

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Stevenson a prisoner at HMP Holme House on 1 September 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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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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 William Stevenson died in hospital of multi-organ failure on 1 September 2015, while a prisoner at HMP Holme House. He was 56 years old. I offer my condolences to Mr Stevenson's family and friends.

I am satisfied that Mr Stevenson received a good standard of care throughout his time at HMP Holme House, equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

February 2016

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Summary

Events

1. In March 2014, Mr William Stevenson was remanded to HMP Holme House. He was subsequently convicted and sentenced to three years in prison.
2. Mr Stevenson had a number of chronic medical conditions, including Klippel-Feil Syndrome (a rare genetic bone disorder where two or more spinal bones in the neck fuse together). He had significant social care needs, which staff mostly managed in the prison's inpatient unit. Some of his medication carried a risk of gastric ulcers, but he accepted this and understood the risk. GPs prescribed additional medication to offer some protection against ulcers.
3. Throughout his time in prison Mr Stevenson suffered from longstanding constipation and anaemia. A prison GP prescribed laxatives and iron supplements. In October 2014, the GP referred him to a haematology specialist in October 2014, but he did not receive an appointment before he died.
4. On 4 August, Mr Stevenson had chest pains and had vomited. He was taken to hospital. In hospital, Mr Stevenson complained of abdominal pain and had a number of tests. He was severely constipated but, by 10 August, his condition appeared to be improving.
5. On 14 August, the prison informed his family that he had been admitted to hospital. His condition subsequently deteriorated and he died in hospital on 1 September. A post-mortem examination found that Mr Stevenson died of multi-organ failure, due to acute peritonitis and a perforated gastric ulcer.

Findings

6. We are satisfied that Mr Stevenson received good care at Holme House, equivalent to that he could have expected to receive in the community. He had a range of complex conditions, which were managed well and he received appropriate mental health support. Healthcare staff responded quickly and appropriately to his health and social care needs. Mr Stevenson did not report any symptoms of a gastric ulcer while he was in prison and doctors had tried to minimise the risks of this by prescribing other drugs. While healthcare staff at the prison did not follow up the referral to a haematologist in October 2014, this was not an urgent appointment. We understand that the prison now has a system to monitor outstanding appointments.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator visited Holme House on 11 September 2015. He obtained copies of relevant extracts from Mr Stevenson's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Stevenson's clinical care at the prison.
10. We informed HM Coroner for Teesside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted Mr Stevenson's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She believed her father had been on a coeliac diet and asked whether this was linked to the stomach problems that had caused his death. She also asked whether he had any other stomach or bowel problems and, if so, whether the prison should have identified these sooner. She was concerned that his accommodation in the prison was not always suitable and, when he was in a cell in a houseblock, he could not reach the cell call bell.
12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
13. Mr Stevenson's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Holme House

14. HMP Holme House is a local prison holding over 1200 men. Most are on remand, or recently convicted by courts in the local area. Since April 2015, G4S has provided the health services at the prison. Care UK was the previous healthcare provider.
15. There is a 24-hour inpatient unit with 16 beds and palliative care facilities.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Holme House was in August 2013. Inspectors reported that the overall quality of health care had improved and was good. They found that patient care was very good, with an appropriate mix of clinics for primary care and lifelong conditions. Waiting times were reasonable and non-attendance rates low. Inpatient care had improved, but the shower and bathing facilities were poor.
17. Inspectors reported that prison healthcare staff had started to assess the level of social care prisoners required.

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 to December 2014, the IMB reported that patient care had improved due to introduction of a triage system, a patient forum and new bathrooms in the inpatient unit. However, they continued to receive many complaints about health services.

Previous deaths at HMP Holme House

19. Mr Stevenson was the fifth person to die from natural causes at Holme House since January 2014. There were no similarities between the circumstances of Mr Stevenson's death and previous deaths at the prison.

Key Events

20. On 31 March 2014, Mr William Stevenson was remanded to HMP Holme House. In September he received a three-year sentence for sexual offences.
21. At an initial health screen, he reported a number of medical conditions, including Klippel-Feil Syndrome, osteoarthritis, kidney disease, angina and high blood pressure. He also had a history of transient ischemic attacks (TIA - often known as mini strokes). Mr Stevenson used an electric wheelchair, though he could bear his own weight and move from his chair without help. He was admitted to the prison's inpatient unit for further assessment. A blood test indicated that he was slightly anaemic.
22. Later that evening, a GP reviewed Mr Stevenson and prescribed several medications, including indomethacin (a non-steroidal anti-inflammatory drug used as a pain killer) and lansoprazole (to reduce stomach acid and treat stomach and intestinal ulcers). The GP saw Mr Stevenson frequently throughout his time at Holme House.
23. On 2 April, a nurse noted that Mr Stevenson had said he had stomach pain and loose stools. Later that day, at a mental health assessment, Mr Stevenson said that he had not eaten since January and only drank coffee.
24. On 3 April, the healthcare manager began a care plan to encourage Mr Stevenson to eat his meals and drink regularly. Healthcare staff regularly checked Mr Stevenson's intake and noted that he ate small amounts of food. He had normal prison meals and was not on a coeliac or other special diet. On 14 April, a nurse noted that Mr Stevenson had gained weight.
25. At an appointment on 23 April, a GP advised Mr Stevenson that indomethacin was not the safest anti-inflammatory for his condition as there could be long-term effects, such as renal impairment and cardiovascular problems. He explained that anti-inflammatories are also known to cause stomach ulcers. Mr Stevenson did not want to change his medication to naproxen (another anti-inflammatory), which the GP believed was safer. The doctor noted that Mr Stevenson was taking lansoprazole, which is often prescribed to those taking anti-inflammatories to protect their stomach and intestines.
26. From 25 April, Mr Stevenson began to suffer from constipation. Healthcare staff treated him with a range of medication, including glycerol suppositories, lactulose and phosphate enemas.
27. On 23 July, a GP examined Mr Stevenson, as he felt tired and constipated. He found no abnormalities, and prescribed lactulose. The GP noted that Mr Stevenson had a low haemoglobin count and prescribed iron supplements on 25 July.
28. On 31 August, Mr Stevenson moved to a cell in the inpatient unit, modified for disabled prisoners. The healthcare manager told Mr Stevenson that he needed to stay in the inpatient unit because the prison could not manage his social care needs on a standard residential houseblock. However, on 26 September, Mr

- Stevenson said that he wanted to mix more with other prisoners and would like to move to a houseblock.
29. On 7 October, Mr Stevenson agreed to take naproxen rather than indomethacin. Nurses told Mr Stevenson that if he wanted to move to a houseblock, the prison would allocate a buddy to help him and nurses and healthcare assistants would also support him. (A buddy is another prisoner who helps fellow inmates with daily living activities.)
 30. On 29 October, a GP noted that Mr Stevenson's mild anaemia had not responded to iron supplements. The GP considered that there were no 'red flag' symptoms to suggest that the anaemia had caused abdominal problems, but he asked Mr Stevenson's community GP for information about previous haematology investigations. The GP faxed a letter indicating that he had been slightly anaemic on and off since 2005. In 2013, he had been admitted to hospital for investigation of his anaemia, but the GP had not received a discharge letter from the hospital to explain the outcome. On 31 October, the GP referred Mr Stevenson to a haematology specialist for a further opinion. The referral letter was sent, but Mr Stevenson did not receive an appointment and did not have further blood tests.
 31. In November, Mr Stevenson said that he had been constipated for a week and had found it difficult to pass urine. Two nurses examined his stomach and noted that there was no bloating.
 32. On 16 December, Mr Stevenson told the healthcare manager that he was happy in the inpatient unit but, after attending a disability meeting with other prisoners, he felt that he would be happier living in a houseblock.
 33. On 12 January 2015, a GP examined Mr Stevenson, who had been constipated for a week. He found no abnormalities and prescribed lactulose and a phosphate enema. A week later, the GP also prescribed macrogol compound (a laxative).
 34. On 27 April, a GP reviewed Mr Stevenson, who had general abdominal pain, without any nausea or fever. The GP examined his abdomen and found some bloating. He thought this was due to the macrogol, so suspended it.
 35. At the beginning of May, healthcare staff began taking Mr Stevenson to mix with other prisoners in Houseblock 3 during association periods, in preparation for moving there, as he had requested. Houseblock officers allocated him a buddy, and Mr Stevenson moved to the houseblock on 18 May. Responsibility for his social care was transferred to the houseblock nurse. The next day, he said he was unhappy about the move.
 36. On 20 May, Mr Stevenson gave the healthcare manager a letter, in which he said that he was praying to God to end his life, because of the discomfort he felt during the night, but had felt better after help from healthcare staff. The next day, officers raised concerns with prison managers and healthcare staff about Mr Stevenson's ability to cope with living in the houseblock.
 37. On 24 May, a nurse noted that Mr Stevenson found it difficult to move around his cell, due to limited space between the bed and the toilet. On 8 June, a social worker reviewed Mr Stevenson's living arrangements and concluded that he

needed a double cell, with a profiling bed and a crash mat. There were no suitable cells available elsewhere at that time, so Mr Stevenson was admitted to the inpatient unit again on 9 June.

38. On 15 June, while a GP was examining him for left-sided chest pain, Mr Stevenson told him that he wanted to take indomethacin again. The GP again explained that naproxen was safer, but Mr Stevenson felt indomethacin worked better for him and said he was prepared to accept the risks. The GP prescribed a smaller dose than previously.
39. On 4 August, staff found Mr Stevenson on the floor of his cell. He complained of chest pain and nausea and said he had vomited. A GP gave Mr Stevenson three doses of glyceryl trinitrate (GTN) spray but his symptoms persisted. The GP thought that he might have had a heart attack and requested an ambulance. Paramedics took Mr Stevenson to hospital. The Head of Security decided that officers should not restrain Mr Stevenson, due to his lack of mobility; a decision that we applaud.
40. When he arrived at hospital, Mr Stevenson said that he also had abdominal pain. Doctors carried out several tests and found that he was very constipated. Prison healthcare staff telephoned the hospital each day for updates on his condition and whether there were any plans to discharge him. Hospital staff gave Mr Stevenson daily enemas and his condition had improved slightly by 10 August.
41. On 14 August, the prison informed Mr Stevenson's family that he had been admitted to hospital. His family then visited him frequently. (We would normally expect prisons to inform families quickly when a prisoner is seriously ill in hospital, but we recognise that, after his original admission, his condition was not regarded as serious or life-threatening and the prison expected him to be discharged soon.)
42. On 30 August, Mr Stevenson's condition declined suddenly and he was admitted to the hospital's intensive care unit. He had surgery late on the evening of 31 August.
43. On 1 September, the hospital informed Holme House that Mr Stevenson was likely to die shortly. The prison appointed a prison manager and an officer as the family liaison officers. The prison manager spoke to prison escort staff at the hospital, who told her that Mr Stevenson's family was with him. Mr Stevenson died that day. His family were with him when he died.

Contact with Mr Stevenson's family

44. After Mr Stevenson's death, the officer went to the hospital to offer his family condolences and support. The officer and the prison manager maintained contact with Mr Stevenson's family in person and by telephone. His family spoke highly of the escort officer who was with him when he died and the quality of the family liaison.
45. Mr Stevenson's funeral was held on 17 September. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

46. The prison posted notices informing staff and other prisoners of Mr Stevenson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Stevenson's death.

Post-mortem report

47. A post-mortem examination concluded that Mr Stevenson died of multi-organ failure, due to acute peritonitis (when the lining of the stomach becomes infected) and a perforated gastric ulcer. Acute pyelonephritis (a sudden and severe kidney infection) also contributed to Mr Stevenson's death.

Findings

Clinical care

48. The clinical reviewer noted that Mr Stevenson had a complex and rare genetic condition which resulted in disability, pain and illness. She considered that his medical and nursing care were of a good standard. In the eighteen months Mr Stevenson was at HMP Holme House, there were six hundred recorded contacts with healthcare staff. Due to his limited mobility and social care needs, Mr Stevenson spent most of his time in the prison's inpatient unit. He had daily contact with healthcare staff, who ensured that he ate and drank regularly and they responded promptly to his health and social care needs.
49. The clinical reviewer found no evidence that Mr Stevenson had any symptoms of an ulcer, the condition that caused his multi-organ failure, while he was at Holme House. Use of indomethacin can cause gastric ulcers, but the GP had discussed the side effects and risks with Mr Stevenson, and took account of his preferences. He also prescribed lansoprazole to offer some gastric protection. The clinical reviewer noted that this was a positive example of involving Mr Stevenson in a decision about his care.
50. Mr Stevenson had longstanding constipation and anaemia. Although he had no 'red flag' symptoms to indicate any worrying changes to his condition, as a precaution, the GP had referred him to a haematology specialist to check his anaemia. He did not receive an appointment but the prison did not chase this up with the hospital.
51. The clinical reviewer did not consider that Mr Stevenson's anaemia warranted urgent investigation but as the referral had been made, this should have been pursued with the hospital. The prison's healthcare administration manager said that, at that time, there was no process to follow up such referrals, but they have since introduced a system because of the need to monitor waiting times. We are satisfied by this response. The clinical reviewer had made recommendations about this and other matters in her clinical review, which the Head of Healthcare will need to address. As they were not directly related to the circumstances of Mr Stevenson's death, we do not repeat them in this report.
52. Overall, the clinical reviewer considered that Mr Stevenson's care was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Stevenson received a good standard of care at Holme House.

Mr Stevenson's location

53. Mr Stevenson was admitted to the prison's inpatient unit, as it would have been difficult to meet his social care needs if he was living in a standard houseblock. In September and December 2014, Mr Stevenson asked to move to a houseblock and healthcare staff arranged for him to move and for a buddy to support him. While the move was ultimately unsuccessful, due to difficulty moving around his cell, we are satisfied that the prison's attempt to manage his social care needs outside the inpatient unit was appropriate and in line with Mr Stevenson's wishes at the time.

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