Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Charles Stevens, a prisoner at HMP Swaleside, on 11 May 2024

A report by the Prisons and Probation Ombudsman

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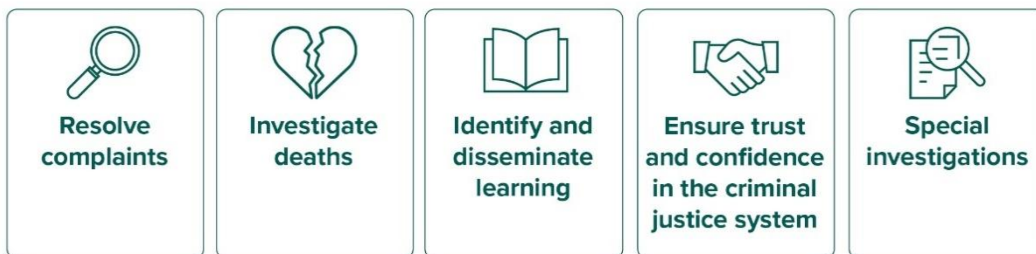
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Charles Stevens died in hospital on 11 May 2024 of a codeine overdose, while a prisoner at HMP Swaleside. He was 78 years old. I offer my condolences to Mr Stevens' family and friends.

Mr Stevens had multiple health conditions which the clinical reviewer concluded were appropriately treated up until 10 May. However, on 10 May, Mr Stevens' health worsened and he experienced significant pain. He should have gone to hospital but did not as there were not enough prison staff available to escort him. Healthcare staff were unaware of this and did not check him further. His clinical care was inadequate.

On 11 May, Mr Stevens' condition deteriorated further and he was taken to hospital by ambulance. He was inappropriately restrained until after he suffered a cardiac arrest.

The investigation found no evidence to indicate that Mr Stevens intentionally took more of his prescribed pain relief medication than he should.

Adrian Usher
Prisons and Probation Ombudsman **November 2025**

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Summary

Events

1. In 2018, Mr Charles Stevens was sentenced to 20 years imprisonment for sexual offences. In August 2019, Mr Stevens transferred to HMP Swaleside.

2. From July 2021, Mr Stevens' was prescribed co-codamol (a painkiller containing paracetamol and codeine) to manage joint pain. On 15 December 2023, Mr Stevens complained of constant pain in his shoulder. Mr Stevens saw a physiotherapist who advised he used ice to alleviate the pain. On 18 December, Mr Stevens missed an appointment to discuss his shoulder pain with no reason recorded as to why he had not attended.

3. On 23 January 2024, healthcare staff referred Mr Stevens to a specialist for further tests for his shoulder pain. Healthcare staff continued to regularly review his physical health needs.

4. On 10 May, Mr Stevens' complained of severe pain in his abdomen and he showed signs of being very unwell. A nurse did not assess him as urgently requiring medical treatment but sought advice from a GP who said he needed to go to hospital. This did not happen as there were not enough prison staff to escort him. Healthcare staff were not aware of this and did not check him further that day.

5. The next morning, a nurse went to see Mr Stevens as he was due a routine vaccination. He was very unwell, staff radioed an emergency code and he was taken to hospital by ambulance. He was restrained by handcuffs until he had a cardiac arrest and the restraints were removed. Hospital staff pronounced Mr Stevens' life extinct at 12.45pm.

Findings

6. The clinical reviewer found that up until 10 May, Mr Stevens' care was of a good standard and equivalent to that he would have received in the community. On 10 May and until he went to hospital on 11 May, his clinical care was inadequate. He did not go to hospital as he should have, healthcare staff did not check him and staff did not document the decisions they made.

7. The clinical reviewer also found that there was no clear pain management pathway for Mr Stevens.

8. Mr Stevens was inappropriately restrained when he went to hospital. Healthcare and prison staff did not assess Mr Stevens in person. He remained in restraints until he went into cardiac arrest.

Recommendations

- The Head of Healthcare should ensure that there is a review of long-term prescribing of opioids for pain relief in line with best practice.

- The Governor and Head of Healthcare should ensure there is a robust process for prioritising prisoners for hospital transfer, clearly defining criteria for prioritisation and documenting the rationale for any delays or decisions for why a prisoner cannot be taken to hospital, which should be documented within prison and medical records.

The Investigation Process

9. HMPPS notified us of Mr Stevens' death on 11 May 2024.

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

11. The investigator obtained copies of relevant extracts from Mr Stevens' prison and medical records. She interviewed nine members of staff by MS Teams between July and October 2024.

12. NHS England commissioned a clinical reviewer to review Mr Stevens' clinical care at the prison. The clinical reviewer jointly interviewed clinical staff with the investigator.

13. We informed HM Coroner for Kent and Medway of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's office contacted Mr Stevens' next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Swaleside

16. HMP Swaleside is a category B prison on the Isle of Sheppey that holds long-term prisoners assessed to be high risk and those serving long sentences. Oxleas NHS Foundation Trust provides physical and mental health services, including 24-hour nursing care. Change Grow Live (CGL) is the substance misuse treatment provider.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Swaleside was in August 2024. Inspectors reported that staff shortages had been addressed through proactive recruitment. However, just over half the officers had less than a year’s experience which was due to increase over the following two months as newly trained officers were due to take up post. This level of inexperience led to a continuing lack of confidence and assertiveness in the management of prisoners. Inspectors also found that there was inconsistent support for prisoners considered to be a risk to themselves.

Independent Monitoring Board

18. 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 2023 to 2024, the IMB reported that healthcare staffing levels remained an issue, especially on weekends. The IMB also found that there was a lack of prison officers to accompany prisoners to hospital appointments which led to cancelled appointments.

Previous deaths at HMP Swaleside

19. Mr Stevens was the twenty first prisoner to die at Swaleside since May 2021. Of the previous deaths, eight were due to natural causes, nine were self-inflicted, and three were due to illicit drugs use. We identified similar concerns in three cases regarding the use of restraints and healthcare assessments between 2022 and 2024.

20. Since the death of Mr Stevens and up until 17 June 2025, there have been nine further deaths at Swaleside. Two of these were self-inflicted, five were from natural causes, one was due to drugs and one is awaiting classification.

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Key Events

21. On 18 May 2018, Mr Charles Stevens was sentenced to 20 years in prison for sexual offences. He transferred to HMP Swaleside from HMP Elmley on 5 August 2019.

22. During his first reception screening, Mr Stevens reported multiple co-morbidities (more than one health condition) including heart disease, asthma and hypertension (high blood pressure). He also had chronic obstructive pulmonary disease (COPD – a lung condition that affects breathing) and a pacemaker (an electrical device that sends electrical pulses to the heart to keep it beating regularly). Healthcare staff regularly monitored his health conditions.

23. A nurse completed a medication in possession risk assessment (MIPRA) with Mr Stevens to determine whether he was suitable to have medication in his cell for him to administer himself. The MIPRA includes whether there are any physical or mental issues that might affect a prisoner's capacity to take medication as required. The nurse concluded that Mr Stevens was suitable to have seven days of medication in his possession.

24. In July 2021, Mr Stevens asked a GP for co-codamol to help manage his joint pain. The GP prescribed 30mg of co-codamol (containing paracetamol and codeine) to be taken three times a day. Mr Stevens received his medication in a dosette box (a plastic tray that organises medication into compartments to be taken each day).

25. Mr Stevens received his co-codamol monthly. In September 2023, healthcare staff reduced Mr Stevens' prescription to 15mg three times a day. There was no rationale recorded for this change.

26. In December 2023, Mr Stevens told a physiotherapist that he had constant pain in his left shoulder which he rated as eight out of ten in terms of severity. The physiotherapist thought that Mr Stevens had osteoarthritis and advised him to put ice on his shoulder for the soreness.

27. On 18 January 2024, Mr Stevens requested to see an orthopaedic specialist (a doctor who diagnoses and treats issues with bones, joints, and muscles). Healthcare staff told him he was on a waiting list to see a specialist and booked him to see a physiotherapist for his shoulder pain again. He also said he wanted to have a steroid injection in his shoulder to relieve the pain.

28. On 23 January, Mr Stevens told a GP that he had had cramps in his legs and hands for the past six years. The GP told him that he had been referred to a specialist and explained that he was on a hospital waiting list and would be contacted for his appointment.

29. On 30 January, Mr Stevens requested a steroid injection for his shoulder pain. Healthcare staff told him that he needed an X-ray first and referred him to hospital for this.

30. The X-ray took place and on 6 February healthcare staff received the results. However, the results were not documented in the medical records.

31. On 18 April, an Advanced Nurse Practitioner (ANP) recorded that Mr Stevens had a chest infection and prescribed him antibiotics. She also provided a rescue pack. (A rescue pack is a set of medications, including antibiotics and steroids, given to prisoners with asthma or COPD to use during worsening breathing difficulties).

32. On 19 April, Mr Stevens told healthcare staff that he was still waiting for the results of his X-ray. Staff noted that they would try and get the results. On 23 April, the ANP reviewed Mr Stevens' chest infection. He said he was feeling better and his observations (which involves checking body temperature, blood pressure, pulse rate and breathing rate) were within normal range, except for his blood pressure, which was high. The ANP told Mr Stevens that she had arranged a GP appointment on 7 May for a referral for further tests to investigate his respiratory issues.

33. On 2 May, Mr Stevens attended an over-65 assessment (a routine check for prisoners aged over 65 conducted by healthcare staff each week). A nurse took his clinical observations and had no concerns.

34. On 7 May, Mr Stevens told a GP that he had had difficulty swallowing for one year and expressed concern that nothing had been done about it. The GP recorded that Mr Stevens looked well, there were no concerns with his airways and his throat and stomach were normal. The GP confirmed that a specialist had reviewed him and found no worsening symptoms. The GP referred him to an ear, nose and throat (ENT) specialist. Mr Stevens also said his shoulder was still stiff and a consultant had reviewed him and he had had an X-ray. The GP re-referred him urgently to the musculo-skeletal service.

Events of 10 May

35. On 10 May at 11.50am, a Senior Nurse saw Mr Stevens in his cell lying on his bed. Mr Stevens told him that he had stomach cramps and had vomited twice. Nurse A described Mr Stevens as having a grey skin complexion, visibly shaking and his abdomen felt hard. Mr Stevens said his pain was ten out of ten and constant. Nurse A told the investigator that a score of ten would describe unbearable pain but that he found it difficult to judge in this case as prisoners can be 'manipulative'. He also told the investigator that Mr Stevens did not show any signs of distress, was breathing normally and got up to show him his medications. His clinical observations were normal.

36. Nurse A asked Mr Stevens what type of pain relief he was taking. Mr Stevens showed him his dosette box and the nurse advised him to take some co-codamol and ask officers to call healthcare if the pain did not improve. Mr Stevens' National Early Warning Score was zero. (NEWS2 – used to determine the level of illness of a patient and whether care needs to be escalated.) The nurse noted that he would seek advice from a GP. There were no further notes in Mr Stevens' clinical record that day.

37. Nurse A told the investigator that he spoke to a GP about Mr Stevens but did not document this conversation in the medical records. He said that the GP told him that, since they did not know what was wrong with Mr Stevens, he would need to go to hospital. To facilitate this, the nurse completed an emergency escort form and spoke to the ANP to sign it off.

38. The ANP told the investigator that Nurse A told her that he had already spoken to the GP and that they had agreed a plan. The ANP said that Nurse A told her that Mr Stevens was stable, did not need an ambulance and could be transferred to hospital in a taxi. She said that Nurse A did not express any concerns about Mr Stevens' condition. She told the investigator that she was not asked to review Mr Stevens and that she was unaware of his grey complexion or his pain score being ten out of ten. She said that if she had known this, she would have reviewed him and requested an ambulance.

39. Healthcare staff then gave the escort form to a senior manager to authorise and the ANP confirmed that Mr Stevens needed to go to hospital. Nurse A said that he returned to the wing and staff confirmed that Mr Stevens would be going to hospital that afternoon.

40. The prison manager in charge each day arranges hospital escorts, but only the duty senior prison manager has the authority to decline an emergency escort request. The prison categorises emergency escort risk assessments as critical, essential, or important. The assessments also include a section for recording the rationale behind approving or denying an emergency escort. They should be recorded on the prison system.

41. Mr A was the duty senior prison manager on 10 May. He told the investigator that five prisoners needed an emergency escort to hospital that day, which was more than normal. The prison was also short staffed which meant that only two prisoners could be escorted to hospital. Mr A did not recall Mr Stevens being prioritised to go to hospital based on the information that he was provided at the time. Prisoners who are documented as being 'critical', would be taken to hospital the same day. The prison was unable to find the emergency escort documents for 10 May, so we have not seen them and cannot confirm which priority level was determined for Mr Stevens on that date. Mr Stevens did not go to hospital on 10 May.

42. The ANP explained that in this situation, she would have expected healthcare staff to carry out a welfare check on Mr Stevens.

43. Nurse A explained that he had not followed up to check if Mr Stevens went to hospital. Once he realised that Mr Stevens had not gone to hospital, he placed him on a ledger for the following day. This meant that healthcare staff would review whether he needed to go to hospital. Nurse A did not check Mr Stevens again that day as he told the investigator that he was not concerned about Mr Stevens' condition.

44. The prison could not confirm whether Mr Stevens collected his lunch or dinner on 10 May because the prison uses a tick sheet which is discarded after meals are served. The prison also could not identify which officers spoke to Mr Stevens when his cell was locked in the evening of 10 May or unlocked in the morning of 11 May. Mr Stevens did not press his cell bell after Nurse A saw him on 10 May.

Events of 11 May

45. On 11 May, the ANP noted that Mr Stevens was on the list for a Covid vaccination. She was not sure if he would be there as she thought that he had gone to hospital the day before. Around 8.30am, the ANP went to his cell and Mr Stevens was lying

on his bed but was able to sit up. Mr Stevens told her that he was short of breath, had a bloated abdomen and felt very unwell. He told her that the pain in his stomach was the same as the day before. The ANP noted that Mr Steven's skin was grey and the white of his eyes looked yellow. She asked a prison officer to radio a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties). Staff called an ambulance immediately at 8.35am.

46. Nurse A responded to the code blue and brought the emergency bag. The nurse administered oxygen as Mr Stevens saturation had dropped to 83%. Nurse B (who was the emergency responder that day) then arrived and took over treatment. Mr Stevens' NEWS2 score was nine (confirming that he needed an emergency transfer to hospital). Nurse B told the investigator that Mr Stevens was very unwell and was struggling to breathe. Paramedics got to the prison at 8.58am and took over Mr Stevens' care.

47. Healthcare and prison staff completed an escort risk assessment. Nurse C a mental health nurse filled in the medical section of the risk assessment. In response to the question regarding any medical objections to restraints, she answered 'no'. Nurse C told the investigator that she was asked to complete the paperwork but had not seen Mr Stevens in person. She stated that she completed the medical information section of the risk assessment solely based on previous entries in his medical record.

48. In the section filled in by the security department, they assessed Mr Stevens as a medium risk to the public and females and low risk of escape. Mr B, a prison manager, authorised a single cuff restraint (when a prisoner is handcuffed to a prison officer). Officer A (one of the escorting officers) told the investigator that Mr Bennett first saw Mr Stevens' condition when he was inside the ambulance.

49. Mr C, a senior prison manager, then authorised the use of an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and explained there were no concerns or issues documented within the medical information section of the form. He based his decision on Mr Stevens' age and health condition at the time. Mr C explained to the investigator that he wanted to allow Mr Stevens more flexibility with movements and ensure he would not be too near officers in case of an emergency. Mr Stevens left the prison around 10.00am, arrived at hospital at 10.45am and was admitted to A&E. Officer A told the investigator that Mr Stevens was in pain but he gave clear and coherent answers during conversations.

50. Officer A told the investigator that at 12.05pm, a nurse came into the room to fix Mr Stevens' cannula and realised he was unresponsive and in cardiac arrest. Officer A said he rang Mr A to inform him that he had removed Mr Stevens' cuffs. He stated that hospital staff needed to perform cardiopulmonary resuscitation (CPR) and use a defibrillator (a medical device used to restore a normal heart rhythm by delivering an electric shock). Mr A told the investigator that he advised Officer A to remove the restraints. It is noted in the medical records that a call was received from bedwatch staff at 11.50am for permission to remove Mr Stevens' restraints as he had gone into cardiac arrest. (Given the discrepancies in accounts, we have been unable to determine the exact circumstances.)

51. Despite resuscitation attempts, hospital staff pronounced Mr Stevens' life extinct at 12.45pm.

Support for prisoners and staff

52. After Mr Stevens' death, two members of the staff care team went to the hospital to offer support to the prison officers who had accompanied Mr Stevens. Once they returned to the prison, Mr A debriefed staff to ensure they had the opportunity to discuss any issues arising, and to offer support.

Post-mortem report

53. The post-mortem report gave Mr Stevens' cause of death as a drug overdose. Mr Stevens had a potentially fatal level of codeine (pain relief medication) in his blood.

Inquest

54. At the inquest, held on 27 April 2026, the Coroner concluded that Mr Stevens' death was drug related.

Findings

Clinical Care

55. The clinical reviewer found that the care Mr Stevens received up until 10 May 2024 was of a good standard and equivalent to that which he could have expected to receive in the community. She found that he had regular health, welfare and long-term condition reviews and appropriate hospital referrals.

Co-codamol prescription

56. Mr Stevens died from an overdose of co-codamol, one of his prescribed medications. He received his co-codamol tablets in a dosette box weekly with his other medication. No issues of non-compliance with his medication were recorded and his cell was therefore never searched. This is in line with the *Kent Prisons Medication in Possession Policy.* His MIPRA was also reviewed in line with this policy which also specifies that co-codamol can be given weekly in possession. There is no evidence that Mr Stevens intentionally took more co-codamol than he should and he did not tell staff treating him that he had taken excess tablets.

57. However, the clinical reviewer found that there was no clear pain management pathway for Mr Stevens, no alternative therapies were offered and there was no rationale for the long-term use of co-codamol since 2021. We make the following recommendation:

    The Head of Healthcare should ensure that there is a review of long-term prescribing of opioids for pain relief in line with best practice.

Treatment on 10 May

58. The clinical reviewer concluded that Mr Stevens' care was not equivalent to that he could have expected to receive in the community on 10 May. Healthcare staff were unaware that Mr Stevens had not gone to hospital and did not further review him that day. The clinical reviewer also identified an issue with a lack of record keeping and documentation. There was no record of a discussion between Nurse A and a GP or information about why Mr Stevens did not attend hospital. The emergency escort form and follow-up plan were not documented in the medical records. Therefore, we have not been able to determine how prisoners were prioritised for hospital treatment on 10 May. We make the following recommendation:

    The Governor and Head of Healthcare should ensure there is a robust process for prioritising prisoners for hospital transfer, clearly defining criteria for prioritisation and documenting the rationale for any delays or decisions for why a prisoner cannot be taken to hospital, which should be documented within prison and medical records.

59. The ANP told the investigator that if a prisoner is seen by healthcare in the morning and it is deemed that they should go to hospital but do not, they should be reviewed in the afternoon, overnight and the following morning by healthcare staff. Since Mr Stevens' death, if a critically ill prisoner does not go to hospital when they should, they are transferred to the inpatient department where they are monitored.

Healthcare staff have also introduced a whiteboard system to document prisoners who have been assessed as needing to go to hospital so that these prisoners are followed up and an action plan put in place if they do not go. We therefore make no recommendation in this regard.

60. The clinical reviewer also concluded that there may have been missed opportunities for Mr Stevens to go to hospital sooner had staff identified that his symptoms required an ambulance and conducted a welfare check later that day. Since healthcare did not see Mr Stevens until the following day, we are unable to establish his pain levels or symptom pain management for the remainder of the day and overnight.

61. The clinical reviewer was also concerned that a nurse deemed that Mr Stevens' account of the severity of pain he was experiencing might have been an attempt to manipulate staff. She urged the Head of Healthcare to review potential cultural assumptions among staff and assure themselves that staff were confident to assess a prisoner's pain. The clinical reviewer also made several recommendations not related to Mr Stevens' death, that the Head of Healthcare will wish to consider.

Restraints, security and escorts

62. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

63. On 11 May, when Mr Stevens was taken to hospital, healthcare and prison staff completed an escort risk assessment. The nurse completing the healthcare aspect of the assessment did not assess Mr Stevens in person, relied on his recent clinical records and, as a result, made no objection to restraints.

64. The ANP said that risk assessments should be done by those who have medical knowledge of the prisoner. She said that, given Mr Stevens could not bend over to put his shoes on and how unwell he was, she would have indicated that restraints were not appropriate in her clinical opinion. Healthcare staff should have reviewed Mr Stevens in person before completing the risk assessment.

65. Staff completing the security aspect of the assessment assessed Mr Stevens as a medium risk to the public and females and low risk of escape. They initially authorised Mr Stevens to be restrained with a single cuff but later changed this to an escort chain when they saw his condition in the ambulance as he was leaving the prison. Given Mr Stevens' ill health, breathing difficulties and mobility issues, it is hard to justify why he was restrained as he left prison. Furthermore, these restraints do not appear to have been removed until Mr Stevens went into cardiac arrest.

66. We have found similar restraint issues in previous cases at Swaleside. In August 2022, a prisoner was restrained for a hospital visit, but the required risk assessment was not completed, and Swaleside failed to provide all relevant assessments to the investigator. In February 2024, a prisoner was inappropriately restrained during a hospital visit, and there were missing escort risk assessments and bedwatch logs. In July 2024, another prisoner was handcuffed during a hospital visit, and medical information from the risk assessment was incomplete, with healthcare staff questioning that the prisoner may not have been as ill as he reported. In those cases, the use of restraints was deemed disproportionate, and managers did not fully consider the prisoners' physical health.

67. In response to the July 2024 case, the prison introduced a new process to improve the documentation of healthcare concerns in daily reports, which are reviewed by the Senior Leadership Team. The process for prison staff to request healthcare's input on a restraints decision has also been reviewed. The prison documented that these changes had been fully implemented by January 2025. Given these changes were implemented after Mr Stevens died, we make no further recommendation but the Governor will want to assure themselves that restraint decisions for elderly and infirm prisoners are appropriate.

Governor to note

Previous escort risk assessments

68. The prison could not locate or provide the person escort records and escort risk assessments for the months leading up to Mr Stevens' death. Therefore, we cannot comment on previous restraint decisions. As noted, Swaleside has previously failed to provide all relevant paperwork to the PPO. We bring this matter to the Governor's attention.

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