Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Green, a prisoner at HMYOI Hatfield, on 31 July 2021

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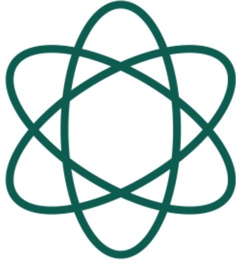
Our vision

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

OGL

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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 Steven Green was found dead in his room at HMP Hatfield on 31 July 2021. Toxicology results showed Mr Green had very high levels of prescription medication in his system and the pathologist concluded that he died from drug poisoning. He was 48 years old. I offer my condolences to Mr Green's family and friends.

It appears that Mr Green took an excessive amount of his prescribed medication. However, it is unknown whether he intended to take his life. He gave staff no indication that he was at risk of suicide and I am satisfied that they could not have foreseen his death.

The clinical reviewer found that the care Mr Green received was of a good standard. However, she noted that healthcare staff had issued Mr Green with 28 days of in possession medication, despite his risk assessment authorising only seven days.

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

Sue McAllister CB
Prisons and Probation Ombudsman **March 2022**

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Summary

Events

1. In March 2011, Mr Steven Green was sentenced to life imprisonment for murder, with a minimum tariff of 11 years. He was moved to HMP Hatfield, an open prison, on 28 October 2020.

2. Mr Green had severe depressive and social anxiety disorder and was prescribed sertraline (an antidepressant) and propranolol (used to treat the physical effects of anxiety).

3. In March 2021, Mr Green told his offender manager that he felt low. She referred him to the mental health team. A mental health nurse assessed him and had no concerns. Mr Green later said that he was fed up of the COVID-19 restrictions but was managing.

4. In May and June, Mr Green had three escorted town visits. Staff noted that he was in good spirits.

5. On 23 June, Mr Green was told that the Parole Board had not approved his release. A mental health nurse subsequently assessed him. She noted he was in a good mood as he had been on town visits and had met his parents. Mr Green said he planned to appeal the Parole Board decision. The nurse noted no concerns.

6. At around 7.55pm on 31 July, during a roll check, an officer found Mr Green unresponsive on the floor of his room. Staff telephoned for an ambulance but did not try to resuscitate Mr Green as it was clear he had died. Paramedics confirmed Mr Green's death at 8.14pm.

7. An empty bottle of propranolol, which should have contained 24 tablets, was found in Mr Green's room, along with opened and unopened boxes of sertraline and paracetamol. Toxicology results showed that Mr Green had very high levels of sertraline and propranolol in his body. The pathologist concluded that he died from drug poisoning.

Findings

8. It appears that Mr Green took an excessive amount of his prescribed medication. No note was found so it is unclear whether he took the medication with the intention of ending his life. We consider that he gave no indication to staff that he was at risk of suicide and we are satisfied that they could not have foreseen his death.

9. The clinical reviewer concluded that the clinical care Mr Green received at Hatfield was of a good standard and equivalent to that he could have expected to receive in the community. However, the clinical reviewer noted that despite Mr Green's medication in possession risk assessment at Hatfield saying he should be prescribed seven days medication, he was prescribed 28 days.

10. The officer who found Mr Green did not call a medical emergency code as he should have done. The Governor has since issued a Notice to Staff reminding them of the medical emergency procedures.

11. None of the staff who attended Mr Green's room on 31 July were able to activate their body-worn video cameras (BWVCs) to record the incident. It is unclear if this was due to a system fault or a training need. The prison has introduced frequent testing of the equipment and has told us it will carry out refresher training.

12. We are concerned that some staff did not feel sufficiently supported after Mr Green's death.

Recommendations

- The Head of Healthcare should ensure that in-possession medication is dispensed in line with the risk assessment.
- The Governor should ensure that all relevant staff are able to attend a debrief following a death in custody and that they receive appropriate aftercare support.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Hatfield informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

14. The investigator obtained copies of relevant extracts from Mr Green's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Green's clinical care at the prison.

16. The investigator interviewed six members of staff and three prisoners. All the interviews were conducted by video or telephone because of the restrictions imposed in response to the COVID-19 pandemic.

17. We informed HM Coroner for Yorkshire South East of the investigation. We have sent the Coroner a copy of this report.

18. The PPO's family liaison officer contacted Mr Green's parents to explain the investigation and to ask if they had any matters, they wanted us to consider. Mr Green's family wanted to know the circumstances of how he died but had no other specific questions.

19. Mr Green's family received a copy of the initial report. They did not identify any factual inaccuracies.

20. The prison also received a copy of the report. They identified a staff members name had not been spelt correctly, which has been amended. An action plan for the recommendations is annexed to the report.

Background Information

HMP Hatfield

21. HMP Hatfield is a category D resettlement prison for men situated near to Doncaster in South Yorkshire, which holds up to 378 men who are due to complete their sentence within two years. Healthcare is provided by Practice Plus Group (formerly Care UK).

HM Inspectorate of Prisons

22. The most recent inspection of Hatfield was in August 2019. Inspectors reported the prison was unequivocally safe. Relationships between staff and prisoners were good and inspectors noted there was a clear sense of community. However, the prison was not funded for the Offender Management in Custody (OMiC) programme, which limited the amount of time available for staff to interact on a one-to-one basis with prisoners.

23. Inspectors found all high-risk multi-agency public protection arrangements (MAPPA) prisoners and those serving indeterminate sentences were appropriately supervised by probation officers, with regular and meaningful contact to drive sentence progression. Security measures were proportionate and there was a well-developed response to the supply of illicit drugs.

24. Inspectors found healthcare was fully staffed and mandatory training was good. Substance misuse services were well advertised on the residential units. New referrals were usually seen on the same day and there was evidence of high-quality individual casework and groupwork on harm minimisation.

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 most recent annual report for the year to 31 March 2021, the IMB found that prisoners were treated fairly, humanely and the prison was a safe environment.

26. The Board noted that, with few exceptions, all prisoners were provided with purposeful activity, were well prepared for release and with partners, provided education and employment. They found that physical and mental health provision was accessible and well managed. The Board noted that the impact of the COVID-19 pandemic and Government restrictions resulted in the suspension of ROTL (release on temporary licence) but it resumed when infection rates and removal of restrictions allowed.

Previous deaths at HMP Hatfield

27. There were no other deaths at Hatfield in the two years prior to Mr Green’s death.

Key Events

28. In March 2011, Mr Steven Green was sentenced to life imprisonment for murder.

29. Mr Green had severe depressive and social anxiety disorder and was prescribed sertraline (an antidepressant) and propranolol (to relieve the physical symptoms of anxiety). He received continued support from mental health services throughout his time in custody, through the IAPT programme (Improving Access to Psychological Therapies – services which provide evidence based psychological therapies to people with anxiety disorders and depression). While at HMP Buckley Hall, Mr Green had an allocated trauma psychotherapist who he saw most weeks. The psychotherapist noted an increase in Mr Green's depressive thoughts during lockdown, but that his mood and depression lifted when he was told he was being moved to an open prison.

30. On 28 October 2020, Mr Green was moved to HMP Hatfield.

31. On 15 March 2021 an offender manager, met with Mr Green. He told the offender manager that his mental health had declined over the previous two weeks and that he had been sleeping during the day. Mr Green said he had good support from his family but had not contacted the mental health team. The offender manager told Mr Green that she would refer him to the mental health team and would meet with him every few weeks to provide additional support. She told Mr Green that he had been approved for periods of supervised release on temporary licence (ROTL) and that he would be able to go out unescorted if they were successful.

32. On 18 March, Nurse A met with Mr Green to assess his mental health. An officer from the safer custody team, was also present. Mr Green said he preferred his own company, although did socialise occasionally with a couple of prisoners, and that he got on well with wing staff. Mr Green said he was bored of the COVID-19 restrictions but declined education or employment. Mr Green said he did not need support from the mental health team but would contact them or safer custody if he needed to. The nurse noted Mr Green had no concerns regarding his medication.

33. On 29 March, the offender manager, Nurse A and the community offender manager, met with Mr Green to review his mood. Mr Green told them that he still felt down but was managing. They encouraged him to gain employment and take exercise to help improve his mood, and he accepted that he could engage more with the wing regime.

34. On 23 April, Mr Green referred himself to the substance misuse team to complete alcohol relapse prevention work, which was a target of his sentence plan. On 28 April, a member of the substance misuse team completed an assessment of Mr Green's needs. She noted that there were no obvious current triggers, that Mr Green had been abstinent since his arrest and had good family support. She noted that Mr Green would be referred for community support at the point of release but would complete relapse work with him.

35. On 6 May, the offender manager met with Mr Green and assisted him with his ROTL application. She also provided him with some pens to encourage him to

continue with his creative writing. Later, Mr Green was told he had been assessed as suitable for escorted town visits.

36. On 20 May, Mr Green was escorted on a town visit and the escorting officer noted that the visit had gone well. On his return, Mr Green met with a member of the substance misuse team who described him as being in good spirits and that he was looking forward to the next planned visits (25 May and 2 June – both went ahead and were noted as being successful). Mr Green was given worksheets to complete before their next meeting.

37. On 25 May, the offender manager arranged for Mr Green to be released on ROTL to Rookwood Approved Premises (APs accommodate offenders released from prison on licence) between 14-16 September, in anticipation of Mr Green being granted parole.

38. On 23 June, the offender manager told Mr Green that the Parole Board had not approved his release, but that he could appeal the decision within 28 days. Wing staff were asked to monitor Mr Green's mood and the offender manager referred him to the mental health team for review. On 28 June, Mr Green's legal representative requested an Oral Hearing (a hearing held in front of a panel from the Parole Board).

39. On 29 June, Nurse A met with Mr Green to assess his mental health. She noted he was confused as he had been given a decision letter, but he had not actually attended a parole hearing in person, and he planned to appeal the decision. The nurse noted Mr Green was in a good mood as he had been on town visits and met his parents. She noted no concerns and decided no further intervention was necessary.

40. On 1 July, Mr Green tested positive for COVID-19 and he was required to isolate until 12 July. Healthcare staff regularly checked him during this period. He did not report feeling unwell, did not have a temperature and did not express any concerns about his physical or his mental health. (Mr Green had his first COVID-19 vaccination on 21 April, the second was due on 14 July, but was not given as Mr Green had recently had COVID-19.)

41. On 19 July, Mr Green was told an Oral Hearing with the Parole Board had been agreed, but that it would not be listed before November.

42. On 27 July, a pharmacist noted in Mr Green's medical record that a wing officer had raised concerns with her that Mr Green appeared low. The pharmacist went to Mr Green's room to issue his medication. He was in bed and said he had no issues. The pharmacist referred Mr Green to the mental health team.

43. The next day, Nurse A reviewed Mr Green. She noted he was surprised that concerns had been raised as he always spent time in his room and that because of the high number of COVID-19 cases, he felt it was better to stay in his room. Mr Green said he had no concerns about his mental health, and that he continued to take his medication as prescribed. The nurse reiterated that he could contact the mental health team if anything changed. This was the last contact Mr Green had with healthcare staff.

31 July 2021

44. There is no CCTV on B Unit where Mr Green lived. During the day prisoners are able to walk around the unit freely and access gym and cooking facilities as well as using the sports field to exercise. Officer A said he saw Mr Green around 5.00pm, when he collected his meal from the servery. The officer said he could not be certain but thought Mr Green had returned to his room to eat his meal, as he typically did not socialise with other prisoners and kept himself to himself.

45. A prisoner on B Unit, said Mr Green had danced and sang along to some music that was playing on the landing when he went to collect his food, which was very out of character as he was usually quiet and withdrawn. The prisoner said he very occasionally got a glimmer of Mr Green's personality and that the music had obviously triggered a happy memory. He said that he never suspected Mr Green was being bullied but isolating was his way of managing his time in prison. The prisoner said he did not think that Mr Green was under the influence, but just had a moment of being happy when he heard the music.

46. At 7.55pm, during the roll check, Officer A found Mr Green lying on his back on the floor of his room; there was blood and vomit around his mouth, his eyes were fixed, and his arms were in an unusual position. The officer did not touch Mr Green. He radioed for urgent assistance from the operational manager and went to the wing office to telephone the 'Gate' (responsible for all communications) to request an ambulance; he did not radio a medical emergency code.

47. Officer B responded to the request for assistance. He went to Mr Green's room and immediately thought he was dead, so did not attempt resuscitation. The operational manager, also responded and asked staff to activate their body worn video cameras (BWVC). Although four cameras were available, staff were unable to activate any of them.

48. Yorkshire Ambulance Service records show an ambulance was requested at 7.55pm. Paramedics attended and at 8.14pm confirmed that Mr Green had died. Officer A was later asked to formerly identify Mr Green's body.

Information after Mr Green's death

49. When police officers inspected Mr Green's room, they found an empty bottle of Bedranol (a brand name for propranolol), which did not have a label. This medication was dispensed to Mr Green on 27 July and, if this was the bottle of medication given to him, it should have contained 24 tablets. Without a label it is not known who this medication was for or when it was prescribed. Police also found other medication, both open and unopened, including sertraline (unopened box dispensed on 14 July and an older opened box from several months earlier) and a total of 104 paracetamol (500mg) tablets in both opened and unopened boxes with dispensing labels dating back to February and May 2020. The police were satisfied there was no sign of any disturbance in Mr Green's room, that it was tidy and organised and there was nothing to suggest that anyone had been in the room and taken the missing medication.

50. Several intelligence reports were submitted which noted prisoners on B Unit said that Mr Green had made comments in the weeks before he died that he had ‘had enough’ and ‘had enough of all this’. Those interviewed said they believed this was in relation to the COVID-19 restrictions and the impact on his town visits, rather than an increase in Mr Green’s risk to himself.

Contact with Mr Green’s family

51. Hatfield appointed a Family Liaison Officer (FLO) and the operational manager as his deputy. The FLO and the operational manager travelled to Mr Green’s parent’s home to break the news of his death. They offered their condolences and ongoing support. In line with Prison Service instructions, the prison contributed towards the costs of Mr Green’s funeral, which was held on 19 August 2021. The prison also facilitated a visit to Hatfield on 15 September, for Mr Green’s parents.

Support for prisoners and staff

52. After Mr Green’s death, there was no collective debrief. The duty governor spoke to staff individually before they left the prison. The Governor facilitated a critical debrief on 27 August. During this debrief staff involved in the emergency response said that although Officer C, a member of the staff care team, spoke to them on the day of Mr Green’s death, they did not have any follow up contact and had no formal contact from managers to check on their wellbeing.

53. The prison posted notices informing prisoners of Mr Green’s death and offering support. They held a memorial service for Mr Green on 9 September and prisoners had a collection for a local charity.

Post-mortem report

54. Toxicology tests showed Mr Green had very high levels of propranolol and sertraline in his blood and urine samples. The pathologist concluded that he died from drug poisoning. He recorded that aspiration of gastric contents contributed to Mr Green’s death

Findings

Assessment of Mr Green's risk of suicide and self-harm

55. Mr Green died as a result of high levels of propranolol and sertraline in his body. Both medications were prescribed to him and held in-possession. Mr Green was last prescribed propranolol on 27 July and should have had 24 tablets left on 31 July. None were found in his room, so it appears he had taken all of them. The toxicology results indicate that he also took an excessive amount of sertraline, but it is unclear how much.

56. No suicide note was found so we cannot be certain whether Mr Green took excessive medication with the intention of ending his life, but this is a possibility. We have considered whether staff should have identified that Mr Green was at risk of suicide.

57. While Mr Green had periods when he reported feeling low, we consider that there were no obvious signs that he was suicidal. Mr Green had been refused parole the month before he died. Staff immediately referred him to the mental health team. They assessed Mr Green and were satisfied that the news had not negatively impacted on him. He told them that he was enjoying his town visits and planned to appeal the Parole Board decision. The mental health team had no concerns about him.

58. We are satisfied that staff could not have foreseen or prevented Mr Green's death.

Clinical Care

59. The clinical reviewer found that the standard of care Mr Green received at Hatfield was good and at least equivalent to that he could have expected to receive in the community.

Medication

60. Mr Green was assessed as suitable for a 28-day supply of medication on 30 May 2018, when he was at HMP Oakwood. On 2 July 2019, when he arrived at HMP Buckley Hall, the in-possession medication assessment was reviewed, and he continued to be given 28 days at a time; this was reviewed again on 18 July 2020, and Mr Green was assessed as suitable for 28-days' supply.

61. When Mr Green arrived at Hatfield, he was assessed as suitable for seven-day in-possession medication, which was reviewed the day after he arrived at Hatfield (there is no record to explain why this had changed from 28 days). However, a 28-day supply of medication was prescribed.

62. Although Mr Green had been prescribed 28-days' worth of medications for over three years, the in-possession medication at Hatfield was only for seven days and he should only have had his medications dispensed weekly. An annual review for in-possession medication was set, but Mr Green died before this had taken place. We make the following recommendation:

The Head of Healthcare should ensure that in-possession medication is dispensed in line with the risk assessment.

Mental health

63. Mr Green suffered from longstanding anxiety and depression. When he arrived at Hatfield, Mr Green was appropriately referred to mental health services. He was seen consistently by the same practitioner and when concerns were raised by prison staff, he was reviewed promptly. There is evidence that healthcare and prison staff communicated extremely well and worked together to support Mr Green.

Emergency Response

Medical emergency code

64. Hatfield's local protocol is clear that an ambulance should be called immediately, when a medical emergency code is radioed, in line with PSI 03/2013 – Medical Emergency Response Codes. When Officer A discovered Mr Green, he did not use his radio to call a code blue medical emergency but went to the wing office to telephone the 'Gate' to make the request. The wing office was a very short distance away and there was no significant delay in him making the request for an ambulance. The officer said that he did not want to alert the other prisoners on the wing to what had happened and made the decision not to use the medical emergency code. Although it made no difference in Mr Green's case, we know that in a medical emergency any delay may be critical.

65. The Governor issued a Notice to Staff (NTS) 087/2021 on 26 August 2021 reiterating the need for staff to use medical emergency codes, in line with Prison Service guidance. As the prison has already taken action to address this issue, we do not make a recommendation.

Body worn video cameras (BWVC)

66. PSI 04/2017, *Body Worn Video Cameras (BWVC)*, states it is mandatory for staff to use BWVCs at any reportable incident (as set out in PSI 11/2012, *Management and Security of the Incident Reporting System*) and that staff should start recording at the earliest opportunity to maximise the material captured by the camera.

67. The BWVCs held by those responding could not be activated and a camera brought to the scene also failed to activate. Subsequent testing of the cameras after the incident did not identify any faults. The deputy governor told the investigator that in order to prevent any similar situations, units are now tested frequently, and staff will have refresher training on when and how to activate cameras. As the prison has already taken action to address this issue, we do not make a recommendation.

Staff support

68. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events.

69. Although staff involved in the emergency response were spoken to individually after Mr Green's death by the duty governor, there was not a collective debrief as there should have been. A member from the staff care team attended on the night of Mr Green's death and also spoke to some staff, but there was no subsequent contact.

70. Officer A was asked to view Mr Green's body to identify him. He said that the police were insistent that Mr Green was formally identified by someone who knew him and due to the limited number of staff on duty, and the absence of staff who had gone to break the news of his death to Mr Green's family, Officer A was the only officer that knew Mr Green well. The officer said he did not receive sufficient support afterwards and that it was difficult viewing Mr Green's body.

71. All staff involved in the emergency response said that support after Mr Green's death could have been better and they did not feel sufficiently supported. The duty governor said there had been a breakdown in communication during the handover between staff care team members, but accepted support could have been more proactive. We make the following recommendation:

The Governor should ensure that all relevant staff are able to attend a debrief following a death in custody and that they receive appropriate aftercare support.

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