

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Raymond, a prisoner at HMP Elmley, on 22 March 2021

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*



© Crown copyright, 2021

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Raymond died in hospital on 22 March 2021, from a bleed on his brain, while a prisoner at HMP Elmley. He was 58 years old. I offer my condolences to Mr Raymond's family and friends.

Mr Raymond had been diagnosed with epilepsy in December 2019 and was hospitalised with this for a week in May 2020. Following this, his medications brought his epilepsy under control and he had no further fits until 21 March 2021, when he was found having seizures when unlocked in the morning. He was taken to hospital but did not recover.

The clinical reviewer was satisfied that Mr Raymond's clinical care was of a reasonable standard and equivalent to that he could have expected to receive in the community.

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

November 2021

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	4
Findings.....	7

Summary

Events

1. In October 2019, Mr Mark Raymond was remanded in prison custody, charged with several assaults, and sent to HMP Elmley. He was subsequently sentenced to 20 months imprisonment. He was released from prison on 21 August 2020 but was arrested by the police on the same day and returned to Elmley on 27 August.
2. Mr Raymond's offending was mainly related to his alcoholism, for which he was treated in prison. In December 2019, he was diagnosed with epilepsy and in May 2020, he had a serious seizure and he spent a week in hospital.
3. Following his return to prison, Mr Raymond's condition stabilised under a new medication regime. He was closely monitored until his release on 21 August.
4. After his return to prison on 27 August, Mr Raymond was often confused, but his epilepsy was stable, and his interactions with healthcare staff were mainly to collect his medications.
5. When an officer unlocked Mr Raymond's cell on the morning of 21 March 2021, he saw that Mr Raymond was having a seizure. Mr Raymond was taken to hospital shortly afterwards but died the next day.
6. A post-mortem examination found that Mr Raymond died from haemorrhagic cerebral infarction (a type of stroke where there is a bleed on the brain).

Findings

7. The clinical reviewer concluded that Mr Raymond's clinical care was equivalent to that he could have expected to receive in the community.
8. There was no record of any follow up support for the bedwatch officers who were at the hospital when Mr Raymond died.

Recommendations

- The Governor should ensure that there are procedures for supporting staff after a death in hospital.

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 him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Raymond's prison and medical records.
11. NHS England commissioned an independent clinical reviewer, to review Mr Raymond's clinical care at the prison.
12. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. The Ombudsman's family liaison officer contacted Mr Raymond's next of kin, his daughter, to explain the investigation. She did not reply.
14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. Their action plan is annexed to this final report.

Background Information

HMP Elmley

15. HMP Elmley holds around 1,100 prisoners, remanded or sentenced, in six houseblocks, with a mixture of single and double cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Elmley was in April 2019. Inspectors reported that health provision was reasonably good. There was a range of primary care services, although the wait for nurse triage appointments was considered to be too long. The inpatient unit was well-run and a GP was available every day. Inspectors also found that non-attendance for appointments had reduced since the previous inspection.
17. The inspectorate also carried out a short scrutiny visit at Elmley in April 2020, during the COVID-19 pandemic. Inspectors reported that there had been a good leadership and management response to a fast-changing situation and management oversight of healthcare was effective. Most routine health provision, such as external hospital appointments had stopped temporarily due to the risks of COVID-19, but there had been an increased focus on oversight and supporting those most at risk.

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 2020, the IMB reported that, given the conditions due to COVID-19, the treatment of prisoners was as fair as possible, but with a large number of staff affected by the pandemic, interactions between prisoners had to be limited. They noted a continuing problem with finding accommodation in the community for prisoners at the end of their sentence, especially as many prisoners had been rough sleepers outside prison. They said that the COVID-19 pandemic had impacted on resettlement planning.

Previous deaths at HMP Elmley

19. Mr Raymond was the 11th prisoner at Elmley to die since March 2019. Seven of the previous deaths were from natural causes, two were self-inflicted and one was drug related. There are no similarities between the findings in this investigation and the previous deaths.

Key Events

20. Mr Mark Raymond was remanded into prison custody on 22 October 2019 and sent to HMP Elmley. He was subsequently sentenced to 20 months imprisonment for several assaults. He had many previous convictions and these were often linked to his use of alcohol.
21. On 20 November, Mr Raymond appeared to have a fit when attending the medications hatch. He was not known to be epileptic. He was taken to A&E, but nothing adverse was found and he returned to the prison the same day.
22. On 28 December, at around 2.30am, staff called an ambulance as Mr Raymond appeared to be having seizures. The paramedics did not think anything was wrong with him and left. At around 7.30am, he had further seizures, including in front of ambulance staff when they attended, and he was taken to hospital. He returned the same day, with a diagnosis of epilepsy.
23. Following an assault on him on 10 January 2020, Mr Raymond requested a transfer to HMP Rochester. He was moved there on 20 January.
24. On 16 March, Mr Raymond returned to Elmley.
25. On 11 May, Mr Raymond was found having fits in his cell. He was taken to hospital where he remained for a week. When Mr Raymond returned to Elmley on 18 May, staff monitored him in the Inpatient Department (IPD), and put in place a care plan for his epilepsy.
26. Until his release from prison on 21 August, Mr Raymond remained in the IPD. On release, he did not have a recorded address to go to, but he told a member of the healthcare staff that he was going to stay with a friend and he told prison staff that he planned to be homeless on the Isle of Sheppey.
27. On the day he was released, Mr Raymond was arrested by the police after being found in a stranger's garden.
28. On 27 August, he returned to Elmley. He initially went back to the IPD, but the next day he moved to a normal shared cell on a wing, where he was isolated from the main prison population until 12 September, in line with COVID-19 procedures. He later moved to a single cell.
29. Over the next few months, Mr Raymond often seemed to be confused. He was referred to the prison's Mental Health In-reach Team (MHIRT) on several occasions, both before and after his return to Elmley in August. On 18 September, the MHIRT determined, as previously, that he had capacity to make decisions around his medications and food and that he had no enduring or severe mental illness, but that he had depression arising from the circumstances he found himself in. Mr Raymond declined a follow up appointment on 30 September, saying that his mood had improved.
30. Mr Raymond was again judged to have full capacity on 16 October after staff expressed concerns about him. However, on 15 December, when Mr Raymond declined to have a blood test in preparation for hip surgery, a nurse assessed

him as lacking capacity. She said that he did not seem to understand information given to him.

31. Mr Raymond appears to have had a more settled period in January and February 2021. He received some help with his daily activities from staff and other prisoners on his wing but there were no particular concerns about him and at the beginning of March, he attended hospital in preparation for a hip operation the following month.
32. In the days following 12 March, prison officers noted that Mr Raymond was quite confused again. He began to be worried that he would be moved in the middle of the night and so slept with a light on in order to be prepared for this.
33. At around 5.44am on 21 March, the night patrol officer looked in on Mr Raymond as part of her roll check round. She said he had his light on and he appeared to be sleeping.
34. At around 9.00am, an officer unlocked Mr Raymond's cell so he could collect his medication, and he saw Mr Raymond slumped on his bed with a leg hanging over the edge, having a seizure. The officer called a code blue (a medical emergency code that alerts healthcare staff to attend immediately and prompts the control room to call an ambulance). Within a few minutes a nurse was with Mr Raymond, who continued to have fits. A paramedic arrived about half an hour after Mr Raymond was found, followed by ambulance crew soon after that. Shortly before 10.00am he was taken to hospital.
35. At hospital Mr Raymond was found to have had a very serious bleed on his brain. He died in the company of his family at 5.25pm on 22 March.

Contact with Mr Raymond's family

36. The prison appointed a Supervising Officer (SO) as the family liaison officer. She telephoned Mr Raymond's nominated next of kin, one of his daughters, shortly after 2.00pm on 21 March to let her know her father had been taken to hospital. The SO maintained contact with Mr Raymond's daughter following his death to provide support and practical advice.
37. In line with national policy, the prison contributed to the costs of Mr Raymond's funeral, which took place on 16 April.

Support for prisoners and staff

38. One of the bedwatch officers went directly home from the hospital and the other officer returned to the prison only to drop off equipment before returning home. Neither officer was involved in any debrief. The prison posted notices informing other staff and prisoners of Mr Raymond's death and offering support.

Post-mortem report

39. The post-mortem report concluded that the cause of Mr Raymond's death was haemorrhagic cerebral infarction (a type of stroke where there is a bleed on the brain), caused by systemic hypertension (high blood pressure). Liver cirrhosis,

due to hepatitis C and alcohol dependence, was listed as an underlying condition which contributed to but did not cause the death.

40. Toxicology tests showed an elevated level of the medication Paroxetine in Mr Raymond's blood. This was a drug that he was prescribed for his depression, and although there was a higher concentration of this than would be expected from therapeutic use, it was not possible to conclude if it had any bearing on his death. No illicit drugs were detected.

Findings

Clinical care

41. Mr Raymond was diagnosed with epilepsy in December 2019. His epilepsy was controlled with medication but he often appeared confused. In December 2020, Mr Raymond was seen by a nurse and considered to be lacking in capacity at that time. However, the clinical reviewer is satisfied that, in subsequent encounters with healthcare staff, there was no issue about his understanding of what was happening that required any clinical interventions.
42. The clinical reviewer concluded that Mr Raymond's clinical care was good and equivalent to that he could have expected to receive in the community. She made some recommendations about processes for the Head of Healthcare to follow up. As these issues did not contribute to the cause of death they are not repeated in this report.

Roll checks

43. When Mr Raymond's cell was opened at around 9.00am on 21 March, he was found slumped on his bed with a leg hanging over the edge and having fits. We do not know for how long that had been going on.
44. Elmley told the investigator that a morning roll check is carried out between 5.30am and 6.00am. The officer who did the roll check shortly before 6.00am said that Mr Raymond had his light on and appeared to be sleeping. It was not unusual for him to sleep with his light on. The CCTV shows the officer looking into his cell and we are confident she would have had a good view of him. Mr Raymond's emergency cell bell record shows that he did not use it that night to try and attract the attention of any staff. We are therefore satisfied that there had not been an earlier opportunity to intervene before his cell door was opened for him to collect his morning medication at 9.00am.

Support for staff

45. The investigator asked why there was no record of a debrief following the death of Mr Raymond or of discussions of support. He was told by Elmley that one of the officers on bedwatch duty at the time of Mr Raymond's death went straight home from the hospital, and the other officer only went back to the prison briefly to drop off items related to the bedwatch duty.
46. Although some staff may not need follow up support following a death, it is important that it is offered and that this is recorded.
47. We recommend that:

The Governor should ensure that there are procedures for supporting staff after a death in hospital.

**Prisons &
Probation**

Ombudsman
Independent Investigations