

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Mullen, a prisoner at HMP Oakwood, on 11 March 2021

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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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Scott Mullen died on 11 March 2021 of ischaemic heart disease at HMP Oakwood. He was 44 years old. We offer our condolences to Mr Mullen's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Mullen received at Oakwood was of a reasonable standard with some evidence of his care being equivalent to that which he could have expected to receive in the community.
5. However, she identified some serious shortcomings in Mr Mullen's aftercare when his blood test results indicated abnormal triglyceride levels, and which could have identified a potential risk of cardiovascular disease. The clinical reviewer concluded that this aspect of Mr Mullen's care was not equivalent to that which he could have expected to receive in the community. Her recommendation about this is repeated in this report.
6. The clinical reviewer also made recommendations about transfers between prisons and continuity of care, poor record keeping, management of long-term conditions and communication between healthcare and custodial staff, which the Head of Healthcare will need to address.
7. We did not find any non-clinical issues of concern.
8. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendation

- The Head of Healthcare and the Primary Care Team at HMP Oakwood should review the effectiveness of the Prison Assist GP service specifically when ongoing monitoring and follow up care is required.

Investigation Process

9. NHS England commissioned a clinical reviewer to review Mr Mullen's clinical care at the prison.
10. The PPO investigator has investigated the non-clinical issues, including Mr Mullen's location, the security arrangements for his hospital escorts and liaison with his family.
11. One of the PPO's family liaison officers wrote to Mr Mullen's next of kin to explain the investigation. She did not have any specific questions for us to consider but asked for a copy of our report.

Previous deaths at HMP Oakwood

12. Mr Mullen was the 15th prisoner to die at Oakwood since March 2019. Of the previous deaths, 12 were from natural causes, and two were possible drug related deaths which are currently under investigation. There are no similarities between our findings in the investigation into Mr Mullen's death and our investigation findings for the previous deaths.

Key Events

13. On 2 September 2019, Mr Scott Mullen was remanded to prison custody for aggravated burglary, fraud and possession of an imitation firearm. On 21 April 2020, he was sentenced to 9 years and 8 months in prison. He spent time at HMP Manchester and HMP Birmingham before transferring to Oakwood on 28 April.
14. Mr Mullen had hepatitis C, epilepsy and mental health issues including schizophrenia and dissociative personality disorder. He received medication for his conditions. On arrival at Oakwood, healthcare staff created care plans for Mr Mullen's conditions and referred him to the prison's mental health team.
15. Mr Mullen was located on Elm Unit and put into COVID-19 isolation for 14 days as part of the 'reverse cohorting' (isolation) of newly arrived prisoners. On 15 May, he was identified as being at moderate risk of developing complications if he became infected with COVID-19 due to his diagnosis of hepatitis C and was advised to shield for 12 weeks. Mr Mullen declined the advice to shield, and he signed a disclaimer to this effect. He said that he understood the potential implications of not fully shielding and was assessed as being capable of making an informed decision.
16. On the 17 September, Mr Mullen had annual physical health check. He declined to have a blood test for high cholesterol. A QRISK2 cardiovascular disease risk score (a tool that estimates a prisoner's risk of cardiovascular disease) was recorded as low.
17. During a keywork session in December, Mr Mullen said that he had initially struggled with the reduced regime and social distancing imposed due to the COVID-19 pandemic but had now got used to it and had no concerns. He raised no concerns about his physical or mental health.
18. On 12 January 2021, Mr Mullen had another physical health check. He needed to have repeated blood tests and an ECG but due to an administrative error, only the blood tests were requested. The blood test results showed that Mr Mullen had an increased triglyceride level which was above the normal range. (Abnormal levels of triglyceride can be a contributory factor to developing heart and circulatory disease.)
19. The test results were reviewed remotely by a Prison Assist GP (a GP that does not work in the prison). The GP did not see Mr Mullen and he did not request follow up care as he should have done.
20. On 1 March, Mr Mullen received his first dose of the COVID-19 vaccination.

Events on 11 March

21. At approximately 9.00am, on 11 March, prisoners on Elm Unit were unlocked to complete their morning tasks which included having a shower and cleaning their cells. At 9.30am, they were allowed to go to the exercise yard for thirty minutes. Mr Mullen went out for exercise before returning to his cell at around 9.45am. Staff said that this was not unusual, and Mr Mullen did not raise any concerns.

22. At approximately 11.40am, a Prison Custody Officer (PCO) went to unlock Mr Mullen's cell to collect his lunch. He opened the door and saw Mr Mullen sitting on a chair in the middle of the cell facing the television. The PCO said that Mr Mullen did not react when he opened the door. He said, 'Come on Scott,' but Mr Mullen did not respond. He approached Mr Mullen and said that his first thought on seeing him was that he was dead. He shouted to colleagues for assistance. The First Line Manager (FLM) arrived and radioed an emergency code blue (indicating a prisoner is unconscious or having breathing difficulties). An emergency ambulance was called at 11.43am.
23. Healthcare staff attended and attempted to resuscitate Mr Mullen until the paramedics arrived shortly before 12.00pm. Paramedics continued to treat Mr Mullen, but he did not respond. At 12.28pm it was agreed by the paramedics and prison medical staff that attempts at resuscitation should stop in order to preserve Mr Mullen's dignity. Mr Mullen was pronounced dead at 12.30pm.

Post-mortem report

24. The Coroner concluded that Mr Mullen died of ischaemic heart disease.
25. Toxicology tests found no illicit substances in Mr Mullen's body at the time of his death.

Findings

Clinical care

26. The clinical reviewer concluded that the clinical care Mr Mullen received at Oakwood was of a reasonable standard with some evidence of his care being equivalent to that which he could have expected to receive in the community.
27. However, the clinical reviewer identified some serious shortcomings in Mr Mullen's care. She was concerned about the lack of aftercare Mr Mullen received following his abnormal triglyceride level test results. She considered that following a high triglyceride level, healthcare staff should provide advice about changes to the prisoner's lifestyle and provide support to maintain healthy eating and a healthy body weight. If the triglyceride level cannot be reduced with these measures in place, healthcare staff could prescribe statin medication.
28. Mr Mullen's blood test results were reviewed remotely by an external GP who did not have any contact with Mr Mullen. The clinical reviewer was particularly concerned that the GP did not instruct any follow up advice or care following Mr Mullen's high triglyceride level results, which should have included another QRISK2 assessment, health and lifestyle advice and repeated blood tests. Although it was not known that Mr Mullen was suffering from ischaemic heart disease at the time of his death, this could have identified a potential risk of cardiovascular disease. The clinical reviewer concluded that this aspect of Mr Mullen's care was not equivalent to that which he could have expected to receive in the community. We recommend:

The Head of Healthcare and the Primary Care Team at HMP Oakwood should review the effectiveness of the Prison Assist GP service specifically when ongoing monitoring and follow up care is required

29. The clinical reviewer also made five recommendations about transfers between prisons and continuity of care, poor record keeping, management of long-term conditions and communication between healthcare and custodial staff, which are not directly related to Mr Mullen's death, but which the Head of Healthcare at Oakwood will need to address.

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