Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Mark Stevens a prisoner at HMP Full Sutton on 20 October 2016

**A report by the Prisons and Probation Ombudsman**
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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*

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 Mark Stevens died on 20 October 2016 while a prisoner at HMP Full Sutton. He was 55 years old. I offer my condolences to Mr Stevens' family and friends.

Mr Stevens was diagnosed with a benign ampullary tumour in May 2015. In August 2016, he became ill and he was sent to hospital where a biopsy indicated that the tumour had grown. Mr Stevens' condition deteriorated and he died on 20 October.

The clinical reviewer found that some of Mr Stevens' care was very good, but that in other areas it was not equivalent to that he could have expected to receive in the community. In particular, there were delays in chasing up hospital results and in giving Mr Stevens information, and there was poor communication between pharmacy and healthcare staff regarding Mr Stevens' non-compliance with medication. I am also disappointed that Mr Stevens' restraints were only removed two hours before he died.

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** **October 2017**

## Contents

# Summary

## Events

1. On 10 June 2008, Mr Mark Stevens was convicted of sexual offences. He was sentenced, on 5 February 2009, to 22 years imprisonment and sent to HMP Full Sutton. He had a mild learning disability and had suffered from psychosis, anxiety and childhood epilepsy.

2. In May 2014, specialists diagnosed Mr Stevens with a benign ampullary tumour but felt he was not suitable for surgery because of high blood pressure in his portal vein (which takes blood to the liver from the stomach and intestines). The specialists wanted prison healthcare staff to monitor him via liver function tests. There was a delay in chasing up this diagnosis and a month's delay in giving Mr Stevens this information but staff did monitor him as requested.

3. In July 2015, an annual health check revealed that Mr Stevens had not been taking any of his prescribed blood pressure medication for ten months and that the pharmacy staff knew about this but had not told healthcare staff. The matter was quickly rectified when doctors simplified his medication regime, reinforced the importance of taking medication and involved nurses and wing staff in ensuring his compliance.

4. In August 2016, Mr Stevens told healthcare staff that he had been vomiting. He was closely monitored for a week and when his liver function tests deteriorated, a doctor arranged for him to be admitted to hospital. Specialists carried out further investigations, including a biopsy on his tumour. These showed that his tumour had grown and there were cell changes that could be indicative of cancer. Again, the specialists did not consider him suitable for surgery. There was a 13 day delay in giving this information to Mr Stevens.

5. On 12 October, Mr Stevens went to hospital for a planned endoscopy. Doctors admitted him to carry out further investigations. Prison managers authorised officers to use double handcuffs for the majority of his time in hospital and restraints were only removed two hours before his death.

6. Hospital doctors did not give Mr Stevens a formal prognosis but he deteriorated quickly and after vomiting profusely for several days, he died on 20 October.

## Findings

7. The clinical reviewer found that some of Mr Stevens' care was very good but that in areas it was not equivalent to that he could have expected to receive in the community. There were delays in chasing up hospital results and giving Mr Stevens the information. There was also a lack of communication between the pharmacy and healthcare staff regarding Mr Stevens' non-compliance with medication. However, the pharmacy and healthcare staff have since implemented a regime to avoid a repeat of this.

8. Although the decision to use restraints for Mr Stevens' hospital visit was appropriate, we believe that the escort chain which was used after five days should have been removed sooner than two hours before Mr Stevens' death.

## Recommendations

- The Head of Healthcare should ensure that a system is in place to chase up expected communications and results from secondary care providers and that staff give these results to a prisoner as soon as possible.
- The Governor and Head of Healthcare should ensure that risk assessments for prisoners taken to hospital are reviewed in a timely manner and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Full Sutton informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded with positive information about Mr Stevens' time at Full Sutton.

10. The investigator obtained copies of relevant extracts from Mr Stevens' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Stevens' clinical care at the prison.

12. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Stevens' sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider but she did not.

14. Mr Stevens' sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

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

# Background Information

### HMP Full Sutton

16. HMP Full Sutton is a high security prison near York, which holds up to 626 men. Spectrum Community Health CIC provides a range of integrated health services. Healthcare staff are on duty for twenty-four hours a day. An inpatient healthcare unit, with six beds, provides full nursing care for patients, including a palliative care suite. Spectrum contracts the East Riding of Yorkshire Council for social care arrangements.

### HM Inspectorate of Prisons

17. The most recent inspection of Full Sutton was an unannounced inspection in January 2016. The inspectors found that healthcare provision was reasonable overall, with good access to an appropriate range of services. Chronic disease management was reasonable but social care arrangements were underdeveloped. The inpatient unit provided a calm and decent service.

### Independent Monitoring Board

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. In its most recently published annual report for 2016, the IMB noted that prisoners reported that they received a good level of healthcare except in dentistry and optometry. The IMB noted that, in March 2016, the prison struggled to maintain minimal healthcare provision due to refurbishment work being carried out in the healthcare wing.

### Previous deaths at HMP Full Sutton

19. Mr Stevens was the ninth person to die of natural causes at Full Sutton since January 2015. We have made previous recommendations about the inappropriate use of restraints.

# Key Events

20. On 10 June 2008, Mr Mark Stevens was convicted of sexual offences. He was sentenced, on 5 February 2009, to 22 years imprisonment and sent to HMP Full Sutton. He had a mild learning disability and had suffered from psychosis, anxiety and childhood epilepsy.

21. On 30 December 2013, a prison GP reviewed Mr Stevens who reported that felt unwell and had loose stools. He weighed Mr Stevens, who was 65.8 kg (but had weighed 73.7kg in November 2012). The doctor performed liver function tests, which produced abnormal results, but he thought that medication Mr Stevens was taking at the time (fluoxetine for low mood) might have been the cause. He discontinued the fluoxetine and planned to review Mr Stevens in two weeks' time. At the same time, he made an urgent referral for an ultrasound scan under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

22. Mr Stevens had an ultrasound scan on 14 January 2014, which identified a mass in the bottom half of his bile duct. The hospital communicated the results to the prison on 15 January and recommended they urgently refer Mr Stevens to an upper gastrointestinal surgeon, which the prison did that day. An administrator chased up the appointment on 29 January and was told that an appointment for 7 February was being made as this was the first date available. However, when he attended the appointment the specialist just told Mr Stevens that a CT scan was needed in order to make a formal diagnosis.

23. The CT scan took place on 5 March and the inconclusive results were sent to the prison on 15 March. The hospital also did an endoscopic ultrasound on 1 April, but again the results did not give complete clarity so, on 12 May, biopsies were taken. On 23 May, a consultant hepatologist contacted a prison GP with the results, which identified Mr Stevens had a benign ampullary tumour. The consultant planned for specialists to discuss the findings at a regional multi-disciplinary team (MDT) meeting and formulate a management plan which they would then communicate to the prison healthcare team. The GP explained all this to Mr Stevens the same day.

24. The records do not indicate when the MDT meeting was supposed to be or that anyone from the prison healthcare team chased it up within a reasonable timeframe. But, on 4 September 2014, the GP contacted the consultant hepatologist to find out what had happened. She was told the team had decided Mr Stevens was not a suitable candidate for surgical intervention (because he had underlying high blood pressure in the portal vein) and that they wanted the prison to monitor his liver function every six months. The consultant confirmed this in a letter to the prison dated 4 September, but a nurse did not tell Mr Stevens until 3 October. There is no reason documented why there was such a delay.

25. Over the next few months, Mr Stevens was occasionally seen in healthcare for issues relating to his mental state and hepatitis B condition.

26. On 29 July 2015, Nurse Bilton carried out an annual health check on Mr Stevens. Mr Stevens said that he had not taken any of the medications prescribed for his

portal hypertension (vitamin b, thiamine, lansoprazole, creon and colecalciferol) for ten months. He said that he did not have cancer and felt well enough to not have to take them. A nurse spoke to the pharmacy team (who were aware of his non compliance, but at the time did not report such matters to healthcare staff) and alerted the GP.

27. The GP reviewed Mr Stevens' medication regime and reduced the number of tablets he had to take. A Matron and a nurse worked closely with Mr Stevens to reinforce the importance of taking his prescribed medication and wing based officers were also involved in ensuring he took his medication.

28. The prison's healthcare staff monitored Mr Stevens, and his condition and weight remained relatively stable. In January 2016, he was admitted to hospital with a biliary obstruction (an area covering the liver, bile ducts and gall bladder) and infection. During investigations, specialists noticed that his benign ampullary tumour had grown. He had a stent inserted as a previous biliary stent had moved out of place, but no further recommendations were made regarding his tumour and he continued to remain stable.

29. Mr Stevens had two instances of diverticulitis (an infection in the large intestine) in July and early August; both of which were treated successfully with medication.

30. On 24 August, Mr Stevens told a nurse that he had vomited three times the day before. Staff monitored him over the next few days by taking his observations and doing liver function tests. They noticed some anomalies but thought they were possibly related to him having a virus or other issue. A prison GP prescribed analgesia and an anti sickness medication on 25 August. Staff continued to closely monitor him, but although he reported feeling slightly better on 28 August, he was still vomiting.

31. On 31 August, Mr Stevens saw a prison GP. He was still vomiting, had increased abdominal pain, was bloated and his liver function test results were deteriorating. He weighed 65.9kg, which had decreased from 67.2kg on 12 August. The doctor arranged for him to be admitted to hospital and he was treated with intravenous antibiotics for what was believed to be a bile duct infection. Another stent was also inserted to deal with a narrowing in his duodenum (the first part of the small intestine) and biopsies taken from the ampullary tumour. Doctors discharged him on 8 September and the prison was told that Mr Stevens' future care would be discussed at another MDT.

32. On 27 September, the prison's healthcare department received a letter from the consultant hepatologist to tell them that Mr Stevens' case had been discussed. The team still did not consider surgical intervention to be an option but confirmed that the tumour had grown. The biopsy results showed cell changes indicative of cancer. The team recommended continued management of his symptoms and planned an endoscopy for 12 October.

33. On 10 October, a prison GP saw Mr Stevens and discussed the results with him. He tentatively broached where Mr Stevens might prefer to be cared for regarding his end of life care (even though no terminal diagnosis had been made) and Mr Stevens just said that he wanted to live.

34. On 12 October, Mr Stevens went to hospital for his planned endoscopy. He was restrained at all times with double cuffs, except when he was receiving treatment, using the toilet or eating, when an escort chain was used instead.

35. Hospital staff identified that Mr Stevens was jaundiced and required a biliary drain (a procedure where a small, flexible, plastic tube is placed through the skin into the liver in order to drain an obstructed bile duct system). Doctors discussed the possibility of transferring him to another hospital, but his condition deteriorated. On 17 October, a Senior Officer (SO) authorised that in light of Mr Stevens' limited mobility and his worsening medical condition, he should be restrained by an escort chain only.

36. On 18 October, the bedwatch records describe Mr Stevens as having an intravenous line inserted to deliver fluids because he was constantly vomiting. A nurse also told Mr Stevens that a case review to discuss the possibility of surgery was going to be discussed in a few days. On 19 October, although he was still vomiting at times, staff took him off the drip and he was able to eat solid foods.

37. However, by 20 October, Mr Stevens was very shivery, vomiting profusely and fell when he went to the toilet. At 12.41pm, in light of Mr Stevens' condition, the deputy governor authorised officers to remove all restraints. At 2.11pm, Mr Stevens had a seizure and was pronounced dead at 2.20pm.

### Liaison with Mr Stevens' family

38. On 17 October, when Mr Stevens' condition deteriorated, prison managers decided they might need to appoint a family liaison officer (FLO). Doctors had not given Mr Stevens a firm prognosis and there was talk of him returning at some point to the prison's care, but he was clearly very unwell.

39. The prison appointed an officer as a FLO on 19 October. He discovered that Mr Steven's next of kin was his probation officer, and contacted her the same day. On 20 October, he informed her that Mr Stevens had died and she made arrangements for his family to be informed. On 21 October, Mr Stevens' sister contacted the FLO and he remained in touch with her offering support and information.

40. Mr Stevens' funeral was held on 2 November and the prison contributed to the cost of the funeral, in line with national instructions.

### Support for prisoners and staff

41. The prison have told us that they do not keep minutes of hot debriefs but that a governor held one at the hospital with the escorting staff. They were offered support and given the Care Team's details.

42. The prison posted notices informing other prisoners of Mr Stevens' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Stevens' death.

## Post-mortem report

43. The post-mortem report confirmed that Mr Stevens died from aspiration of gastric contents (the contents of his stomach entering his larynx and lower respiratory tract), caused by an upper gastrointestinal tract haemorrhage caused by ampullary cancer.

# Findings

## Clinical care

44. The clinical reviewer felt that the care Mr Stevens received at Full Sutton was mostly equivalent to that he could have expected to receive in the community and that many aspects of his care were very good. However, there were some unnecessary delays in keeping Mr Stevens informed about his condition and treatment plan, and communication between the pharmacy staff and healthcare staff was poor.

45. In 2014, the hospital did not communicate the results of the MDT to the prison healthcare team, though no one from the prison chased up the matter until 4 September when a prison GP phoned the consultant hepatologist. As a result, Mr Stevens was not informed of the outcome or that he was not a candidate for surgery until 3 October 2014.

46. We asked the Head of Healthcare why the MDT results had not been chased up and why there was a delay giving them to Mr Stevens. She explained that it was not unusual for there to be a three month wait for the results of MDT meetings, so she did not consider that there was a particular delay in chasing or getting the results. However, she said she did not know why there was a delay giving Mr Stevens the results, as her expectation was that this would have been done sooner. She assumed it was an oversight.

47. A similar delay occurred two years later. On 27 September 2016, the healthcare department received a letter from the consultant hepatologist, which confirmed that Mr Stevens' tumour had grown and there were cell changes that were indicative of cancer. However, a prison GP did not give Mr Stevens this information until 10 October. We asked the Head of Healthcare why there had been a delay and she said that the correct diagnosis was 'not documented' until 5 October. This does not explain the reason for the delay or why it took a further five days to inform Mr Stevens. We are disappointed at the delays that Mr Stevens experienced in being told about his condition and treatment plans. We make the following recommendation:

    **The Head of Healthcare should ensure that a system is in place to chase up expected communications and results from secondary care providers and that staff give these results to a prisoner as soon as possible.**

48. There were also issues with Mr Stevens' compliance with medication. On 29 July 2015, a nurse discovered that Mr Stevens had not been taking any of the medication to treat his portal hypertension for ten months. It became clear that pharmacy staff were aware of his non compliance.

49. We asked the Head of Healthcare how this had come about and she told us that at the time pharmacy staff did not routinely report non compliance. She explained that it was a patient's responsibility to take their medication but that Mr Stevens chose not to do so. She explained that the healthcare unit introduced a new system whereby if prisoners do not collect their in possession medication they are re-invited to do so. After two failures to collect, the pharmacy team will

inform the healthcare team and a nurse will speak to the prisoner. Further to this, the nurse will refer the patient to a GP to discuss the matter further.

50. While we feel that the matter of Mr Stevens' non compliance should have been reported much sooner, we are satisfied that appropriate steps have been taken to ensure this does not happen again. As a result, we do not make a recommendation.

### Restraints, security and escorts

51. 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. The judgment indicated 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.

52. On 12 October 2016, Mr Stevens had a planned appointment for an endoscopy. A prison GP completed the medical risk assessment. She did not object to restraints and said that Mr Stevens' medical condition did not restrict his ability to escape unaided. A SO completed the security risk assessment and said that all of Mr Stevens' risks (including of escape) were low, apart from his risk to children which was medium. He recommended that two officers accompany Mr Stevens and restrain him with double cuffs, though an escort chain could be used for going to the toilet and treatment. A governor authorised this.

53. Double cuffing entails the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health. 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.

54. After he went in for his procedure, hospital staff discovered Mr Stevens was jaundiced and they wanted to carry out other investigations. Apart from he was eating meals, undergoing procedures or using the toilet, he remained double cuffed.

55. On 17 October, a SO was advised that Mr Stevens' mobility was now limited because of his worsening medical condition. It is not clear who told him this but the SO authorised that double cuffs be swapped for an escort chain. Mr Stevens was vomiting a lot and this situation continued with only very brief respite. The escort chain remained in place until two hours before his death on 20 October when a prison manager recorded on the risk assessment document that the duty governor had given permission for the removal of all restraints in order to maintain Mr Stevens' decency.

56. We asked the Head of Security and Intelligence about the decision to keep Mr Stevens restrained by double cuffs for so long and why the escort chain was only removed shortly before his death. He told us that restraints must be applied in all but exceptional circumstances and pointed out that Mr Stevens' initial appointment was planned. Although it resulted in a longer stay and he was vomiting, he said that staff conversed with hospital staff throughout and, although vomiting, Mr Stevens was mobile. He considered that the use of an escort chain was proportionate right up until the two hours before his death.

57. We appreciate that, initially, Mr Stevens went to hospital for a planned procedure, did not appear to be in very poor health and there had been no medical objection to the use of restraints. However, it was clear that Mr Stevens' condition deteriorated quickly and that the risks that he presented were mostly low.

58. We consider that the initial decision to use restraints when escorting Mr Stevens to hospital was reasonable. A prison GP advised that Mr Steven's medical condition did not restrict his ability to escape. We are pleased that the level of restraint was reviewed in line with Mr Stevens' risk. We are concerned, though, that it took a period of five days and a very clear deterioration in Mr Stevens' condition before this decision was made and we are particularly concerned that the escort chain then remained in place until two hours before Mr Stevens died by which point he had become very seriously ill. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of the prisoner and are based on the actual risk the prisoner presents at the time.**

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