

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Stevenson a prisoner at HMP Elmley on 27 March 2018

A report by the Prisons and Probation Ombudsman

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Raymond Stevenson died in hospital on 27 March 2018 of bronchopneumonia while a prisoner at HMP Elmley. He was 78 years old. I offer my condolences to those who knew him.

Mr Stevenson was admitted to hospital on the morning of 27 March and died that evening. The post-mortem found that his bronchopneumonia was caused by chronic obstructive pulmonary disease (COPD – a collection of lung diseases) but he was not diagnosed with either condition prior to his admission to hospital. We are satisfied, however, that prison healthcare staff did not miss any opportunities to diagnose these conditions earlier and that his care at Elmley was equivalent to that which he could have expected to receive in the community.

However, Mr Stevenson's care plan specified that staff should take his physical observations daily but they were not doing so in the period leading up to his death. If healthcare staff had done this, it is possible that they might have identified that Mr Stevenson's health was deteriorating.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

August 2018

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Summary

Events

1. Mr Raymond Stevenson entered prison custody in June 2006. After a spinal injury in October 2011 and a stay in hospital, he was discharged to HMP Elmley on 29 December 2011. He had incomplete paraplegia (partial damage to the spinal cord), which left him unable to stand and requiring help with most of his personal care. He was admitted to the inpatients department at Elmley, where 24-hour healthcare was available. Initially he used a wheelchair but in his later years, he was mostly confined to his bed.
2. In the week leading up to Mr Stevenson's death, he was sleeping throughout the morning and was difficult to wake. He also refused personal care, although it was not unusual for him to do so. The prison nurses who cared for Mr Stevenson said that apart from his increased sleepiness, they thought he was his normal self.
3. On the morning of 27 March 2018, Mr Stevenson was confused and shaking, with slurred speech. A prison GP examined him and found he had low blood pressure and a slow pulse. He arranged for an emergency ambulance to take him to hospital. Mr Stevenson died at 9.30pm that evening. The post-mortem report shows that he died from bronchopneumonia, caused by chronic obstructive pulmonary disease (COPD – a collection of lung diseases including chronic bronchitis and emphysema).

Findings

4. Mr Stevenson was not diagnosed with COPD or pneumonia prior to his admission to hospital. The clinical reviewer was satisfied that prison healthcare staff had not missed any opportunities to diagnose these conditions earlier and that his care was equivalent to that which he could have expected to receive in the community.
5. However, one of Mr Stevenson's care plans at Elmley specified that his physical observations should be taken daily. This was not being done in the weeks before his death. It is possible that, had healthcare staff been taking daily observations in line with the care plan, they might have identified that Mr Stevenson's health was deteriorating.

Recommendations

- The Head of Healthcare should ensure that staff are aware of the care plans in place for individual prisoners and that they provide care in line with them.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Stevenson's prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Stevenson's clinical care at the prison.
9. The investigator and clinical reviewer jointly interviewed three members of staff at Elmley on 2 May 2018.
10. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Elmley

12. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that healthcare services at the prison had improved since the last inspection in June 2014 and were generally good. The inpatient unit provided a calm and well-run environment with good care for prisoners with the most acute needs.

Independent Monitoring Board

14. 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 31 October 2017, the IMB reported that the overall care for patients located in healthcare was of a high standard due to the commitment of the staff. The outpatients department remained very busy and despite the department's efforts, complaints by prisoners to the Board remained at a high level. However, not all complaints proved to be justified.

Previous deaths at HMP Elmley

15. Mr Stevenson was the 19th prisoner at Elmley to die since March 2015. Of the previous deaths, fifteen died from natural causes, two took their own lives and two died from drug overdoses. Two prisoners have died since Mr Stevenson's death, both from natural causes. There were no similarities between Mr Stevenson's death and the other prisoners' deaths.

Key Events

16. Mr Raymond Stevenson was convicted on 16 June 2006 of sexual offences and sent to HMP Wandsworth. On 18 December, he was given an imprisonment for public protection (IPP) sentence with a minimum tariff of 18 months. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release.) He was convicted of further sexual offences on 25 July 2007 and on 15 February 2008, was given another IPP sentence with a minimum tariff of two years.
17. In October 2011, Mr Stevenson fell in his cell at HMP Maidstone. He was admitted to hospital a few days later after he was found on the floor of his cell, unable to stand and with severe back pain. He was diagnosed with a spinal fracture and spinal stenosis (compression of the spinal cord). When he was discharged from hospital on 29 December 2011, he had incomplete paraplegia. (Complete paraplegia is absolute damage of the region of the spinal cord; incomplete paraplegia is partial damage. An individual with complete paraplegia may have total sensory and motor function loss of the lower body whereas someone with incomplete paraplegia may have sensory function but no movement, or vice versa.) He was sent to HMP Elmley.
18. Mr Stevenson was admitted to the inpatients department at Elmley where 24-hour healthcare was available. Because of his spinal injury, he was unable to stand, was incontinent of urine and had little bowel sensation so needed help to pass stool. He could feed himself but needed help with all his personal care and regular turning while in bed to prevent pressure sores. Initially he used a wheelchair but in his later years, he mostly stayed in his bed. Staff had to use a hoist to lift Mr Stevenson out of his bed and into a chair, but he often refused to be moved, preferring to stay in bed. Healthcare staff put in place numerous care plans to manage his clinical and personal care needs.
19. Mr Stevenson often refused care interventions and was sometimes abusive to staff delivering his care. In September 2014, a prison psychiatrist assessed that Mr Stevenson had dissocial personality disorder (a particularly challenging type of personality disorder, characterised by impulsive, irresponsible and often criminal behaviour, where the person is typically manipulative, deceitful and reckless, and will not care for other people's feelings) but he had full mental capacity to make decisions about his care. Nonetheless, staff put a care plan in place to prompt them to reassess his mental capacity whenever Mr Stevenson refused important aspects of care, and there were several occasions recorded in his notes when this was done.
20. On 19 March 2018, a nurse recorded that Mr Stevenson had refused all personal care and other interventions. A prison GP visited him at lunchtime and recorded that he had no concerns.
21. On 20 March, a nurse recorded that all personal care was given but that Mr Stevenson had refused to attend an X-ray appointment for his arm. (On 21 February, he was found to have a fracture of his right upper arm and was awaiting a fracture clinic review.)

22. On 21 March, a nurse recorded that Mr Stevenson had refused to be turned and had been asleep most of the morning. A GP spoke to him later that day about his refusal to attend his X-ray appointment.
23. On 22 March, a nurse recorded that Mr Stevenson had been asleep all morning and that he had been unable to wake him. When Mr Stevenson woke up around midday, he refused personal care.
24. On 23 March, the nurse again recorded that Mr Stevenson had been asleep all morning and he had tried to wake him four times.
25. On 24 March, a nurse noted that Mr Stevenson had refused personal care all day, despite being asked many times. That evening, another nurse noted that he had been refusing care all week and that there was a strong smell coming from his cell. She and a care assistant got his consent to attend to his personal care needs later that evening and they found he was soaked in faeces and urine. They washed him and dressed his pressure sores. The nurse washed him again in the morning before finishing her shift.
26. On 26 March, a nurse recorded that she attended to Mr Stevenson's personal hygiene needs with encouragement and that minimal assistance was given because he had been attended to the previous day.
27. At 10.37am on 27 March, a prison GP saw Mr Stevenson because he had been unwell that morning. He was confused, shaking, had slurred speech and a low temperature. The GP recorded that he had low blood pressure, a slow pulse and cold extremities, and requested an emergency ambulance. When the ambulance arrived at 12.33pm, Mr Stevenson refused to be moved. The GP, together with another GP colleague, and the ambulance crew carried out a mental capacity assessment. They all agreed he lacked capacity at that time so a decision was made to take him to hospital. Two prison officers accompanied him but he was not restrained.
28. Mr Stevenson died in hospital at 9.30pm that evening.

Contact with Mr Stevenson's family

29. The prison appointed a prison chaplain as family liaison officer. He checked all the relevant prison records but found no record of a next of kin for Mr Stevenson. The prison arranged his funeral, which took place on 1 June, and paid for it in line with national policy.

Support for prisoners and staff

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

Post-mortem report

32. The post-mortem report shows that Mr Stevenson died from bronchopneumonia, caused by chronic obstructive pulmonary disease (COPD – a collection of lung diseases including severe bronchitis and emphysema).

Findings

Clinical care

33. Mr Stevenson died from bronchopneumonia, caused by COPD. He was not diagnosed with COPD before his hospital admission. The clinical reviewer noted that there was no evidence in Mr Stevenson's medical records that he had experienced any COPD symptoms, such as wheezing or breathlessness. Mr Stevenson's weekly physiotherapy sessions included breathing exercises and, again, there was no mention of any breathing problems. As Mr Stevenson was largely bedbound in his later years, he never took significant exercise and this could have explained why he never showed any symptoms of breathlessness. The clinical reviewer was satisfied that prison healthcare staff did not miss any opportunities to diagnose COPD.
34. Mr Stevenson was not diagnosed with bronchopneumonia before his admission to hospital. The clinical reviewer noted that there was no evidence of a cough or breathlessness in the days leading up to 27 March, and no reports of chest pain or fever. The only apparent change was Mr Stevenson's increased sleepiness and increased refusal of personal care. However, the refusal of personal care was not unusual and the staff interviewed said that apart from Mr Stevenson being sleepier, he seemed his normal self in the days leading up to his death.
35. The clinical reviewer found no concrete evidence to alert staff that Mr Stevenson's health was seriously deteriorating. However, he considered that staff could have investigated his sleepiness and declining personal hygiene by performing two simple tests: taking his temperature and measuring his oxygen saturation level. Mr Stevenson had a care plan in place that specified his physical observations should be taken daily, but staff stopped doing this routinely in early March 2018 and his last oxygen saturation level reading was taken on 14 March. Part of the reason was that because of the size of Mr Stevenson's medical record, it had been split into two parts, an old volume and a new volume, and the physical observations care plan had not been transferred to the new volume. The second reason was that Mr Stevenson repeatedly refused to have his physical observations taken.
36. The clinical reviewer noted that Mr Stevenson's physical observation readings would have been used to generate a National Early Warning System (NEWS) score, which is an indicator of deteriorating health. Therefore, had these readings been taken daily in line with the care plan, it is possible that staff would have identified that Mr Stevenson's health was deteriorating. However, the clinical reviewer noted that the NEWS system was generally used to monitor patients with acute illnesses and that Mr Stevenson did not fall into this category. He said that daily readings would not have been taken in the community and therefore, based on community guidelines, there were no missed opportunities to diagnose pneumonia. The clinical reviewer concluded that Mr Stevenson's care was equivalent to that which he could have expected to receive in the community.

37. Nevertheless, we are concerned that the care plan in place for Mr Stevenson was effectively being ignored by staff. We make the following recommendation:

The Head of Healthcare should ensure that staff are aware of the care plans in place for individual prisoners and that they provide care in line with them.

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