 November 2019. She obtained copies of relevant extracts from Mr Riley's prison and medical records.

17. The investigator interviewed three members of staff at HMP Oakwood on 7 November 2019.

18. NHS England commissioned a clinical reviewer to review Mr Riley's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

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

20. One of the Ombudsman's family liaison officers contacted Mr Riley's next of kin to explain the investigation and to ask if she had any matters she wanted us to consider in the investigation. Mr Riley's next of kin did not have any specific questions.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

22. Mr Riley's next of kin received a copy of the initial report and indicated that she was satisfied with the findings.

Background Information

HMP Oakwood

23. 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

24. 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. They noted that 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, they found that there were often delays in arranging hospital appointments because of the high demand and insufficient escort staff.

Independent Monitoring Board

25. 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

26. Mr Riley's death was the twelfth at Oakwood since September 2017. Of those deaths, 11 were from natural causes. There are no similarities between Mr Riley's death and any of the previous deaths at HMP Oakwood. Since Mr Riley died, there have been three more deaths at Oakwood from natural causes and one death which is yet to be classified.

Key Events

27. On 16 March 2019, Mr Shaun Riley was remanded to HMP Birmingham, charged with drug offences.

28. On 16 March, a nurse completed Mr Riley's initial health screen. Mr Riley told the nurse that that he had a history of blackouts. He said that he had had an electrocardiogram (ECG - a test to check the rhythm and electrical activity of the heart), and that the result was abnormal. He said that he had also had a magnetic resonance imaging (MRI - a medical imaging technique used in radiology) scan, and that the result was normal. Mr Riley told the nurse that it had been suggested that he should take medication but that he had declined it, and that he had a follow-up appointment on 13 April. The nurse referred Mr Riley for an ECG, and to the Wellman's Clinic for a general follow-up to check his overall health. A request was made to Mr Riley's GP for his medical record.

29. That day, a nurse completed an ECG for Mr Riley and sent the results to the GP. The results showed no abnormalities.

30. On 18 March, a nurse reviewed Mr Riley as part of the Wellman's Clinic. Mr Riley declined a sexual health screen.

31. That day, a nurse noted in Mr Riley's medical record that an epilepsy care plan had been put in place, and that he had been referred to the GP for a routine review.

32. Later, a pharmacy technician noted that on 30 April 2018, Mr Riley's community GP had prescribed him an anti-epileptic drug but that it had not been prescribed again.

33. On 19 March, a healthcare administrator attached a patient summary from his community GP to Mr Riley's electronic medical record (known as SystmOne). Later that day, a receptionist at Mr Riley's community GP attached the same information to SystmOne.

34. On 20 March, an administrator noted that Mr Riley had an appointment booked for 15 April at a hospital's neurology department. In line with prison security policy, the appointment was cancelled as Mr Riley knew the date. The administrator noted that the hospital had put Mr Riley on the waiting list for another appointment.

35. On 25 March, Mr Riley was sentenced to three years and three months in prison and sent to HMP Hewell. A nurse completed Mr Riley's initial health screen and noted that he said he had a history of seizures, that an MRI scan had shown no issues and that he was not taking any medication. No one reviewed Mr Riley's community GP patient summary or requested his community medical records.

36. On 2 April, Mr Riley was transferred to HMP Oakwood. A nurse completed Mr Riley's reception screen and noted that Mr Riley said he had a history of epilepsy but that he did not have seizures often and no medication was needed. No one reviewed Mr Riley's community GP patient summary or requested his community medical records.

37. On 3 April, a nurse completed Mr Riley's secondary health screening. She noted that Mr Riley appeared to be mentally and physically well. The nurse noted that Mr Riley did not have any health concerns and did not want to be referred to anyone in the healthcare team at that time.

38. On 10 April, an administrator noted in Mr Riley's medical record that he had received an appointment for 26 April at a hospital's neurology department. On 15 April, the administrator noted that she had tried to refer Mr Riley locally but a hospital could not find the original referral and were not sure why he had been referred to them. A prison GP was told that the hospital did not have the original referral and he decided to take no further action.

39. On 29 April, the prison received a discharge letter for Mr Riley from a hospital's neurology department as he did not attend his appointment.

40. On 3 September, Mr Riley saw a nurse, and told her that before he came to prison, he had blackouts which were being investigated. He told her that he had had an MRI scan but no follow-up appointments. The nurse noted in Mr Riley's medical record that he said he had not had any episodes since being in prison but he was concerned that it might happen again. The nurse told Mr Riley that she would refer him to the GP for an appointment, and noted that he was happy with the plan.

41. At 8.00am on 7 September, an officer completed prisoner welfare checks. He told us that he saw Mr Riley move in bed.

42. At 12.10pm, the officer went in to Mr Riley's cell, and found him lying in the shower on the floor. He radioed a medical emergency code blue as Mr Riley was not breathing. The officer pulled Mr Riley out of the shower, laid him on his back and started cardiopulmonary resuscitation (CPR).

43. At 12.11pm, an ambulance was requested for Mr Riley.

44. At 12.11pm, two officers arrived at Mr Riley's cell and assisted with CPR. Prison staff moved Mr Riley onto the landing to provide more space for CPR.

45. A healthcare support worker and a nurse were the first healthcare staff to attend the incident. The healthcare support worker took over CPR from prison staff, followed by the nurse. The defibrillator was applied every two to three minutes but no shock was advised. Two other nurses also attended and supported the CPR efforts.

46. A prison paramedic told us that he arrived at Mr Riley's cell five minutes after he heard the code blue as he was located at the other end of the prison. The prison paramedic took over the CPR and checked Mr Riley's vital signs. He told us that he did not find a pulse and that Mr Riley was unresponsive. He noted that Mr Riley had abrasions to his forehead, knuckles and feet, and that his blood sugar was low. He gave Mr Riley glucose, and attached the defibrillator but again, no shock was advised.

47. At 12.31pm, the ambulance crew arrived. Paramedics gave Mr Riley adrenaline and glucose, and rechecked his blood sugar level. It had risen but there were no signs of recovery.

48. At 12.52pm, attempts to resuscitate Mr Riley were stopped, and the paramedics confirmed that Mr Riley had died.

Contact with Mr Riley's family

49. On 7 September, an officer was appointed as the family liaison officer.

50. At 3.40pm, the family liaison officer arrived at Mr Riley's next of kin's address, but a neighbour told the family liaison officer that Mr Riley's next of kin was abroad.

51. At 6.40pm, after receiving confirmation that Mr Riley's next of kin was abroad, the family liaison officer spoke to Mr Riley's next of kin on the telephone and informed her that Mr Riley had died. Two days later, the family liaison officer visited Mr Riley's next of kin at home, and offered his condolences and support.

52. Mr Riley's funeral took place on 26 September. Oakwood contributed to the cost, in line with national instructions.

Support for prisoners and staff

53. After Mr Riley'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.

54. The prison posted notices informing other prisoners of Mr Riley'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 Riley's death.

Post-mortem report

55. The Coroner concluded that Mr Riley died of sudden unexpected death in epilepsy.

Findings

Clinical care

56. The clinical reviewer concluded that the care that Mr Riley received at HMP Oakwood was equivalent to that which he could have expected to receive in the community. She found that there were no concerns about Mr Riley's health while he was in prison. She identified that when he expressed concern about the lack of follow-up for his blackouts, he confirmed that he had not had any since being in prison and was happy for an appointment to be arranged with a GP to discuss it.

57. The clinical reviewer found that it was not clear to healthcare staff at Oakwood why Mr Riley had been referred for a neurology appointment, and that he was not re-referred. The clinical reviewer found that a prison GP explored reasons for a re-referral, and she concluded that his decision not to re-refer Mr Riley was reasonable as there was no indication that he needed a neurology appointment. However, in these circumstances, it would have been useful for healthcare staff to have reviewed Mr Riley's community GP patient summary, due to the short time that he had spent in custody and the fact that a hospital could not locate his original referral. We expand on this issue below.

58. The clinical reviewer found that prison and healthcare staff responded promptly to the emergency on 7 September.

Requesting community medical records after a transfer

59. The clinical reviewer found that staff at Hewell and Oakwood did not review Mr Riley's community medical records or re-request them if they could not locate them in his SystmOne record.

60. The Head of Healthcare at Oakwood told the clinical reviewer that it was not standard practice to request the GP history for a transferred prisoner, unless there was a medical need to obtain them.

61. Mr Riley, however, told a nurse at his reception screening at Hewell that he had a history of fits. He also told a nurse at his reception screen at Oakwood, that he had a history of epilepsy. Healthcare staff at Hewell and Oakwood should have reviewed or re-requested Mr Riley's community medical records, particularly as he told them that he had a history of epilepsy. We make the following recommendation:

    The Heads of Healthcare at HMP Hewell and HMP Oakwood should ensure that, when prisoners are transferred from other prisons, healthcare staff review or request community GP summaries for them if they report medical conditions.

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