Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Southam, a prisoner at HMP Rye Hill, on 24 July 2022

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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

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 Stephen Southam died in hospital of multiple organ failure and non-alcohol fatty liver disease on 24 July 2022 while a prisoner at HMP Rye Hill. He was 67 years old. We offer our condolences to Mr Southam's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Southam received at Rye Hill was equivalent to that which he could have expected to receive in the community. She made three recommendations about mental health training, prescribing medication for long-term conditions and on-going training on record keeping, which are not directly linked to Mr Southam's cause of death and are not repeated in this report, but which the Head of Healthcare will need to address. She also made two findings for the NHS England Commissioning Team to note about the improvement in the management of long-term conditions at Rye Hill and repeated concern about GP communication in relation to prescribing.

5. We found no non-clinical issues of concern.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Southam's clinical care at Rye Hill.

7. The PPO investigator investigated the non-clinical issues relating to Mr Southam's care, including Mr Southam's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

8. On 23 August 2022, the investigator and clinical reviewer conducted one interview over Microsoft Teams with the Head of Healthcare.

9. The PPO family liaison officer wrote to Mr Southam's next of kin, his sister, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not have any questions but asked for a copy of our report. This report has been shared with her.

10. Mr Southam's family received a copy of the initial report. They did not make any comments.

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

Previous deaths at HMP Rye Hill

12. Mr Southam was the eleventh prisoner to die at Rye Hill since July 2020. All the previous deaths were from natural causes. There are no similarities between our findings in the investigation into Mr Southam's death and our investigation findings for the previous deaths.

Key Events

13. Mr Stephen Southam was convicted of sexual offences on 12 January 2016 and sentenced to 15 years in prison.

14. Mr Southam had several long-term health conditions, including severe liver disease, chronic heart failure, type 2 diabetes, chronic kidney disease stage 3, pancytopenia related to hypersplenism (enlarged spleen, symptoms are anaemia, infection or bleeding), epilepsy and portal hypertension (increased pressure within the portal vein that carries blood from the digestive organs to the liver).

15. On 1 November, Mr Southam was sent to HMP Rye Hill.

16. Healthcare staff created care plans to manage Mr Southam's long-term conditions. These were updated regularly. Where necessary, healthcare staff arranged for him to have reviews with hospital consultants and arranged for a care package to assist him with daily living activities such as showering, dressing and meal collection. The prison's In-Reach Mental Health Team also saw him regularly.

17. Mr Southam's care plan for diabetic control worked well until December 2020, when he began to have glucose control issues. The prison GP monitored his high blood sugar levels and discussed his case with the diabetic nurse specialist. They made changes to his insulin prescription. A consultant haematologist reviewed Mr Southam for blood disorders regularly. He was diagnosed with anaemia and prescribed blood thinning medication to prevent clots.

18. From July 2021, Mr Southam had regular falls. Although he was not injured from these falls, healthcare staff found that he was often confused. He was taken to hospital on several occasions for further assessment and x-rays. Hospital specialists noted that his falls were linked to his liver condition as he had episodes of gastrointestinal disorders, including constipation and diarrhoea. These episodes also impacted his Type 2 diabetes and caused fluctuating glucose levels and also affected his mental health. Healthcare staff monitored his glucose levels and changed his insulin medication to try and stabilise his condition.

19. On 19 August, safer custody staff arranged for a full social care package to help Mr Southam with his physical needs. They provided him with supportive equipment, including a hospital bed, a Zimmer frame, shoes to prevent slips and a pendant alarm, and they continued to support and review him regularly.

2022

20. Healthcare staff raised concerns that Mr Southam had periods of confusion and aggression. They arranged for a psychiatric assessment. On 12 January 2022, a psychiatrist assessed Mr Southam and noted that he had mild cognitive impairment, with underlying diabetes and kidney disease. He concluded that Mr Southam did not have dementia and was not suitable for cognitive enhancer medication. Mr Southam was discharged from the In-Reach Mental Health Team.

21. On 25 May, a hospital consultant endoscopist completed a colonoscopy and gastroscopy (a test passing a camera into the body) and noted that Mr Southam

had abnormal enlarged veins in his oesophagus (food pipe), high blood pressure and damage to the lining of his stomach.

22. On 27 June, a prison GP diagnosed Mr Southam with a build-up of fluid in his body and diarrhoea. He also noted that there was evidence of congestive heart failure. Healthcare staff created a care plan to manage this condition. By July, a prison GP noted that despite revising his medication for Mr Southam's conditions he continued to deteriorate. On 13 July, the prison GP sent Mr Southam to hospital for further care and treatment.

23. Mr Southam's condition deteriorated further in hospital. On 20 July, Mr Southam was placed on the end of life pathway.

24. On 24 July, it was confirmed that Mr Southam had died in hospital.

Cause of death

25. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Southam's cause of death as multi organ failure, caused by non-alcohol fatty liver disease. Type 2 diabetes and heart failure were also listed as contributory factors.

Lisa Burrell
Assistant Ombudsman **March 2023**

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