Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Allan Stevens, a prisoner at HMP Gartree, on 11 April 2019

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 Allan Stevens died in hospital on 11 April 2019 from pneumonia, while a prisoner at HMP Gartree. Toxicology tests showed that he had taken psychoactive substances (PS) before he died, but it is unclear whether they contributed to his death. He was 77 years old. I offer my condolences to those who knew him.

The investigation found that overall, the care Mr Stevens received at Gartree was of a good standard and equivalent to that which he could have expected to receive in the community.

However, I am concerned that when staff found Mr Stevens unresponsive, they did not call a code blue immediately which caused a delay in an ambulance being called.

I am also concerned that Mr Stevens was restrained when he was taken to hospital. It was not justified by an appropriate risk assessment that took into account Mr Stevens' age and poor health.

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

Sue McAllister CB
Prisons and Probation Ombudsman **June 2020**

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Summary

Events

1. On 8 April 1992, Mr Allan Stevens was sentenced to life in prison for murder. On 4 August 2016, he was moved to HMP Gartree.

2. Mr Stevens had several long-term health conditions, including high blood pressure, arthritis and depression. He was prescribed appropriate medication for these conditions.

3. On 9 April 2019, at around 8.30am, prisoners told staff that they were worried about Mr Stevens because he was still in bed. An officer went to Mr Stevens' cell and saw him lying on his bed with his eyes open. The officer called to Mr Stevens but he just made a noise. The officer telephoned the control room to ask for a nurse to attend but was told they were busy giving out medication. The officer returned to Mr Stevens' cell and called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).

4. Healthcare staff attended and found Mr Stevens breathing but not responsive. They gave him oxygen but then he stopped breathing and they started cardiopulmonary resuscitation (CPR). Ambulance paramedics arrived 15 minutes later and took Mr Stevens to hospital. He was restrained using double cuffs. When he arrived at hospital, he was diagnosed with a collapsed lung and pneumonia. He died in hospital two days later.

5. Toxicology tests showed that Mr Stevens had used psychoactive substances (PS) before he died. However, it is unclear whether they contributed to his death.

Findings

6. The clinical reviewer found that, overall, the care Mr Stevens received at Gartree was equivalent to that which he could have expected to receive in the community. However, she noted that there were no care plans in place to manage Mr Stevens' long-term health conditions, which was not in line with National Institute for Health and Care Excellence (NICE) guidelines.

7. The officer who went to check on Mr Stevens at around 8.30am, should have called a code blue when he could not get a response from Mr Stevens. He did not call the code blue until five minutes later, which caused a short delay in calling an ambulance. While this does not appear to have affected the outcome for Mr Stevens, such a delay could be critical in another medical emergency.

8. We are also concerned that staff applied restraints when Mr Stevens was taken to hospital. There was no healthcare input to the escort risk assessment and there is no evidence that the authorising manager had taken Mr Stevens' physical health into account when deciding to use restraints.

9. When we asked Gartree for its current drugs strategy, they provided a version dated November 2017. This is not in line with the national Prison Drugs Strategy, which says that all prisons should have updated their local drugs strategy by September 2019.

Recommendations

- The Head of Healthcare should ensure that all patients with complex health needs have clear and personalised plans, consistent with NICE guidelines.
- 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
    - healthcare staff complete the healthcare section of the risk assessment in all cases.
- The Governor should ensure that the risk assessment form for hospital escorts makes it clear that:
    - healthcare staff must provide information on the prisoner's current state of health and mobility; and
    - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.
- The Governor should share this report with a prison manager and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should share this report with the officer and arrange for a senior manager to discuss the Ombudsman's findings with him.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.
- The Governor should ensure that the key drug issues at Gartree are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

12. The investigator interviewed five members of staff at Gartree on 21 May 2019.

13. NHS England commissioned an independent clinical reviewer to review Mr Stevens' clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

14. We informed HM Coroner for Leicester City and South District of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

15. We did not contact Mr Stevens' family as they told the prison that they did not want anything to do with Mr Stevens.

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

Background Information

HMP Gartree

17. HMP Gartree, which is near Market Harborough in Leicestershire, holds up to 700 men sentenced to life imprisonment and other indeterminate sentences. MITIE Care and Custody (Health) Ltd provided healthcare until November 2018. Nottinghamshire Healthcare Foundation Trust now provide the service. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Gartree was in November 2017. Inspectors reported that new arrivals received prompt, comprehensive health screening, and appropriate onward referrals. Inspectors said that the 24-hour primary care service had a limited range of services. Waiting times for a routine GP appointment were good and emergency slots were allocated daily for patients needing to see a GP urgently.

19. Secondary appointments at a local external hospital were well managed by administrators, with clinical input when required, and health services staff supported the risk assessment of prisoners before escort.

Independent Monitoring Board

20. 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 November 2018, the IMB reported that it was very concerned about the provision of healthcare services, particularly mental health services, following the introduction of the new healthcare provider (MITIE) in April 2017. Low and frequently changing staffing levels in healthcare were having a serious effect on the level of care offered to prisoners.

Previous deaths at HMP Gartree

21. Mr Stevens was the fourth prisoner to die at HMP Gartree since April 2017. Of the previous deaths, one was self-inflicted and two were from natural causes.

22. Following an investigation into the death of a prisoner in May 2017, we made a recommendation about ensuring restraints are not used inappropriately on prisoners being taken to hospital. In response the prison told us in March 2018 that a review of the local risk assessment policy had been completed in December 2017 by the Heads of Security, Healthcare and Safety, and that this would ensure that the Security Manager would be aware of the prisoner's circumstances and would consider this as part of the overall risk assessment for hospital escorts.

Key Events

23. On 8 April 1992, Mr Allan Stevens was sentenced to life in prison for murder. He was sent to HMP Leicester. Over the next 27 years he spent time in various prisons. In August 2016, he was moved to HMP Gartree.

24. Mr Stevens had several long-term health conditions including high blood pressure, arthritis and depression. He was prescribed regular medication for these conditions. However, Mr Stevens did not always take his medication and often refused to attend healthcare appointments.

25. In February 2018, the Parole Board recommended that Mr Stevens spend time in an open prison before being considered for release, and he was downgraded to Category D (meaning he was considered to be a prisoner "who can be reasonably trusted not to try to escape"). However, his application to transfer to an open prison was later rejected on the grounds of his rude behaviour and poor personal hygiene, and in February 2019 he told his offender supervisor that he had behaved badly because he did not want to be transferred to open conditions. He said that Gartree was "a real jail" and he would not be able to cope in an open prison, and that, even if he was released, he had no family support and the best he could hope for would be either a hostel or an old peoples' home.

Events of 9 April

26. On 9 April 2019 at 7.15am, an officer carried out the early morning roll check (a count of prisoners on the wing). CCTV shows that the officer looked into Mr Stevens' cell, walked off and then went back and looked again. When the officer was asked at interview why she did this, she said that she saw Mr Stevens was in bed and thought this was unusual as he was normally awake and sitting looking out of his window at roll check. She said that she went back to check on him. She saw that he was breathing so was satisfied he was okay and continued with the roll check.

27. An hour later at 8.30am, an officer was told by other prisoners that they were worried because Mr Stevens was still in bed and they thought that he had not moved since the previous evening. The officer went to Mr Stevens' cell and saw that he was lying on the bed with his eyes open. When the officer spoke to him, he did not respond normally and just made a noise. The officer thought that Mr Stevens needed to be seen by a nurse. He left the cell and went to the office downstairs and telephoned the control room to ask a nurse to come to Mr Stevens' cell. He was told that the nurses were busy giving out medication so could not attend.

28. At 8.35am, the officer went back to the cell but could still not rouse Mr Stevens so he called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).

29. At 8.36am, a nurse responded to the code blue. She found Mr Stevens to be breathing but not responsive. She gave him oxygen and inserted an airway. Another nurse also attended and when Mr Stevens stopped breathing, he started cardiopulmonary resuscitation (CPR).

30. At 8.54am, ambulance paramedics arrived. They recorded that Mr Stevens was in severe respiratory distress. At 9.25am, they took Mr Stevens by ambulance to hospital. Mr Stevens was escorted by two officers, using the double cuffing method. (Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs.)

31. When Mr Stevens arrived at hospital he was diagnosed with a collapsed lung and pneumonia. The hospital said the prognosis was poor, and they put a do not attempt resuscitation (DNAR) order in place.

32. Later that day at 12.15pm, a security intelligence analyst at Gartree, received intelligence to suggest that Mr Stevens may have taken a psychoactive substance (PS) that day. She contacted an officer who was at the hospital with Mr Stevens. The officer passed this information to hospital staff.

33. Over the next two days, Mr Stevens' condition rapidly deteriorated and he died at 9.18pm on 11 April.

Contact with Mr Stevens' family

34. On 9 April, when Mr Stevens was taken ill, the prison appointed an officer as the family liaison officer (FLO). The FLO checked Mr Stevens' prison record and found that there were no next of kin details held on file. However, a probation officer had a contact address for Mr Stevens' next of kin. The FLO and a prison manager went to the address. Mr Stevens' brother-in-law answered the door and said that the family did not want anything to do with Mr Stevens and did not wish to be notified of Mr Stevens' death. No further contact was made.

35. The prison arranged and paid for Mr Stevens' funeral in line with national guidelines. The funeral took place on 8 May.

Support for prisoners and staff

36. After Mr Stevens' death, a prison manager debriefed the staff involved in Mr Stevens' care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

37. The prison posted notices informing other prisoners of Mr Stevens' death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Stevens' death.

Cause of death

38. The coroner accepted the cause of death provided by the hospital and no post-mortem examination was conducted. The hospital recorded Mr Stevens' cause of death as pneumonia.

39. Toxicology results showed that Mr Stevens had taken PS before he died. The cause of death has not been revised since the toxicology results were received. Therefore, we cannot say whether Mr Stevens' PS use contributed to his death.

Findings

Clinical Care

40. The clinical reviewer concluded that overall, the standard of care and treatment Mr Stevens received at Gartree was equivalent to that he could have expected to receive in the community.

41. The clinical reviewer noted, however, that there were no care plans in place to monitor Mr Stevens' conditions, which was not in line with National Institute for Health and Care Excellence (NICE) guidelines.

42. The clinical reviewer noted that this same issue had been identified in the last HMIP inspection of Gartree in November 2017, and that in their action plan submitted in June 2018, Gartree had said that they had identified all prisoners with long-term conditions so they could receive personalised care planning. We make the following recommendation:

    The Head of Healthcare should ensure that all prisoners with identified long-term conditions have a specific personalised management plan in place in line with NICE guidelines.

Restraints, security and escorts

43. 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 considers the prisoner's health and mobility.

44. 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 said 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.

45. Prison Service Instruction (PSI) 33/2015 says:

    > "Normal practice is for male Category B and Escape-List prisoners to be double cuffed while on escort. All other prisoners will be single cuffed unless the individual risk assessment indicates that double cuffing is required and is proportionate."

    The PSI goes on to say:

    > "Handcuffs will not normally be used … if "the prisoner's medical condition or advanced age or physical impairment renders restraints inappropriate. Restraints will not normally be necessary for example, when the prisoner's mobility is severely limited, e.g. due to advanced age or disability unless there are grounds for believing that an escape attempt may be made with external assistance."

46. Mr Stevens was taken to hospital and restrained using double cuffs. The risk assessment form does not show that the authorising manager, took into account that Mr Stevens had just been resuscitated and was very unwell. He did not consider whether other options may have been more appropriate given Mr Stevens' state of health.

47. When the authorising manager was interviewed he said that he had instructed that Mr Stevens should be double cuffed when he was taken to the ambulance and then when he got to the ambulance, he should be restrained using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer and the other to the prisoner.) When he was asked at interview why he thought that this method of restraint was appropriate, he said that he did not know how ill Mr Stevens was at that time. However, we note that he had attended the cell and was aware that Mr Stevens had just been resuscitated.

48. In addition, Mr Stevens was a Category D prisoner. The PSI makes it clear that double cuffing is normally only used for Category B prisoners and that the default position for prisoners in lower security categories is a single cuff. We can, therefore see no justification at all for Mr Stevens to have been double cuffed, even before his health and mobility was taken into account.

49. The risk assessment form had no input from healthcare staff: the section that should have been completed by healthcare staff was missing. The authorising manager said that it was often the case that healthcare staff did not complete their part of the risk assessment.

50. We are concerned that, although the prison told us in March 2018 that escort risk assessments were taking account of the prisoner's health and mobility, this clearly did not happen in Mr Stevens' case. We therefore make the following recommendations:

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**
- **healthcare staff complete the healthcare section of the risk assessment in all cases.**

The Governor should ensure that the risk assessment form for hospital escorts makes it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

The Governor should share this report with the prison manager and arrange for a senior manager to discuss the Ombudsman's findings with him.

Emergency response

51. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', issued in February 2013, says that prisons should have a local protocol in place that gives guidance to staff on efficiently communicating the nature of a medical emergency and ensures that there are no delays in calling an ambulance. It says that staff should call a code blue where a prisoner is unconscious or having breathing difficulties, which alerts healthcare staff to the medical emergency and directs control room staff to call immediately for an ambulance.

52. When an officer went to Mr Stevens' cell, he found him lying on his bed with his eyes open. When the officer spoke to him, he just made a noise. Instead of calling a code blue immediately, the officer went to an office to telephone the control room. When he was told that no nurses were available to attend because they were busy dispensing medication, he returned to the cell and called a code blue. When the officer was interviewed he said that he did understand when a code blue should be called but he did not initially think it necessary because Mr Stevens had responded, albeit with just a noise.

53. We consider that the officer should have called a code blue when he first went to Mr Stevens' cell. He did not call it until around five minutes later, which caused a short delay in calling for an ambulance. While we are satisfied the delay did not affect the outcome for Mr Stevens, any delay could be crucial in other cases. We make the following recommendations:

    The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies.

    The Governor should share this report with the officer and arrange for a senior manager to discuss the Ombudsman's findings with him.

Drugs strategy

54. Toxicology tests showed that Mr Stevens had taken psychoactive substances (PS) before he died, but it is unclear at present whether they contributed to his death.

55. After Mr Stevens was taken to hospital on 9 April 2019, there was intelligence suggesting that he may have taken PS that day. However, there was no other recent intelligence suggesting that he was a drug user. The only previous recorded incident of suspected drug use was in September 2017, when Mr Stevens was taken to hospital because he had collapsed. He later admitted to hospital staff that he had taken PS. Mr Stevens received counselling for his PS use and it was documented that he told the counsellor that it was a one off and he did not have an issue with PS.

56. At the time of Mr Stevens' death, Gartree had a drug strategy in place, published in November 2017. This remains the current policy.

57. In April 2019, HMPPS issued the Prison Drugs Strategy, which set out plans to reduce drug misuse within prisons across England and Wales. It says that all prisons should have implemented their own local drugs strategy, in line with the national strategy and tailored to their own specific needs and challenges, by September 2019. Gartree has not yet done this. We make the following recommendation:

The Governor should ensure that the key drug issues at Gartree are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

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