

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Gevaux a prisoner at HMP Elmley on 26 November 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.

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 Paul Gevaux died on 26 November 2017 of a heart attack at HMP Elmley. He was 55 years old. I offer my condolences to Mr Gevaux's family and friends.

I am satisfied that, overall, the care Mr Gevaux received at Elmley was equivalent to that which he could have expected to receive in the community. However, the care fell short in two specific areas.

When Mr Gevaux was found to have high cholesterol levels in his blood in 2014, healthcare staff at Elmley did not carry out a cardiovascular disease risk assessment. Had they done so, they might have put in place measures to reduce his cholesterol levels and minimise the risk of a cardiovascular event in the future.

A medication review was not carried out when Mr Gevaux returned to Elmley from hospital. He subsequently took too much medication, which resulted in him fainting. The failure to check his medication could have had more serious consequences.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2018

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Summary

Events

1. Mr Paul Gevaux was remanded to custody in September 2014 and sent to HMP Elmley. He remained at Elmley following his conviction for violent offences in June 2015.
2. In December 2014, blood tests revealed that Mr Gevaux had high cholesterol. GPs gave Mr Gevaux dietary advice. In June 2015, a nurse noted that Mr Gevaux was obese but he refused a referral to the weight management clinic.
3. On 19 October 2017, Mr Gevaux was taken to hospital with chest pain. Hospital doctors diagnosed a cardiac arrest and fitted a stent (a tiny tube inserted into a narrowed or blocked blood vessel to keep it open.) Hospital doctors prescribed Mr Gevaux medication for angina and to lower his blood pressure.
4. On 6 November 2017, Mr Gevaux was taken to hospital again. Hospital doctors diagnosed congestive heart failure and prescribed appropriate medication. On 17 November, Mr Gevaux fainted in his cell after accidentally taking too much of his prescribed medication.
5. At 4.05pm on 26 November, prisoners found Mr Gevaux unresponsive on his cell floor. A prison officer immediately called a medical emergency code. Healthcare staff and paramedics performed cardiopulmonary resuscitation (CPR) but were unable to resuscitate Mr Gevaux. At 4.57pm, paramedics recorded that he had died. The post-mortem examination found that he had died of a heart attack.

Findings

6. Despite Mr Gevaux being found to have high cholesterol in 2014, he was not offered a formal cardiovascular risk assessment. The clinical reviewer considered that GPs missed an opportunity to monitor Mr Gevaux's cholesterol level and to consider treatment to reduce his risk of a cardiovascular event in the future. In this respect, Mr Gevaux's care was not equivalent to that which he could have expected to receive in the community.
7. Mr Gevaux fainted in his cell after accidentally taking too much of his blood pressure medication that he kept in-possession. There was no evidence that GPs reviewed Mr Gevaux's prescribed medication when he returned to Elmley to ensure that he was taking the correct dose. We are concerned that when nurses finally checked his cell they found medication in his cell that he did not need.
8. With the above exceptions, the clinical reviewer considered that overall Mr Gevaux's care was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that cardiovascular risk assessments are offered to all prisoners aged over 40 with relevant risk factors, in line with NICE guidance.

- The Head of Healthcare should ensure that GPs complete a medication review when prisoners return from hospital. Checks should be made to ensure that prisoners have the correct items of medication in-possession.

The Investigation Process

9. 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.
10. The investigator obtained copies of relevant extracts from Mr Gevaux's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Gevaux's clinical care at the prison.
12. 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.
13. The investigator wrote to Mr Gevaux's son to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
14. Mr Gevaux's son received a copy of the initial report. He 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 Elmley

16. HMP Elmley is a local prison on the Isle of Sheppey, which serves the courts in Kent. It holds more than 1,200 men in five wings, with a mixture of single, double and triple cells. Integrated Care 24 Ltd (IC24) provides primary healthcare services, with input from Minster Medical Group. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

17. 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

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 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 out patients 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

19. Mr Gevaux was the seventh prisoner to die of natural causes at Elmley since January 2017. There were no similarities with the other deaths.

Key Events

20. On 17 September 2014, Mr Paul Gevaux was remanded to custody for violent offences and sent to HMP Elmley. On 22 June 2015, he was sentenced to 9 years and 6 months in prison.
21. At an initial health screen at Elmley, a nurse noted that Mr Gevaux did not have any significant medical conditions. Mr Gevaux was a smoker and declined help to stop. He complained of headaches caused by a head injury 15 years earlier and said he was prescribed codeine by his community GP. The same day a prison GP, examined Mr Gevaux and noted that his blood pressure was raised (160/100). The prison GP requested Mr Gevaux's community GP records. These were received on 19 September and said that Mr Gevaux was not on any regular medication.
22. On 18 September, Mr Gevaux did not attend an appointment to have his blood pressure taken. On 25 September, a nurse recorded Mr Gevaux's blood pressure as normal (138/89).
23. On 11 December, a prison GP, recorded Mr Gevaux's blood pressure as high (140/95) and his weight as 95kgs. He arranged for Mr Gevaux to have a routine full set of blood tests. The results revealed abnormal lipid levels (high cholesterol). On 16 December, a prison GP gave Mr Gevaux dietary advice to reduce his cholesterol. There was nothing else of significance in his medical records until July 2015.
24. On 8 July 2015, Mr Gevaux attended the 'well man' clinic with a nurse. His blood pressure was recorded as normal (138/84) and his cholesterol level had reduced from 5.8 mmol/l in December 2017 to 4.4 mmol/l. However, this was a random cholesterol test rather than a full-fasting lipid profile. She noted that Mr Gevaux was obese (98kgs) and gave him weight reduction advice. Mr Gevaux refused a referral to the weight management clinic.
25. During his time at Elmley, Mr Gevaux complained of urinary problems which were assessed in October 2015 by a urology specialist at Sheppey Hospital. He was diagnosed with lifestyle-related urinary tract symptoms and discharged by the urology specialist in July 2016. Mr Gevaux also had basal cell carcinomas (benign skin cancers) removed from his back. There was nothing else of significance in his medical record until October 2017.
26. On 19 October 2017, Mr Gevaux complained of chest pain on his left side which radiated to his left arm. A nurse attended and performed an electrocardiogram (ECG – a test that measures the rhythm of the heart). The results were faxed to the coronary care unit at hospital who advised admission to hospital. She arranged an emergency ambulance to take Mr Gevaux to hospital. Two officers accompanied Mr Gevaux and did not use restraints. A family liaison officer (FLO) contacted Mr Gevaux's son and told him Mr Gevaux was in hospital.
27. Hospital doctors diagnosed a cardiac arrest and fitted Mr Gevaux with a stent (a tiny tube inserted into a narrowed or blocked blood vessel to keep it open). During this procedure he had another cardiac arrest and another 24 hours later. Hospital doctors treated Mr Gevaux for aspiration pneumonia (lung infection) and

prescribed a GTN spray (glyceryl trinitrate is used to relieve the symptoms of angina) and ramipril to lower his blood pressure. Mr Gevaux returned to the inpatients unit at Elmley on 26 October.

28. On 27 October, a prison GP examined Mr Gevaux and advised daily blood pressure and weight readings. Mr Gevaux insisted on returning to the wing and the prison GP told him to press his cell bell if he experienced shortness of breath, leg swelling or chest pain. The prison GP authorised Mr Gevaux to keep his prescribed medication in his possession.
29. There is no evidence that nurses recorded Mr Gevaux's blood pressure or weight until 1 November when Mr Gevaux saw a prison GP. Mr Gevaux's blood pressure was recorded as normal (109/74) and his weight was 87.5kg.
30. At 11.31pm on 6 November, Mr Gevaux complained of chest pain and a nurse attended. Mr Gevaux was pale, clammy and nauseous. The nurse radioed an emergency code blue (which is used to indicate a prisoner has chest pain or difficulty in breathing) and the control room immediately called an ambulance. The paramedics arrived at 11.49am and took Mr Gevaux to hospital. Two officers accompanied Mr Gevaux and did not use restraints. A prison family liaison officer (FLO) contacted Mr Gevaux's son and told him he was in hospital. Hospital doctors diagnosed congestive heart failure and prescribed atorvastatin (for cardiovascular disease), bisoprolol (to lower blood pressure) and bumetanide (used to treat heart failure). A nurse saw Mr Gevaux on his return to Elmley on 11 November. He noted that Mr Gevaux kept his medication in his possession.
31. On 12 November, a prison GP assessed Mr Gevaux and reviewed his hospital discharge summary. The prison GP noted that nurses should record Mr Gevaux's blood pressure every other day and record his weight weekly. On 13 November, a nurse created a blood pressure and weight monitoring care plan.
32. At 1.44pm on 17 November, a healthcare assistant recorded Mr Gevaux's blood pressure as low (95/70) and asked a nurse to assess him. A nurse attended and found Mr Gevaux on his cell floor, looking very pale and confused. She radioed an emergency code blue and the control room immediately called an ambulance. The paramedic on duty, also attended and performed an ECG. He applied a defibrillator as a precaution. Mr Gevaux told the nurse he had taken the wrong dose of his in-possession medication. A paramedic responder arrived and took Mr Gevaux to hospital at 2.41pm. Again, prison officers did not restrain Mr Gevaux and the FLO informed his son.
33. Hospital doctors diagnosed fainting due to low blood pressure. Doctors concluded that Mr Gevaux had accidentally taken too much of his blood pressure medication. Mr Gevaux returned to Elmley on 18 November and was assessed by a prison GP. The hospital discharge summary was received on 20 November and noted that Mr Gevaux's in-possession medication might contain medication from both hospitals he had attended.
34. On 20 November, a nurse went to Mr Gevaux's cell to review his in-possession medication. She removed medication that Mr Gevaux did not need and gave him medication from his hospital discharge bag to ensure he had the correct amount.

35. On 22 November, Mr Gevaux had a further episode of chest pain which was not relieved by his GTN spray. A non-emergency ambulance took Mr Gevaux to hospital for further investigations. Mr Gevaux was returned to Elmley on 23 November. Hospital doctors increased the dose of Mr Gevaux's atorvastatin and bumetanide.
36. On 24 November, a nurse noted that healthcare staff were unaware that Mr Gevaux had returned to Elmley. This meant a GP or nurse did not assess Mr Gevaux before he returned to the wing. A prison GP reviewed Mr Gevaux's hospital discharge summary and amended his in-possession medication.

Events of 26 November 2017

37. At approximately 4.05pm on 26 November, prisoners alerted an officer that Mr Gevaux had collapsed in his cell. The officer radioed an emergency code blue and the control room immediately called an ambulance. Another officer and a colleague arrived and started cardiopulmonary resuscitation (CPR).
38. At 4.09pm, a nurse arrived and continued with CPR and advanced lifesaving procedures. The paramedics arrived at 4.36pm and took over Mr Gevaux's care. Mr Gevaux did not respond to treatment and at 4.57pm, paramedics recorded that he had died.

Contact with Mr Gevaux's family

39. At 7.05pm on 26 November 2017, the FLO visited Mr Gevaux's son, his nominated next of kin, and informed him of Mr Gevaux's death. He offered condolences and support.
40. The FLO remained in contact with Mr Gevaux's son until Mr Gevaux's funeral on 22 December. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

41. After Mr Gevaux's death, a prison 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.
42. The prison posted notices informing other prisoners of Mr Gevaux'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 Gevaux's death.

Post-mortem report

43. A post-mortem examination found that Mr Gevaux died from an acute myocardial infarction (heart attack).

Findings

Clinical care

44. We are satisfied that overall, the care Mr Gevaux received at Elmley was equivalent to that which he could have expected to receive in the community. However, there were two areas where the clinical reviewer felt that the standard of care fell short.
45. Mr Gevaux's age, obesity, smoking and high cholesterol level were obvious risk factors of heart disease. NICE guidance for cardiovascular disease states that there should be a systematic process for risk assessment of the condition for those likely to be at risk from the ages of 40 up to 84 years. There was no record that anyone considered a cardiovascular risk assessment for Mr Gevaux, particularly when his high cholesterol level was identified in 2014. The clinical reviewer considered that a risk assessment and further monitoring of his cholesterol level might have led to treatment to reduce Mr Gevaux's risk of a cardiovascular event in the future. We make the following recommendation:

The Head of Healthcare should ensure that cardiovascular risk assessments are offered to all prisoners aged over 40 with relevant risk factors, in line with NICE guidance.

46. When Mr Gevaux was returned to Elmley from hospital, prison GPs reviewed his hospital discharge summary. However, there is no evidence that GPs completed a medication review to ensure that Mr Gevaux was taking the correct dose of his medication and that he did not have unnecessary medication in his cell. It was not until Mr Gevaux fainted after taking too much of his blood pressure medication that nurses checked his in-possession medication. The failure to check earlier could have had serious consequences. We make the following recommendation:

The Head of Healthcare should ensure that GPs complete a medication review when prisoners return from hospital. Checks should be made to ensure that prisoners have the correct items of medication in-possession.

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