Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Johnson a prisoner at HMP Swaleside on 14 February 2017

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*

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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 Stephen Johnson died on 14 February 2017 of a lung infection and pneumonia at HMP Swaleside. He was 55 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Johnson received a good standard of clinical care at Swaleside. Staff on the inpatients unit monitored his mental and physical health well, although Mr Johnson refused to attend a hospital appointment, which might have identified his illness.

While I am satisfied there was nothing that healthcare or prison staff could have done to predict or prevent his death, it is disappointing that staff did not know how to prioritise an emergency radio transmission.

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**

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Summary

Events

1. On 19 December 2007, Mr Stephen Johnson received an indeterminate sentence for public protection for violent offences. On 14 February 2014, he was transferred from HMP High Down to HMP Swaleside.

2. At his initial health screen, Mr Johnson was recorded as a non-smoker who did not have a history of substance misuse or thoughts of suicide or self-harm. He had been held in a secure mental health hospital before sentencing, but was not diagnosed with a mental health illness.

3. There were no significant entries in Mr Johnson's medical record until 21 November 2016 when a mental health nurse assessed Mr Johnson due to episodes of confusion. The nurse referred him for a MMSE (mini-mental state screening) on 23 November. Mr Johnson denied having any mental health issues and declined further in-reach support.

4. By 2 December, Mr Johnson had lost more than 10 per cent of his body weight and had a BMI of less than 18.5. The Head of Healthcare moved him to the inpatient unit, where a prison GP recommended a nutritional drink, a referral to a dietician, blood tests, a chest X-ray and an abdominal ultrasound. Care plans were also put into place.

5. Mr Johnson's X-ray on 6 December produced a normal result and he was prescribed cholacalciferol capsules (for vitamin D deficiency) and ferrous sulphate (for iron and anaemia deficiency).

6. On 12 December, a psychiatric consultant confirmed that Mr Johnson should remain on the inpatient unit for weight monitoring, blood tests and other physical checks. He arranged a neurology referral for 8 February, which Mr Johnson refused to attend.

7. On 22 December, a consultant haematologist at the hospital recommended a CT scan of Mr Johnson's chest, abdomen and pelvis, and depending on the results, a possible haematology review or bone marrow biopsy.

8. An ultrasound on 11 January identified a small amount of ascites (an abnormal fluid accumulation) in the pelvis and a right-sided pleural effusion (excess fluid around the lungs), which the sonographer noted would be explored during Mr Johnson's upcoming CT scan.

9. Mr Johnson remained on the inpatient unit until 25 January, when a multi-disciplinary team meeting concluded that there was no evidence that he had psychosis or severe mental illness.

10. He was discharged to a standard location and, on 9 February, signed a disclaimer refusing to attend his hospital appointment for the CT scan.

Events of 14 February

11. During the next two weeks, Mr Johnson gave no cause for concern and was locked up as usual on the evening of 13 February. At 8.20am the next day, an officer unlocked and went into Mr Johnson's cell after he did not respond. He checked for a pulse and alerted a healthcare assistant on the wing. The officer tried to call a medical emergency code blue several times but the signal was busy. Another officer arrived and transmitted a code blue five minutes later.

12. The healthcare assistant checked Mr Johnson's pulse and airway and began CPR until a senior nurse arrived, who assessed Mr Johnson and instructed the healthcare assistant to stop CPR. A prison GP pronounced Mr Johnson dead at 8.54am.

Findings

13. When Mr Johnson became unwell he was placed in the inpatient unit where his psychological and physical health was frequently monitored. He was subsequently referred for hospital appointments with a neurologist and for a CT scan of his chest, abdomen and pelvis. Despite the best efforts of prison GPs, Mr Johnson refused all further investigations, which might have identified a lung infection. We agree with the clinical reviewer that the care Mr Johnson received was equivalent to that which he could have expected in the community.

14. Although it did not change the outcome for Mr Johnson, a code blue emergency call could not be transmitted for five minutes after he was found because the network was busy and the officers did not know how to prioritise their transmission.

Recommendations

- The Governor should ensure that all staff who use radios understand how to transmit an emergency when the network is busy.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact her.

16. The investigator visited Swaleside on 28 February 2017 and obtained copies of relevant extracts from Mr Johnson's prison and medical records.

17. NHS England commissioned a clinical reviewer to review Mr Johnson's clinical care at the prison.

18. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We sent the coroner a copy of this report.

19. The investigator wrote to Mr Johnson's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not respond to our letter.

20. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Swaleside

21. HMP Swaleside, HMP Elmley and HMP Standford Hill form a group of prisons in the Isle of Sheppey. Swaleside houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17 bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Swaleside was in April 2016. Inspectors reported that only 15 per cent of prisoners were satisfied with healthcare provision. While prisoners had access to an appropriate range of primary care services and visiting specialists, they reported that not all long-term conditions clinics ran regularly because staffing was inconsistent. Despite this, prisoners were positive about the care and treatment they received in the inpatient unit where bed occupancy was low at about 70 per cent.

Independent Monitoring Board

23. 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 April 2016, the IMB reported that prison staff shortages continued to impact lock up time on the inpatients unit, non-delivery of attendance forms on wings for appointments in the Healthcare Unit resulting in non-attendance, and outpatient appointments being cancelled because staff were unavailable for escort duties.

Previous deaths at HMP Swaleside

24. Mr Johnson was the second prisoner to die from natural causes at Swaleside since January 2015. There have been four deaths since. There were no significant similarities between the investigations.

Key Events

25. On 19 December 2007, Mr Stephen Johnson received an indeterminate sentence for public protection for violent offences. He was transferred from HMP High Down to HMP Swaleside on 14 February 2014.

26. At his initial health screen, a healthcare assistant recorded that Mr Johnson was a non-smoker and he did not have a history of substance misuse or thoughts of suicide or self-harm. He had not been diagnosed with any mental health issues.

27. There were no significant entries in Mr Johnson's medical record until 21 November 2016 when a mental health nurse assessed Mr Johnson. Mr Johnson had told officers on the wing that he was waiting for a van, and they noted he appeared disorientated, isolated and blank. She noted that he couldn't recall her name, he was unaware of the date and was flat in mood. He denied mood issues, lack of appetite or problems sleeping. She told him she would see him again for a mini mental state screening.

28. On 23 November, Mr Johnson asked a nurse for a haircut and appeared confused. At the mini mental state screening on 25 November, a mental health nurse noted that Mr Johnson denied having any mental health issues and refused consent to obtain medical information from the hospital where he was admitted in 2005. Mr Johnson declined in-reach support and she closed his case.

29. A healthcare support worker noted on 2 December, that Mr Johnson had not drunk anything for over 24 hours and had had little food. The Head of Healthcare moved him to the inpatient unit.

30. A prison GP assessed Mr Johnson the same day. He noted he had lost more than 10 per cent of his body weight and had a BMI of less than 18.5. He recommended an oral intake of Fortisip (a nutritional drink), a referral to a dietician, bloods tests, a coeliac screen, a check of cortisol levels, a chest X-ray, and an abdominal ultrasound. The healthcare team created care plans to address Mr Johnson's weight loss, physical observations, and food refusal instruction.

31. Mr Johnson had a chest X-ray on 6 December, which produced a normal result. The following day, a prison GP noted that Mr Johnson was deficient in vitamin D and prescribed cholacalciferol capsules. The GP prescribed ferrous sulphate (iron to treat his anaemia).

32. A psychiatric consultant assessed Mr Johnson on 12 December. He confirmed that Mr Johnson should remain on the inpatient unit for weight monitoring, blood tests and other physical checks. He recommended a neurology referral, which a prison GP did immediately.

33. On 22 December, the prison GP spoke to a consultant haematologist at the hospital. He recommended a CT scan of Mr Johnson's chest, abdomen and pelvis, and a possible haematology review or bone marrow biopsy if the CT scans were normal.

34. On 3 January 2017, the prison GP noted that Mr Johnson declined a formal examination and declined the neurology appointment. He recorded that he would continue with Mr Johnson's current care and would not cancel the neurology appointment as it had already been arranged for 8 February. However, Mr Johnson signed a disclaimer refusing the neurology appointment.

35. Mr Johnson had an ultrasound on 11 January, and the sonographer noted a small amount of ascites (abnormal fluid accumulation) in the pelvis and a right-sided pleural effusion (excess fluid around the lungs). He noted a CT scan was already booked, and although he recommended a chest X-ray, the GP decided that another X-ray was not necessary given the normal result two weeks earlier.

36. Mr Johnson remained on the inpatient unit where he was monitored several times a day. On 25 January, the psychiatric consultant, the Head of Healthcare and a nurse had a meeting about Mr Johnson. The consultant reported that he had not found any evidence that Mr Johnson had psychosis or severe mental illness. He assessed Mr Johnson as fit for discharge from the inpatients unit, but that physical health investigations should continue.

37. On 27 January, a healthcare assistant carried out Mr Johnson's last physical observations. On 9 February, Mr Johnson signed a disclaimer refusing to attend hospital for the CT scan of his chest, abdomen and pelvis. He did not give any cause for concern and, on the evening of 13 February was locked up as normal.

Events of 14 February

38. At 8.20am on 14 February, an officer unlocked Mr Johnson's cell. He greeted Mr Johnson but did not hear a response. He went into the cell and checked for a pulse. When he found none, he alerted a healthcare assistant who was on the wing administering medication. He tried to call a code blue, but there was too much radio traffic. He told a prisoner to alert another officer while he continued to attempt a code blue transmission. When the healthcare assistant arrived, he checked Mr Johnson's pulse and airway and began cardiopulmonary resuscitation.

39. At 8.25am, a senior manager arrived and called an emergency code blue, and the control room called an ambulance. A clinical nurse manager and the deputy Head of Healthcare were telephoned to attend as extra assistance and arrived moments later. The clinical nurse manager immediately assessed that Mr Johnson was cold, blue and had signs of rigor mortis. She instructed the healthcare assistant to stop cardiopulmonary resuscitation. The deputy Head of Healthcare instructed the control room to stand down the ambulance. A prison GP pronounced Mr Johnson dead at 8.54am.

Contact with Mr Johnson's family

40. At 9.30am, the prison appointed an officer as the family liaison officer. Mr Johnson's parents were his next of kin. They lived more than a four-hour drive from Swaleside. She arranged for a senior manager from HMP Exeter to visit the parents. He left Exeter at 10.30am and arrived at 1.15pm. He informed Mr Johnson's parents of their son's death and offered his condolences.

41. The officer telephoned Mr Johnson's parents the next day and spoke to his mother. She maintained contact with her until after the funeral.

42. Mr Johnson's funeral was held on 22 March. The officer and a senior manager attended. The prison contributed to the costs of the funeral in line with national policy and held a memorial service.

Support for prisoners and staff

43. After Mr Johnson's death, a senior 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.

44. The prison posted notices informing other prisoners of Mr Johnson'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 Johnson's death.

Post-mortem report

45. The post-mortem concluded that Mr Johnson died of empyaema thoracis (lung infection) with pneumonia. No drugs or alcohol were detected in his system.

Findings

Clinical care

46. When Mr Johnson began to display signs that he was unwell, he was appropriately moved to the inpatient unit immediately where he had several examinations for his mental and physical health, frequent monitoring and several care plans were initiated. A prison psychiatrist made a neurology referral and a prison GP referred Mr Johnson for a CT scan on 9 February. Despite the prison GP trying to ensure Mr Johnson received treatment, he refused the CT scan, which the clinical reviewer considered might have helped to identify a lung infection. Healthcare staff provided a holistic approach to Mr Johnson's care and there is nothing more they could have done to prevent his death. We agree with the clinical reviewer that the care Mr Johnson received was equivalent to that which he could have expected in the community.

Emergency response

47. The officer who found Mr Johnson failed to transmit a code blue at 8.20am because the movement of prisoners created a busy radio network. He was not aware that when the network was busy and there was an emergency, the correct procedure to transmit a code blue was to radio "urgent message". When control room staff identify those words, they prioritise that channel to allow a code blue to be transmitted. After further attempts, another officer transmitted the code blue five minutes later. If the officer who found Mr Johnson had been aware of the correct emergency procedure, a code blue would have been called five minutes earlier. While this did not affect the outcome for Mr Johnson, in different circumstances a five minute delay could prove fatal. We make the following recommendation:

    The Governor should ensure that all staff who use radios understand how to transmit an emergency when the network is busy.

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