Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Hotson, a prisoner at HMP Dovegate, on 9 October 2021

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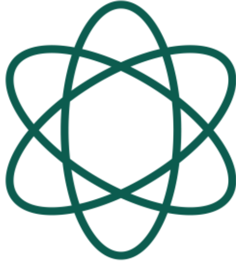
Our vision

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 Stephen Hotson died on 9 October 2021 of heart disease at HMP Dovegate. He was 55 years old. I offer my condolences to Mr Hotson's family and friends.

The clinical reviewer found that aspects of Mr Hotson's clinical care were not equivalent to that which he could have expected to receive in the community. Mr Hotson had several long-term conditions which increased his risk of heart disease, including high blood pressure, high cholesterol and diabetes. The clinical reviewer found that although healthcare staff monitored these conditions, there was no evidence of care plans. She also found that staff failed to monitor Mr Hotson's blood pressure after changing his medication and failed to review his diabetes medication when his blood sugar levels continued to rise.

I am very concerned that it took staff 18 minutes to respond to Mr Hotson's cell bell on the day he died. Staff were on their lunch break, and it appears the cell bell was answered only because an officer happened to be walking past Mr Hotson's cell. Staff should be available to answer cell bells at all times. The delay was unacceptable.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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Summary

Events

1. In January 2012, Mr Stephen Hotson was sentenced to life imprisonment for murder. He was moved to HMP Dovegate on 14 February 2017.

2. Mr Hotson had several long-term health conditions including type 2 diabetes, high blood pressure and high cholesterol. He was also morbidly obese.

3. On 9 October 2021 at 12.17pm, Mr Hotson rang his cell bell. No one responded as all the wing officers were on their lunch break.

4. At 12.35pm, an officer happened to go onto Mr Hotson's wing while he was on the way to the staff office and saw that Mr Hotson's cell bell light was on. He asked Mr Hotson what was wrong, and Mr Hotson pointed to his stoma bag (used to collect stools following a bowel operation). When the officer asked if Mr Hotson needed help with his stoma bag, Mr Hotson nodded. The officer then went to fetch more staff to enable him to enter the cell.

5. At 12.37pm, the officer returned with more staff, and they entered the cell. Mr Hotson was grumbling and pointing to his stomach. He then collapsed. Staff started CPR and called a medical emergency code.

6. A nurse and healthcare assistant arrived, and staff continued CPR until ambulance paramedics arrived. They continued resuscitation attempts but at 1.20pm, declared that Mr Hotson had died.

7. The post-mortem report concluded that Mr Hotson died of heart disease.

Findings

8. The clinical reviewer found that the care Mr Hotson received at HMP Dovegate was only partly equivalent to that which he could have expected to receive in the community.

9. The clinical reviewer found no evidence of care plans for Mr Hotson's hypertension, high cholesterol or diabetes, or that a weight management programme was offered to Mr Hotson. She found that staff did not monitor Mr Hotson's blood pressure after they changed his medication in August 2021 or review his diabetes medication when his blood sugar levels continued to rise after he was restarted on the medication in March 2021. She noted that no one appeared to notice that Mr Hotson had stopped taking his diabetes medication in 2018.

10. The delay in responding to Mr Hotson's cell bell was unacceptable. It took 18 minutes to respond and that was only because an officer happened to walk past Mr Hotson's cell. Staff should be available to respond to cell bells at all times.

11. Only one of the officers who responded to Mr Hotson turned on their body worn video camera, and this was only after the paramedics had arrived.

Recommendations

- The Head of Healthcare should ensure that all prisoners with a chronic health condition have a patient involved management of care and treatment plan as per NICE guidance.
- The Head of Healthcare should investigate why the change in hypertensive medication was not monitored by nursing staff or GPs in the three months prior to Mr Hotson's death.
- The Head of Healthcare should investigate why Mr Hotson did not take prescribed medication of metformin for almost three years before this was discovered.
- The Director should ensure that there is appropriate cover over the lunch period for staff to respond to cell bells and that all cell bells are answered within five minutes.
- The Director should ensure that staff switch on their body-worn video cameras (BWVCs) at the earliest opportunity during any reportable incident.

The Investigation Process

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

13. The investigator was sent copies of relevant extracts from Mr Hotson's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Hotson's clinical care at the prison.

15. The investigator and clinical reviewer jointly interviewed five members of staff at Dovegate on 2, 7, 22 and 23 December.

16. We informed HM Coroner for Staffordshire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Hotson's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He had concerns about Mr Hotson's access to healthcare supplies and services, particularly in relation to his stoma bag. These questions have been addressed in the clinical review.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

19. We sent a copy of our initial report to Mr Hotson's brother.

Background Information

HMP Dovegate

20. HMP Dovegate is a Category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult prisoners. There is also a therapeutic community, separate to the main prison, which holds up to 220 prisoners. Practice Plus Group provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Dovegate was in September/October 2019. Inspectors found that health care provision was reasonably good overall, governance systems were efficient, and well-being and health promotion initiatives were impressive. However, they also found that many of the prisoners they spoke to said cell bells were not always answered promptly.

Independent Monitoring Board

22. 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 30 September 2020, the IMB reported that good cooperation between the healthcare and custodial teams produced positive outcomes for residents' health, and any concerns that the Board raised were generally dealt with immediately.

Previous deaths at HMP Dovegate

23. Mr Hotson was the eighth prisoner to die at Dovegate since October 2019. Of the previous deaths, two were self-inflicted, one was drug-related, and four were from natural causes.

24. We have previously made a recommendation about ensuring prisoners with hypertension are managed in line with National Institute for Health and Care Excellence (NICE) guidelines. We were told that the Head of Healthcare and Lead GP had reviewed the process for monitoring prisoners with hypertension.

Key Events

25. In January 2012, Mr Stephen Hotson was sentenced to life imprisonment for murder with a minimum tariff of 13 years. He was moved to HMP Dovegate on 14 February 2017.

26. Mr Hotson had hypertension (high blood pressure), high cholesterol, type 2 diabetes, diverticular disease (when small pouches form and push outward through weak spots in the wall of your colon) and steatosis of the liver (too much fat built up around the liver). He was also morbidly obese.

27. Mr Hotson underwent bowel surgery in May 2018, after which he required use of a stoma bag (a detachable bag fitted to the abdomen which collects urine or faeces).

28. On 9 October 2021 at 12.17pm, Mr Hotson rang his cell bell. No one responded as all the wing officers were on their lunch break.

29. At 12.35pm, an officer went onto the wing to get a drink from the staff office and noticed the cell bell light in Mr Hotson's cell was on.

30. The officer told the investigator that when he asked Mr Hotson what was wrong, Mr Hotson pointed to his stoma bag. When he asked if Mr Hotson needed help with his stoma bag, Mr Hotson nodded. He told Mr Hotson that as they were locked down for lunch, he would have to get more officers before entering the cell.

31. At 12.37pm, the officer returned to the cell accompanied by a custodial operations manager (COM) and two more officers. An officer unlocked the cell, and staff entered.

32. The COM asked Mr Hotson if he was alright, or if he had taken anything. In their statements and interviews, officers said Mr Hotson was grumbling and pointing at his stomach, which was swollen and moving quickly. Mr Hotson collapsed at 12.39pm. The COM told the officers to start CPR, which they did.

33. The COM called a medical emergency code over her radio, and the control room called an ambulance at 12.39pm.

34. At 12.42pm a nurse and a healthcare assistant arrived at Mr Hotson's cell and assisted the officers with CPR.

35. The ambulance arrived at the gate at 12.52pm and paramedics entered Mr Hotson's cell at 1.04pm.

36. The paramedics took over CPR, but they were unsuccessful in resuscitating Mr Hotson and declared his death at 1.20pm.

Contact with Mr Hotson's family

37. At 6.30pm, the prison appointed a family liaison officer (FLO). The FLO informed Mr Hotson's brother of his death by phone and offered her condolences. The prison contributed to the funeral costs in line with policy.

Support for prisoners and staff

38. After Mr Hotson’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.

39. The prison posted notices informing other prisoners of Mr Hotson’s death and offering support.

Post-mortem report

40. The post-mortem report concluded that Mr Hotson died of diabetic and hypertensive heart disease.

Findings

41. The clinical reviewer found that the care Mr Hotson received at HMP Dovegate was only partly equivalent to that which he could have expected to receive in the community.

42. The clinical reviewer found that while healthcare staff regularly monitored Mr Hotson's blood cholesterol levels and prescribed appropriate medication, there was no evidence of a care plan. Similarly, she found no evidence of a care plan for his hypertension. She also noted that when staff changed his hypertension medication in August 2021, there was no evidence that they monitored the effectiveness of this change or his blood pressure between then and his death.

43. The clinical reviewer found that healthcare staff monitored Mr Hotson's cardiovascular risk (QRisk score) given his combined risk factors of diabetes, high cholesterol and hypertension. However, despite identifying that he was obese, there was no evidence he was offered a weight management programme or plan of care, nor was there any evidence of a care plan to manage his cardiovascular risk.

44. The clinical reviewer also identified some shortcomings in Mr Hotson's diabetes care. Although staff identified in March 2021 that Mr Hotson's blood sugar levels were high and recommenced his metformin medication (which he had stopped taking in 2018), they did not arrange a GP review to consider increasing his metformin dose when Mr Hotson's blood sugar levels continued to rise. It was also unclear if anyone had noticed that Mr Hotson had stopped taking his metformin medication for almost three years. There was also no evidence of a diabetes care plan.

45. We recommend:

The Head of Healthcare should ensure that all prisoners with a chronic health condition have a patient involved management of care and treatment plan as per NICE guidance.

The Head of Healthcare should investigate why the change in hypertensive medication was not monitored by nursing staff or GPs in the three months prior to Mr Hotson's death.

The Head of Healthcare should investigate why Mr Hotson did not take prescribed medication of metformin for almost three years before this was discovered.

Delay in answering cell bell

46. The delay in answering Mr Hotson's cell bell was unacceptable. It was answered after 18 minutes only because an officer happened to walk past Mr Hotson's cell and saw his cell bell light was on.

47. The wing officers were on their lunch break at the time. When the investigator interviewed the COM to ask about who was responsible for answering cell bells, she said that staff would answer cell bells between them, and if an officer was on a

lunch break, someone else would do it. However, there should be someone designated to cover cell bells over the lunch period. We recommend:

The Director should ensure that there is appropriate cover over the lunch period for staff to respond to cell bells and that all cell bells are answered within five minutes.

Body Worn Video Cameras

48. Only one of the officers who responded to Mr Hotson turned on their body worn video camera (BWVC). They only did so after the paramedics had arrived. Prison Service Instruction (PSI) 04/2017, *Body Worn Video Cameras*, 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. We recommend:

The Director should ensure that staff switch on their body worn video cameras (BWVCs) at the earliest opportunity during any reportable incident.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **March 2023**

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