

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Steven Bouquet, a prisoner at HMP Elmley, on 5 January 2022**

**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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## Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Steven Bouquet died in hospital on 5 January 2022, while a prisoner at HMP Elmley. He was 55 years old. The cause of his death was COVID-19 pneumonia, due to lung disease. Mr Bouquet also had underlying thyroid cancer. I offer my condolences to his family and friends.
4. The clinical reviewer found weaknesses in Mr Bouquet's clinical care, notably in information sharing between the prison healthcare and hospitals; and recording of hospital appointments and medical correspondence.
5. We are concerned that some of the security risk assessments for hospital visits did not properly reflect Mr Bouquet's poor health and reduced mobility, and that the use of restraints was not justified. Another concern was that the prison did not tell his next of kin that he was seriously ill and in hospital.
6. We cannot say for certain where Mr Bouquet caught COVID-19, as he had been outside the prison to hospital several times in the weeks leading to testing positive.

## Recommendations

- The Head of Healthcare should ensure that there is a clear process to gather and share information when a prisoner has several medical conditions managed by more than one hospital.
- The Head of Healthcare should ensure that all hospital attendance is recorded in prisoners' medical records; documents are scanned systematically; and difficulties in obtaining clinical information are recorded and escalated.
- 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 that in all cases:
  - the medical information accurately reflects the prisoner's mobility, current clinical condition and impact on their ability to escape unaided; and
  - operational staff take this information into account in recommendations and decisions on the level of risk and use of restraints.
- The Governor should ensure that, in line with national policy, prisoner's next of kin are notified promptly when a prisoner becomes seriously ill.

## The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Bouquet's care at HMP Elmley.
8. The PPO investigator investigated the non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Bouquet's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
9. The investigator and clinical reviewer jointly interviewed five healthcare staff, using Microsoft Teams video conferencing, on 15 September 2022.
10. The Ombudsman's family liaison officer wrote to Mr Bouquet's next of kin, his brother, to explain the investigation. Mr Bouquet's brother asked for the investigation to consider the circumstances of a fall in prison and whether Mr Bouquet was appropriately located, given his condition and general health.
11. We sent a copy of our report to Mr Bouquet's brother. No factual inaccuracies were identified.
12. We shared our report with HM Prisons and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

## Previous deaths at HMP Elmley

13. Mr Bouquet was the fifteenth prisoner at Elmley to die since January 2020. Of the previous deaths, ten were from natural causes (none were due to COVID-19), two were self-inflicted and two were drug-related. Since Mr Bouquet's death, there has been another death from natural causes and one self-inflicted. We have previously raised the issue of management of long-term conditions at Elmley.

## COVID-19 (coronavirus)

14. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
15. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. In response to the pandemic, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain outbreaks - to be implemented at local level, depending on the needs of individual prisons. (A key strategy was 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly arrived prisoners from the main population.)
16. In September 2021, the shielding programme ended in the community, but HMPPS continued to routinely offer shielding to clinically high-risk prisoners. This has recently been replaced by a system of individual risk assessments by clinical staff, to determine the measures necessary to support such prisoners. The agreed

adjustments are documented in a *Personal Management Plan*, which is then facilitated by operational staff.

## Key Events

17. Mr Steven Bouquet was convicted (in his absence) of damaging and destroying property and possession of a weapon. On 30 June 2021, he was nominally remanded to HMP Lewes, while receiving inpatient treatment in hospital. (He was later sentenced to five years and three months imprisonment.)
18. Mr Bouquet was discharged from hospital to Lewes on 16 July 2021. At initial and secondary health screens, it was noted that he had thyroid cancer which had spread to his liver and lungs, as well as an acute kidney injury, skin infections and chronic diarrhoea.
19. In line with the COVID-19 policy on newly arrived prisoners and those returning from hospital admissions, Mr Bouquet was isolated from the main prison population (known as reverse cohorting) until 27 July. Mr Bouquet received his first COVID-19 vaccination on 21 July.
20. On 9 August, Mr Bouquet transferred to HMP Rochester. A multidisciplinary team meeting was held on 2 September, to discuss clinical investigations and his cancer treatment. His second COVID-19 vaccination was given on 23 September.
21. Mr Bouquet's chronic medical conditions were overseen by specialists at four hospitals, in London, Sussex and locally. Over the following weeks, he underwent tests related to his cancer diagnosis, as well as inpatient treatment for cellulitis and surgery to remove his thyroid gland.
22. On 17 November, Mr Bouquet was sent to hospital after a fall in his cell. He said that he had not lost consciousness but had been too weak to grab the support rail. In hospital, he was diagnosed with several conditions, including sepsis, gastroenteritis, cardiac failure and type 1 respiratory failure.
23. The clinical nurse manager visited twice to discuss Mr Bouquet's care with hospital clinicians. It became clear that he needed a prison with 24-hour healthcare.

### Transfer to HMP Elmley

24. Mr Bouquet was discharged to HMP Elmley on 1 December. He was admitted to the healthcare centre's inpatient unit. The nurse who welcomed him noted he was frail, with poor mobility and vulnerable to infections. He used a walking aid and a wheelchair to move around. She created a basic care plan, noting the need for additional specific plans to support his cancer care. She also arranged a GP review and requested a referral for palliative support. In the evening, Mr Bouquet fell, but was uninjured. (The prison later provided medical and disability aids for his cell.)
25. On 2 December, the prison GP held a multidisciplinary meeting, attended by Mr Bouquet, to discuss his care and end-of-life needs. His prognosis was said to be poor. Mr Bouquet said he was willing to try any treatment options but did not want to be resuscitated if his heart or breathing stopped. The GP completed the relevant form and prescribed anticipatory medication.

26. Mr Bouquet was referred to the palliative care team and for social care. A family liaison officer was assigned, and he nominated his brother as his next of kin.
27. Shortly after the meeting, the Governor and Mr Bouquet discussed the possibility of release on temporary licence (ROTL), or early release on compassionate grounds. However, as Mr Bouquet was estranged from most of his family, there seemed to be no suitable accommodation to which he could be released.
28. Later that day, Mr Bouquet's vital signs were abnormal, and he was sent to hospital. He was discharged on 5 December. He went back to hospital twice between 6 and 8 December and attended outpatient appointments on 13 and 15 December.
29. Mr Bouquet said he felt too weak to contact his brother personally. He initially agreed to staff updating his brother and disclosing that he was unwell, but he later asked that no information be given at that time.
30. On 22 December, Mr Bouquet was examined by a prison GP, as he had developed a cough. The GP diagnosed a chest infection and prescribed antibiotics.
31. On 24 December, Mr Bouquet received his COVID-19 vaccination booster.

### **Deterioration in Mr Bouquet's health**

32. In the early hours of 27 December, Mr Bouquet felt weak. Clinical observations taken later that morning showed that both his temperature and his blood oxygen saturation levels were low, so he was sent to hospital. Officers told healthcare staff that Mr Bouquet's next of kin need not be informed, unless he was in hospital for more than 72 hours.
33. At 6.34am on 28 December, an entry in Mr Bouquet's medical record noted that he was COVID-19 positive. Healthcare staff obtained sporadic updates from hospital staff on his condition and treatment, but recorded difficulties with contact.
34. On 4 January 2022, the hospital informed the prison that Mr Bouquet had been diagnosed with COVID-19 pneumonia, bacterial pneumonia and a blood clot on his lungs. He was receiving active treatment and expected to recover but was not medically fit for discharge and likely to be in hospital for at least another three days.
35. Mr Bouquet died at 9.50pm on 5 January. The Governor immediately went to the hospital. She spoke to hospital staff, debriefed the escort officers and offered support.
36. The family liaison officer broke the news of Mr Bouquet's death to his brother at around 10.00pm. The next morning, the Governor and the family liaison officer jointly spoke to him to offer condolences, advice and support. The prison arranged and paid for Mr Bouquet's funeral, which was held on 21 March.

### **Post-mortem report**

37. The post-mortem report concluded that Mr Bouquet died of COVID-19 positive pneumonia, due to underlying chronic obstructive pulmonary disease. Thyroid cancer was listed as a contributory factor.

# Findings

## Clinical Findings

38. Mr Bouquet had complex health conditions. The clinical reviewer considered whether key aspects of his care were of an acceptable level. She concluded that, overall, a lack of clinical ownership and inconsistent communication had impacted on the quality and consistency of his care. Full details of her findings are in the clinical review report. We reflect below those relevant to the health conditions that caused or contributed to Mr Bouquet's death.

### Management of Mr Bouquet's terminal illness

39. The clinical reviewer was concerned that Elmley and the hospital treating Mr Bouquet's cancer did not share significant information with each other and there were no links between each hospital. Therefore, healthcare decisions were taken without a care plan and prognosis, and prison healthcare staff found it difficult to understand how to manage increases in the severity of his illness. This had led to frequent emergency hospital admissions. We recommend:

**The Head of Healthcare should ensure that there is a clear process to gather and share information when a prisoner has several medical conditions managed by more than one hospital.**

### Record keeping

40. The clinical reviewer considered that clinical record keeping needed to be improved. Some of Mr Bouquet's hospital visits were not clearly recorded and medical correspondence was scanned haphazardly, making it difficult to follow the sequence of Mr Bouquet's care. We recommend:

**The Head of Healthcare should ensure that all hospital attendance is recorded in prisoners' medical records; documents are scanned systematically; and difficulties in obtaining clinical information are recorded and escalated.**

### Management of Mr Bouquet's risk of infection from COVID-19

41. In line with national HMPPS policy, Elmley implemented protective measures to manage the risks associated with COVID-19, such as a limited regime and restricted movement across the prison.
42. Mr Bouquet self-isolated when he arrived at Elmley and after subsequent hospital visits. He was closely monitored while living in the healthcare unit and had received all the COVID-19 vaccinations due at the time of his death.
43. Mr Bouquet tested positive for COVID-19 on admission to hospital. We cannot say for certain whether he contracted the virus in prison, or during previous hospital visits. However, we are satisfied that Elmley managed his risk of infection appropriately.

## Security risk assessments and the use of restraints

44. 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 takes into account the prisoner's health and mobility.
45. 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 he has a serious medical condition. The judgment indicated 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. This is reinforced in the *Prevention of Escape – External Escorts* policy framework, which states that restraints will not normally be necessary if a prisoner's mobility is severely limited, e.g. due to advanced age or disability, unless there is intelligence to suggest that an escape might be made.
46. Mr Bouquet was seriously ill when he arrived at Elmley. Over the following four weeks, he was sent to hospital several times. Security risk assessments reflected that he was a category C prisoner and a low risk of escape. However, there were inconsistencies in the clinical judgements on the impact of his condition and mobility on his risk and the decisions on the use of restraints varied. Restraints were not used on 6 December, but single handcuffs and an escort chain were used on 13 December and an escort chain on 15 December.
47. The clinical section of security risk assessment for Mr Bouquet's final hospital admission on 27 December, noted that he was frail, a wheelchair user and that there were medical objections to the use of restraints. The officer who completed the risk assessment concluded that restraints were unnecessary. The authorising manager appeared to overrule this, but the information on other parts of the form, as well as the escort documents suggest that there were no restraints. When the investigator requested clarification, the authorising manager believed that he had ticked 'yes' to restraints in error, but they had not been used. The weight of evidence supports this.
48. While we are satisfied that no restraints were used the last time Mr Bouquet went to hospital, the inconsistencies in handling of previous visits suggest that some staff do not fully understand their responsibilities in completing risk assessments. We recommend:

**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 that in all cases:**

- **the medical information accurately reflects the prisoner's mobility, current clinical condition and impact on their ability to escape unaided; and**

- **operational staff take this information into account in recommendations and decisions on the level of risk and use of restraints.**

## **Contacting Mr Bouquet's next of kin**

49. HMPPS guidance on contacting a prisoner's next of kin during the pandemic states that if a prisoner is symptomatic, or has contracted COVID-19, they should be given the opportunity for someone to be informed and, with consent, the prison should arrange to do this. Additionally, prisons are expected to comply with the existing policy (set out in Prison Rule 22 and PSI 64/2011) that a prisoner's next of kin should be informed immediately if they become seriously ill, or if there is unpredicted or rapid deterioration in their physical health.
50. Elmley followed best practice by promptly assigning a family liaison officer to support Mr Bouquet and his next of kin during his terminal illness. When his condition initially worsened, the family liaison officer complied with his wish not to tell his brother and we are not critical of this. However, we are concerned that Mr Bouquet was not given the opportunity to reconsider this when he was diagnosed with COVID-19, or at any time during his nine days in hospital. The information given to healthcare staff about waiting for 72 hours before notifying his next of kin seems to have been a misinterpretation of the local policy that no hospital visits should be authorised for 72 hours.
51. Although Mr Bouquet was expected to recover from the infection, he remained seriously ill. If there was any doubt about the severity of his illness, or that his wishes about contact would be compromised, it would have been better to discuss it with him again. We recommend:

**The Governor should ensure that, in line with national policy, prisoner's next of kin are notified promptly when a prisoner becomes seriously ill.**

**Susannah Eagle**  
**Deputy Ombudsman**

**July 2023**

## **Inquest**

The inquest, held on 31 August 2023, concluded that Mr Bouquet died from natural causes.

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Third Floor, 10 South Colonnade  
Canary Wharf, London E14 4PU

Email: [mail@ppo.gov.uk](mailto:mail@ppo.gov.uk)  
Web: [www.ppo.gov.uk](http://www.ppo.gov.uk)

T | 020 7633 4100