Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Stephens, a prisoner at HMP The Verne, on 28 May 2021

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Robert Stephens died from bilateral bronchopneumonia (an inflammation of the airways and lungs) on 28 May 2021, while a prisoner at HMP The Verne. Mr Stephens was 83 years old. We offer our condolences to his family and friends.

The clinical reviewer concluded that while Mr Stephens' care needs were met for the majority of his time at HMP The Verne, this was not the case during the last month of his life. He found that Mr Stephens' end-of-life care needs would have been better met in a prison with a 24-hour healthcare presence. The clinical reviewer also raised concerns about safeguarding and the arrangements for prisoners with complex health needs.

We concluded that, at the point that Mr Stephens received his terminal diagnosis and no longer met The Verne's admission criteria, the prison should have vigorously pursued all options to move him to a more suitable environment.

Staff lacked awareness and understanding of the safeguarding process, and we also identified issues with the use and support of and communication with the Residential Support Assistants (prisoners trained to provide care and support with daily living needs to older and disabled prisoners).

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

Adrian Usher
Prisons and Probation Ombudsman **August 2024**

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Summary

Events

1. On 4 January 2018, Mr Robert Stephens was sentenced to twelve years in prison for sex offences. He was 80 years old. He was initially sent to the healthcare unit at HMP Winchester. He was transferred to HMP The Verne on 10 June 2019, with a social care plan in place.

2. On 20 February 2021, Mr Stephens was admitted to hospital for COVID-19. He returned to The Verne on 5 March and needed fifteen hours of supplementary oxygen each day.

3. On 7 April, following a second admission to hospital, a hospital consultant told the prison that Mr Stephens was severely frail and was in the last few months of his life.

4. On 17 April, Mr Stephens was sent to hospital again. He returned to The Verne on 5 May, and he was located in B1, a medical room. A 24-hour care package was put in place until 17 May.

5. Once the 24-hour care had ended, Mr Stephens was moved back to a dormitory, where he remained until 24 May when he was moved to another dormitory, Dorm 5.

6. On 26 May, one of the nurses reviewed Mr Stephens and concluded that he was unresponsive and at the end of his life. Overnight end-of-life care was arranged to start at 8.00pm.

7. At 4.56am on 28 May, the agency nurse noted that Mr Stephens' breathing had slowed and shortly after, he died. A GP operating at The Verne verified his death at 8.40am.

Findings

8. The clinical reviewer concluded that from April 2021 until his death, the care provided to Mr Stephens was not equivalent to that which he could have expected to receive in the community.

9. Until the last few days of his life, it seems HMP The Verne thought that they would be able to meet Mr Stephens' needs adequately, but our investigation found that this was not the case. We consider that they should have pursued a move to a more suitable location before his condition deteriorated to such an extent that he was too ill and frail to be moved.

10. The Verne did not recognise the impact of Mr Stephens' deteriorating health on others in the prison, particularly the Residential Support Assistants and the prisoners living alongside him.

11. The decision to move Mr Stephens to Dorm 5, without specific safeguards in place, created additional risks and was therefore inappropriate.

12. Prison and healthcare staff were confused and lacked understanding about the prison's safeguarding process and the division of responsibilities.

13. The communication between those involved in Mr Stephens' care was at times poor. This impacted on how his situation was managed.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a process in place to transfer prisoners with a terminal diagnosis or whose medical needs cannot be met at The Verne to a more suitable environment at the earliest opportunity.
- The Governor and Head of Healthcare should ensure that there is a suitable location where a prisoner can receive short-term 24-hour nursing care if required.
- The Governor should ensure that adequate supervision and support arrangements are in place for RSAs and issues they raise are discussed at the relevant social care MDT meeting.
- The Governor should ensure that all staff understand and follow the safeguarding policy, particularly with regard to the division of responsibilities for action to be taken.
- The Governor should ensure that applications for early release on compassionate grounds for prisoners who meet the criteria are progressed and if in doubt staff should seek advice from HMPPS' Public Protection Casework Section (PPCS).

The Investigation Process

14. HMPPS notified us of Mr Stephens' death on 28 May 2021.

15. NHS England commissioned an independent clinical reviewer to review Mr Stephens' clinical care at The Verne.

16. The PPO investigator investigated the non-clinical issues relating to Mr Stephen's care.

17. The investigator and an Assistant Ombudsman visited HMP The Verne between 16 and 18 November 2021. They obtained copies of relevant extracts from Mr Stephens' prison and medical records.

18. The investigator and Assistant Ombudsman interviewed nine members of staff and two prisoners at The Verne on 17 and 18 November. The clinical reviewer joined the interviews on 17 November by telephone. The investigator and Assistant Ombudsman met the Governor during the visit and gave him feedback by telephone on 19 November. The investigator and clinical reviewer interviewed two members of staff by telephone on 8 and 10 December 2021.

19. Another investigator took over the investigation in November 2023. During April and May 2024, she contacted the prison for an update on their actions since Mr Stephens' death.

20. We informed HM Coroner for Dorset of the investigation. who gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. The PPO wrote to Mr Stephens' next of kin to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP The Verne

23. HMP The Verne is a Category C prison in Dorset for men convicted of sex offences. At the time of Mr Stephens' death, Dorset Wing accommodated prisoners with mobility or social care needs and consisted of dormitory-style rooms, divided into wooden cubicles, partitioned with screens that did not reach the floor or ceiling. There were no cell bells and toilets were up to 30-40 metres from some dormitories. During the COVID-19 pandemic, the dining room on Dorset Wing was converted into accommodation known as Dorm 5. It contained a bed, surrounded by privacy screens. This room was regularly used to isolate prisoners coming into the prison from the community or from hospital to prevent the spread of COVID-19. A CCTV camera covering Dorm 5 could be viewed from the wing office. The Verne also had three medical rooms, known as B1. Each had a medical bed and a call bell and was close to a bathroom. The rooms were accessible through a locked, secure door.

24. At the time of Mr Stephens' death, Practice Plus Group managed the healthcare department. It was staffed between 7.30am and 6.00pm and operated as a clinic. Outside those hours, prison staff had to call the NHS 111 telephone line for health advice or 999 in an emergency. Oxleas NHS Trust currently provides healthcare and social care at The Verne. The prison completes social care referrals to the local authority which funds social care. At the time of Mr Stephens' death, social care was provided between 7.30am and 6.00pm but could be extended to 8.00pm.

HM Inspectorate of Prisons

25. The most recent inspection of The Verne was in February 2020. Inspectors reported that the prison performed well in terms of safety and decency, but they had concerns about healthcare provision, with many aspects stretched and under-resourced to meet the complex health needs of an ageing population. They noted that prisoners on Dorset Wing said that the unit enabled them to improve their health and social wellbeing. Inspectors found that Dorset Wing provided excellent care and nurses were supported. Prisoners were trained as Residential Support Assistants (RSAs) to help other prisoners with daily living activities. Inspectors noted that The Verne had a comprehensive safeguarding adults policy in place but no safeguarding referrals had been made to the local authority. Staff they had spoken to had limited knowledge of safeguarding practice and procedures, but this weakness was mitigated by a well-developed sense of community in the prison.

Independent Monitoring Board

26. 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 July 2021, the IMB raised ongoing concerns about healthcare provision. They noted there was mutual respect between staff and prisoners. They described the prison as very safe, but conditions fell short of humane in the lack of 24-hour social care provision for a small but growing number of frail, elderly prisoners who needed regular personal care. They said they were conscious of the ageing population and that the local authority's care

packages were usually minimal and more on-site provision for 24-hour care of the elderly was needed. The IMB noted that Dorm 5 had been out of commission for large parts of the year as it was used as a care room for prisoners who were too sick, dying or had too much disability equipment for a dormitory. While they noted that prison staff did their best to ensure the sick were comfortable, the IMB did not consider it a dignified or suitable area for the dying.

Previous deaths at HMP The Verne

27. Mr Stephens was the ninth prisoner to die at The Verne since 28 May 2018. The previous eight deaths were from natural causes and there were no similarities between our findings about Mr Stephens' death and those of the previous investigations. Since Mr Stephens' death and up to the end of May 2024, there were 11 deaths of prisoners at The Verne, 10 from natural causes and one self-inflicted death. In October 2023, we issued a report into the death of a prisoner who died in March 2022. We found similar issues as those raised by this investigation: The Verne was not able to manage the prisoner's complex care needs and there was no clear pathway for prisoners whose needs could not be met in the prison. HMPPS accepted our recommendations, and their action plan is due to be completed by October 2024.

Safeguarding

28. Prison Service Instruction (PSI) 16/2015, *Adult Safeguarding in prison,* sets out the duty of care and requirements on prisons to protect adults, particularly vulnerable adults. Adult safeguarding in prisons means keeping prisoners safe and protecting them from abuse and neglect. Prison staff have a common law duty of care to protect prisoners. Prisons have a range of processes to meet this duty. These processes should ensure that prisoners who are unable to protect themselves as a result of their care and support needs are given a level of protection that is equivalent to that provided in the community. Responsibility for safeguarding in prisons rests with the Governor who appoints a prison manager to lead on safeguarding. The PSI encourages Governors to be proactive in engaging with the relevant local authority's Safeguarding Adults Board, both at a strategic level and as a source of advice. Dorset Safeguarding Adults Board (DSAB) oversees all safeguarding processes at The Verne.

Residential Support Assistants (RSAs)

Residential Support Assistants (RSAs) provide prisoner peer support in line with PSI 17/2015, *Prisoners assisting other prisoners*. RSAs are prisoners trained to provide care and support to older and/or disabled prisoners. Prison staff vet prisoners to work as RSAs and they complete a range of training courses. RSA tasks include collecting meals, helping with cell cleaning and tidying, and limited personal care. RSAs are not permitted to provide medical or intimate care. At The Verne, the RSAs are managed by the prison's social care lead and undertake a bespoke training programme. An officer told the investigator that a designated prisoner coordinated the RSAs who were expected to keep a record of the support they provided. They were also told to report concerns about a prisoner's health or wellbeing to a member of staff.

Key Events

29. On 4 January 2018, Mr Stephens was sentenced to 12 years in prison for sexual offences and was sent to HMP Winchester. He was a category C prisoner. When he arrived, healthcare staff carried out an initial health screen and noted he was a frail man who had a number of medical conditions. He used a walking frame and a wheelchair for longer distances. He lived on the healthcare wing and had access to 24-hour nursing care. He had a number of seizures and falls at Winchester.

2019

30. A Custodial Manager (CM), the social care lead at The Verne, told the investigator that HMP Winchester asked The Verne to take a number of wheelchair-using prisoners with social care needs because their healthcare department was closing for refurbishment. He said that the suitability criteria at that time was that the prisoner needed to be continent, able to move independently and that the prison could meet their medical needs.

31. In early 2019, the Head of Healthcare, the CM and an occupational health assessor for the local authority visited Mr Stephens to assess his suitability for The Verne. The Head of Healthcare told us that she did not have access to his medical records before the assessment. However, they all concluded that Mr Stephens was suitable, and a transfer was agreed.

32. On 10 June 2019, Mr Stephens arrived at The Verne with a social care plan in place. He lived in a dormitory and received daily living support from the RSAs. During his initial healthcare screen, Mr Stephens had a seizure and was taken to hospital by ambulance. He returned that day. During his second health screen, healthcare staff identified a number of medical conditions.

33. On 19 and 20 June, Mr Stephens had further seizures. Following the second seizure, a GP operating at the prison and the Head of Healthcare reviewed Mr Stephens, and his case was discussed at the multi-professional complex case meeting (MPCC). The GP said that staff had raised concerns about whether Mr Stephens should be in a prison without 24-hour healthcare facilities. He raised these concerns with the Head of Healthcare for her to discuss with prison governors.

34. Later that day, two nurses met Mr Stephens to review his mental health needs. Towards the end of the meeting, Mr Stephens had a seizure, and an ambulance was called. A nurse recorded that Mr Stephens was not appropriately placed at The Verne and needed more physical health-driven clinical care. He noted that Mr Stephens needed a transfer to a more suitable setting as a priority.

35. On 21 June, a prison GP met Mr Stephens to discuss his physical health needs. She spoke to him about moving to a prison with 24-hour healthcare. She recorded that Mr Stephens preferred to stay at The Verne, regardless of the health risks. Mr Stephens had frequent seizures over the following months.

2021

36. On 10 February 2021, Mr Stephens tested positive for COVID-19. On 20 February, a nurse saw Mr Stephens because his oxygen saturation levels were low. She recorded a NEWS2 score of 11. (NEWS2 is a tool to respond to clinical deterioration. A score above seven indicates the need for an emergency response.) Mr Stephens was taken to hospital by ambulance.

37. On 5 March, Mr Stephens was discharged to The Verne with respiratory failure secondary to COVID-19 infection. He was moved to a dormitory on Dorset Wing and needed fifteen hours of supplementary oxygen a day. At this time, a prisoner and RSA was supporting Mr Stephens. He told an officer that he was concerned about the level of care Mr Stephens needed, particularly as he needed oxygen. The officer recorded that she had passed on this concern and would seek guidance from the healthcare and safer custody teams. The prisoner said that the RSAs took it in turns to check on Mr Stephens at night.

38. The Clinical Team Leader (CTL) said that healthcare staff provided forms for each dormitory which RSAs could use to raise concerns or share information. However, the prisoner told the investigator that when he began work as an RSA, there were weekly meetings, but these had stopped and communication between those involved with Mr Stephens' care was poor. He said he was supposed to prompt Mr Stephens to take his prescribed medications but had not been told when Mr Stephens' medication had changed.

39. On 6 March, a nurse spoke to Mr Stephens' RSAs. They said they were keeping a record of their support. That day, a prisoner and RSA completed a safeguarding form stating that the level of care Mr Stephens needed exceeded RSA duties.

40. On 7 March, a nurse recorded that prison staff on the wing were concerned about the effect Mr Stephens had on the other prisoners. She recorded that the RSAs were 'strained and tired', and wing staff were suggesting that he should be moved to another dormitory and a rota devised for the RSAs to provide cover. The same day, she raised concerns with the Deputy Governor that Mr Stephens needed more care than the RSAs could provide. She forwarded a safeguarding referral for Mr Stephens and highlighted numerous concerns including:

    - the noise from the oxygen machine was keeping people awake and Mr Stephens was not using it correctly;
    - Mr Stephens had a variety of mobility, eating and drinking issues;
    - Mr Stephens called out at night for help to the toilet or because he was in pain;
    - the obligations felt by the RSAs to care for him because of his vulnerabilities;
    - having to help him onto the toilet and pulling up his underwear and clothes when he felt weak; and
    - the limited availability of healthcare staff.

41. The Deputy Governor told the investigator that he spoke to the nurse about her concerns and wrote back to her. A copy of the response was not provided to the PPO. He said that at the time, the prison was under a great deal of pressure due to COVID-19, with entire dormitories testing positive. He said that he did not think that her was overlooked, but they could not do much at the time. He said that he

believed the letter and the safeguarding referral were passed to a CM, as he liaised with social services about safeguarding issues.

42. On 10 March, a multidisciplinary team (MDT) meeting took place, involving senior prison and healthcare staff, to discuss RSA support and Mr Stephens' situation. There is no record of the discussion.

43. On 11 March, a meeting took place between a prison manager, a Supervising Officer (SO) and the RSAs. It was agreed that:

- a welfare log would be maintained to record all interactions with Mr Stephens;
- Mr Stephens would move to the medical bed in Dorm 5;
- he would be given a personal alarm for overnight assistance (which officers would be responsible for responding to);
- he would be given urine bottles if he could not get to the toilet at night;
- healthcare staff would check on him at the end of their working day; and
- RSAs would only assist Mr Stephens with agreed tasks between 8.30am and 8.00pm.

44. That evening, a prisoner alerted wing staff that Mr Stephens' personal alarm was going off. Officers attended and Mr Stephens told them that he had used the alarm as he had difficulty breathing. Officers reviewed the CCTV footage and noted that the alarm had sounded for twenty minutes before a prisoner walking past had alerted them.

45. On 18 March, an MPCC meeting took place to discuss Mr Stephens. The CTL was tasked with contacting the local authority for a fresh social care review and he was to speak to the Head of Healthcare about the nearest 24-hour healthcare facility. Later that evening, Mr Stephens fell and had to be helped back to bed.

46. On 1 April, Mr Stephens had a fall trying to get to the toilet. Officers noted from CCTV footage that Mr Stephens had tried to use the rubbish bin as a toilet and had fallen. Healthcare staff assessed him and recorded a NEWS2 score of six. An ambulance was called and took Mr Stephens to hospital.

47. On 7 April, Mr Stephens returned from hospital to Dorm 5. Before his discharge, the hospital's consultant geriatrician told the healthcare team that Mr Stephens was severely frail and in the last months of his life. His medical records indicate that relevant staff were aware of his discharge and prognosis, the social care team were aware of his additional needs and agreed to contact the local authority and the prison planned to move him to a care suite once his condition deteriorated and became palliative.

48. On 7 April, the Deputy Governor asked the Offender Management Hub (OMH) Manager to start an application for early release on compassionate grounds (ERCG). OMH asked the Head of Healthcare to speak to the local authority about a care home place for Mr Stephens.

49. On 8 April, a prison GP completed the medical section of the compassionate release form and passed it to the Head of Healthcare. She noted that Mr Stephens had less than three months to live.

50. On 13 April, a nurse completed a referral to the local hospice for symptom control. She asked for urgent training on using a syringe driver (a pump that provides a continuous flow of medication) due to Mr Stephens' poor prognosis.

51. That day, the OMH manager emailed prison and healthcare managers about the ERCG application. The Head of Healthcare confirmed that Mr Stephens did not have a terminal diagnosis but was extremely frail and old. She said she had spoken to the local authority who said that a place in a nursing home would be available, but they could not confirm where. The OMH manager responded that an address was needed to progress the ERCG application.

52. On 16 April, the Head of Healthcare and the OMH manager exchanged emails about the ERCG application. The Head of Healthcare stated that she was happy to speak to colleagues in the local authority to see what bed spaces were available in the community, but it was a quickly changing landscape and an address may not remain available. She also wrote that if The Verne could not meet Mr Stephens' needs, the prison would need to arrange to move him to a prison with 24-hour healthcare. The OMH manager responded that if a move was needed for health reasons, healthcare providers needed to arrange it rather than the prison and OMH would only get involved once a place had been found. She said their involvement was limited to arranging the transport.

53. The Head of Safety told the investigator that the OMH manager was incorrect, and if a prisoner needed to transfer from The Verne to somewhere with 24-hour healthcare, OMH would work with the Observation, Categorisation and Allocation team (OCA) to facilitate this.

54. The Deputy Governor told the investigator that the healthcare team would notify him if someone needed to be transferred to a prison with a specialist service. He said that sometimes, the healthcare team brokered deals with other prison healthcare teams, and he would then arrange the transfer. He said there were conversations about moving Mr Stephens, but it was agreed that it was better for him to remain where he was and that was what he wanted. He said that at the time, it would have been very difficult to move Mr Stephens within the region as HMP Exeter's palliative care suite was out of operation and HMP Bristol had a waiting list.

55. The Head of Healthcare told the investigator that if the healthcare team decided that they were not able to meet a prisoner's needs, they would raise their concerns with the healthcare commissioners, the Governor and the prison's healthcare lead. She told the investigator that she believed that they were able to meet Mr Stephens' needs until his death.

56. Between 10.15pm and 11.05pm on 16 April, an officer recorded that he had to help Mr Stephens as he was stuck on the toilet and then later again when he was seen wandering around the unit. He recorded that that Mr Stephens had been hallucinating, was not talking sense and had become agitated. He asked an RSA to sit with Mr Stephens until he settled.

57. On 17 April, a nurse spoke to the community nurse specialist at the local hospice about Mr Stephens' presentation the previous night and was told to contact 111 (NHS non-emergency healthcare) to rule out an infection. Just after 2.00pm, an out-of-hours GP spoke to the nurse and recorded that Mr Stephens needed a doctor to review his palliative medicines.

58. At approximately 2.25pm, an out-of-hours GP reviewed Mr Stephens at The Verne. He noted that he was concerned that it was unsafe to manage Mr Stephens in prison as care staff were only present 12 hours a day. He said that Mr Stephens' intermittent confusion, unsteadiness and end-of-life care could not be managed in the prison. He recorded that he tried to ring a hospice, but they had no beds available, so he asked for an ambulance to take him to hospital.

59. On 19 April, there was an exchange of emails about the ERCG application. A CM emailed the Head of Healthcare and other staff to say that transfers on health grounds could only be negotiated between relevant healthcare departments. He confirmed that the local Category B establishments with 24-hour healthcare were HMP Winchester, Exeter and Bristol.

60. On 20 April, the CTL spoke by telephone to a hospital nurse who advised that Mr Stephens was ready to be discharged but needed care in place to administer end-of-life medications when required. Mr Stephens could not be discharged as The Verne did not have healthcare staff overnight.

61. That day, the Head of Healthcare emailed colleagues involved in the ERCG application. She advised that the hospital consultant had said that Mr Stephens had a terminal illness. She said that if a release address was needed for the application, she could continue conversations with the local authority about a care home placement. Later that day, a Senior Probation Officer responded by email to say that an address was needed for the application. He asked the Head of Healthcare to speak to the local authority about a care home placement. The OMH manager told the investigator that they collated the information needed for the ERCG application but did not submit it to the specialist casework team because they did not have an address for release (which was one of the criteria).

62. On 5 May, Mr Stephens returned to The Verne as the hospital said he was no longer considered end-of-life. The Head of Healthcare arranged for an agency nurse and an HCA between 8.00pm and 7.30am until 19 May. Mr Stephens was moved to B1 (a single room in a secure area of the prison) to provide a safe working environment for the agency staff. The Head of Healthcare told the investigator that the overnight care package had originally been arranged because Mr Stephens was considered to be near the end of his life and was receiving medication through a syringe driver. However, when they discharged him, the hospital had said that Mr Stephens was no longer actively dying. She kept the care package in place to assess his overnight needs.

63. The Head of Safety told the investigator that he was concerned that the prison was not set up to take palliative prisoners and they did not have an end-of-life care suite. He said that he raised these concerns with the healthcare team.

64. On 13 May, an MDT meeting, which included healthcare staff, took place. A prison GP recorded that the overnight agency's care would stop on 17 May and the plan was to return Mr Stephens to Dorset Wing.

65. On 15 May, a prison chaplain recorded that Mr Stephens had had a phone call with his daughter. He told her he was afraid of being left alone at night without nursing care. She raised these concerns with the Head of Safety.

66. On 17 May, Mr Stephens' overnight care stopped. The Head of Healthcare told the investigator that Mr Stephens had been assessed as not having overnight needs and a nurse was not justified. She said that officers knew that they could call 111 for advice during the night.

67. Later that day, Mr Stephens returned to a dormitory on Dorset Wing and was given a medical bed with a pressure mattress. An MDT meeting was held (the record of the meeting did not state who attended) and agreed Mr Stephens should have a personal alarm, urine bottles and an oximeter (to measure oxygen saturation levels). It was agreed that the RSAs would only work between 8.30am and 8.00pm and were not to undertake personal care or measure oxygen saturations. They were to alert staff if there was an issue with his oxygen levels or he appeared unwell. The Head of Healthcare told the investigator that Mr Stephens was moved back to Dorset Wing as they did not want him to be isolated from his friends. She said that healthcare staff were not always involved in the discussions about where Mr Stephens should live, and they were not always involved in the MDT meetings. A prison GP told the investigator that Mr Stephens was involved in the decision to return him to Dorset Wing.

68. On 20 May, Mr Stephens fell. He was not seriously hurt but complained of rib pain. That evening, paramedics attended because Mr Stephens complained of further rib pain. The paramedics told officers that Mr Stephens might continue to experience pain for six weeks. The information was not passed to the healthcare team.

69. During the day of 21 May, Mr Stephens frequently complained of rib pain. By the evening, an officer recorded that Mr Stephens could barely move to the bathroom. (Being able to independently travel to the bathroom was one of the criteria for acceptance at The Verne.)

70. On the morning of 22 May, wing staff told a Senior Nurse (SN) that the RSAs had said that Mr Stephens was calling out in pain at night. The SN noted that Mr Stephens was visibly in pain. He told the Head of Healthcare, and they agreed to provide enough pain relief during the day to maintain him overnight. They said they would review it over the weekend and the Head would discuss this with prison management after the weekend.

Events of 23 May to 27 May

71. On 23 May, healthcare staff made various entries in the medical record about Mr Stephens' pressure sores and inability to move easily in bed. Nursing staff were concerned that he needed more care than was available at The Verne and escalated their concerns to senior colleagues.

72. That day, a CM completed a social care referral form. He noted that Mr Stephens' care plan needed to be urgently reviewed due to his worsening health. He stated that Mr Stephens was unable to propel himself, was weak, frail, had fits and falls, was developing pressure sores and bruising and was in severe pain.

73. On 24 May, a prison GP reviewed Mr Stephens with an HCA. She noted that Mr Stephens was complaining of pain but that some pain relief options (morphine, for example) were difficult to prescribe without overnight healthcare.

74. Later that day, an MDT meeting took place but there is no record of the discussion or attendees. The Head of Safety told us that he decided to move Mr Stephens to Dorm 5 so that he would cause less disruption to other prisoners. He said that they considered moving him to B Wing but were told he was too weak to move.

75. During the night, Mr Stephens fell out of bed. He had cut his head and staff called 111, who advised staff to monitor Mr Stephens overnight. Healthcare staff reviewed him the following morning. They noted that he appeared to be hallucinating and became agitated.

76. A nurse recorded that she had twice helped Mr Stephens as he had been seen on camera trying to get out of bed. She recorded that he was extremely frail, agitated, only occasionally coherent and at a high risk of falls. She submitted a safeguarding report online (through a system called Datix), which alerted the CTL, the Head of Safety, the Head of Healthcare, and the regional governance lead. The Head of Healthcare said that she was not aware of the nurse's Datix report.

77. At 9.00am on 26 May, a nurse reviewed Mr Stephens and noted he was unresponsive and at the end of his life. She notified prison and healthcare managers. An MDT agreed that Mr Stephens' social care package should be reviewed as he needed more bed care. That morning, the Head of Healthcare contacted NHS England's local commissioners and arranged for overnight end-of-life care from that day between 8.00pm and 7.30am.

78. A prison GP told the investigator that it was difficult to identify the best option for Mr Stephens because he was not acutely unwell for hospital admission, he did not need complex palliative care so did not need a hospice bed, the ERCG had not been agreed and there was no prison with 24-hour healthcare that could take him. He said that if Mr Stephens did not have a medical or nursing need, there would be no reason to arrange overnight nursing care.

79. On 27 May, the CTL commissioned the SN to investigate the nurse's Datix report. (The investigation was concluded after Mr Stephens' death.) That morning, a nurse reviewed Mr Stephens and noted that the daytime care plan was for prison officers and the chaplain to stay with Mr Stephens during the day and healthcare staff would visit in the afternoon.

80. At 4.56am on 28 May, an agency nurse noted that Mr Stephens had died. At 8.40am, a prison GP verified Mr Stephens's death.

Contact with Mr Stephens' family

81. The prison appointed a family liaison officer (FLO) on 19 June 2019. Mr Stephens' family were updated about his deteriorating health and there were good efforts made to facilitate contact between them. (Due to the restrictions in place during the COVID-19 pandemic, the family was unable to visit Mr Stephens, but the prison arranged for them to speak to him by phone.) The FLO notified Mr Stephens' next of kin of his death at 8.00am on 28 May 2021.

Support for prisoners and staff

82. There is no evidence that The Verne debriefed staff involved in Mr Stephens' care or death to offer support and give them the opportunity to discuss any issues. The prison posted notices informing other prisoners of Mr Stephens' death and offering support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by his death.

83. One of the RSAs told us that a CM and other prison managers had been to see him and asked if he needed any particular support after Mr Stephens' death.

Post-mortem report

84. The Coroner concluded that Mr Stephens died of bilateral bronchopneumonia (an inflammation of the airways and lungs). He also had cachexia (extreme weight loss and muscle wastage) which did not cause but contributed to his death.

Inquest into the Mr Stephens death

85. The inquest into Mr Stephens death was held on 19 May 2025 and a verdict of natural causes was recorded. The coroner concluded that Mr Stephens death was due to bilateral bronchopneumonia. He also had cachexia.

Clinical Findings

86. The clinical reviewer found that the care Mr Stephens received from April 2021 onwards was not equivalent to that which he could have expected to receive in the community. He identified a number of concerns, including about safeguarding arrangements and processes, managing prisoners with complex needs and arrangements for increasing care or moving prisoners to a more suitable environment. He made a number of recommendations about safeguarding and arrangements for those with complex or end-of-life care needs which the Head of Healthcare will need to address.

Head of Healthcare to note

87. On 21 May, when Mr Stephens had hurt himself following a fall, his care was not escalated despite a NEWS2 score of five. Although he was seen a further three times by healthcare staff, there is no record that any subsequent clinical observations were taken. There were a number of entries about Mr Stephens not having the required pillows for his comfort and to minimise pressure sores.

Non-clinical findings

Suitability of The Verne to meet Mr Stephens' needs

88. Mr Stephens lived in the healthcare unit at HMP Winchester. The Verne completed a suitability assessment, involving three specialisms, and concluded that Mr Stephens was suitable for transfer there. However, his healthcare records were not made available to The Verne before their assessment. This would have better informed them of his medical needs and enabled them to consider how to manage his conditions, especially the seizures. Shortly after Mr Stephens arrived at The Verne, there was some concern and difference of opinion among healthcare and prison staff about whether The Verne could meet Mr Stephens' care and medical needs.

89. When Mr Stephens returned from hospital in March 2021, his health had deteriorated, and he needed fifteen hours of supplementary oxygen. The level of support and social care that he needed had increased and the RSAs immediately flagged their concerns about his condition and the increased assistance that he needed.

90. Shortly after this, on 7 April, The Verne started the ERCG process following the diagnosis that Mr Stephens was severely frail and in the last months of his life. Healthcare and prison staff expressed concerns that there was not a clear pathway to transfer a prisoner whose social care and medical needs could not be met at The Verne. It is clear from the information we reviewed and our interviews that Mr Stephens was happy at The Verne and wanted to remain there, surrounded by his friends. However, although discussions about moving Mr Stephens to a different prison began in April 2021, we saw no evidence that this was properly explored, and prison and healthcare staff were unclear about who was responsible for taking this forward.

91. The investigator contacted HMPPS' Head of Health and Social Care Team about the process for transferring a prisoner for health reasons. She said that prisoners can be moved where the transfer is in their best interests and clinically supported. She told us that prison governors were responsible for the location and movement of prisoners and therefore led on organising transfers, working closely with prison staff, healthcare providers and local authorities at both sites.

92. It is evident from the records and interviews that the extent of Mr Stephens' clinical and social care needs affected those around him. The RSAs described being 'burnt out' from providing care, fellow prisoners were frequently disturbed during the night and worried about Mr Stephens dying among them, prison officers often had to deal with social care and health issues and healthcare staff were worried and upset that they were unable to meet his needs.

93. We recognise that the situation was complex and multi-faceted due to the pandemic, Mr Stephens' wish to remain at The Verne, his fluctuating medical and social care needs and the willingness of staff and prisoners to do their best to look after him. The Verne's physical environment and layout of the accommodation added to the complexity of the situation. However, at the point when Mr Stephens was unable to safely move around independently (which is one of the admission criteria for the prison) and he had been given a terminal diagnosis of months, the prison and healthcare team should have recognised that The Verne would not be able to meet his needs. A move to a more suitable environment should have been robustly pursued before his condition deteriorated to such an extent that he was too ill or frail to be moved.

94. A social care unit was introduced at The Verne in December 2023 which caters for up to sixteen prisoners with social care needs. It is staffed by two HCAs 24 hours a day and there is also a social care lead who works on the unit during the day. We were told it is a regional resource and only prisoners who meet the criteria live in the unit.

95. The NHS Clinical Nursing and Quality Manager (CN&QM) from the Health and Justice Commissioning Team attends fortnightly meetings to review new applications for the unit and to consider their current caseload. The GP at The Verne reviews all prisoners on the unit weekly. All prisoners on the unit are risk-assessed and have a full clinical assessment. The Manager told us that having a 24-hour healthcare presence increases their ability to identify deterioration early and to make appropriate plans.

96. The CTL said that healthcare staff met medical needs during core operating hours and outside these hours, staff reverted to 111/999 depending on the situation. He said that if 24-hour nursing care was needed, it could be arranged through an agency, although the unit was not set up for this as it was dormitory-style accommodation.

97. The introduction of this unit is extremely positive and addresses a number of concerns that we identified. However, we make the following recommendations:

The Governor and Head of Healthcare should ensure that there is a process in place to transfer prisoners with a terminal diagnosis or whose medical needs cannot be met at The Verne to a more suitable environment at the earliest opportunity.

The Governor and Head of Healthcare should ensure that there is a suitable location where a prisoner can receive short-term 24-hour nursing care if required.

Dorm 5

98. Mr Stephens was twice moved to Dorm 5 because it was considered more suitable when he disturbed other prisoners and the RSAs, especially at night. He lived there between 11 March and 5 May (except for periods in hospital) and then again from 24 May until his death.

99. On 11 March, Mr Stephens activated his personal alarm, but it took prison officers twenty minutes to respond (and only after they were alerted by a passing prisoner) as they could not hear the alarm. This incident did not prompt a review of whether Dorm 5 was the right location for Mr Stephens.

100. We understand that the decision to return Mr Stephens to Dorm 5 on 24 May was made following an MDT. We were not provided with a record of the MDT meeting and therefore do not know who was involved in this decision and what, if any, consideration was given to the risks posed. Mr Stephens had been identified as being in the last few months of his life and prone to falls and confusion. Only a few hours after moving to Dorm 5, prisoners told officers that Mr Stephens had fallen out of his bed.

101. A nurse told the investigator that she was concerned about Mr Stephens being in Dorm 5 due to his high risk of falls and, while he was visible at all times on CCTV, it was not constantly monitored as officers had other duties to perform.

102. We recognise that at this time, the prison was dealing with many complex challenges arising from the pandemic and was under immense pressure. However, if Dorm 5 was the only suitable space for Mr Stephens, additional safeguards should have been put in place to mitigate the risks. As The Verne now has an established social care unit, it is unlikely that this situation would arise again and so we make no recommendation.

Resident Support Assistants

103. The social care and general support provided by the RSAs was invaluable and without their involvement, Mr Stephens' situation would have been considerably worse. In all of the interviews, there was universal recognition and praise for the contribution and conscientiousness of the RSAs involved in Mr Stephens' care. However, on occasion, the RSAs' support exceeded the requirements of PSI 17/2015. The extent of RSA support provided was made more complex by the fact that some of them lived alongside Mr Stephens in the dormitory. Inevitably, they felt compelled to help him whenever he needed support, day or night. While the prison tried to manage this by agreeing the type of care and support RSAs should provide and setting out their working hours, there were also occasions when staff asked RSAs to help with Mr Stephens outside their working hours.

104. Mr Stephens' potential isolation should have been balanced against the impact on the RSAs of him remaining in the dormitory. The prison should have recognised that even though they had told the RSAs not to assist past 8.00pm, they could not have

ignored Mr Stephens' cries for help. The RSAs told us that they had felt exhausted and emotionally drained and there were no clear supervision or support mechanisms in place for them. They said that a weekly RSA meeting had stopped and the paperwork they completed when undertaking their duties was not considered. The Verne did not fulfil their duty of care towards the RSAs, and we make the following recommendation:

The Governor should ensure that adequate supervision and support arrangements are in place for RSAs and issues they raise are discussed at the relevant social care MDT meeting.

Safeguarding

105. There were two safeguarding referrals made for Mr Stephens at The Verne. The first was made by the OMH manager in March 2021 when Mr Stephens was discharged from hospital to the dormitories, needing fifteen hours of supplementary oxygen. While we were told that the Deputy Governor responded to her about this safeguarding referral, the PPO was not provided with a copy of the response. The OMH manager said that she believed an MDT meeting was arranged in response and a decision was made to move Mr Stephens to Dorm 5. No minutes of the meeting were available.

106. A nurse made the second safeguarding referral on 25 May. We saw no evidence that this was dealt with. The Head of Healthcare told us that she was unaware of this referral and the Head of Safety said that the healthcare team would have dealt with any safeguarding concerns for Mr Stephens.

107. There was general confusion and a lack of understanding among staff about the prison's safeguarding process and the division of responsibilities. At the time, the Head of Safety was the safeguarding lead for the prison. However, he too appeared unclear about the existence of safeguarding policies and how safeguarding issues raised by healthcare staff should be managed and progressed.

108. HMIP noted in their last inspection that although The Verne had a comprehensive safeguarding adults' policy in place, no safeguarding referrals had been made to the local authority and staff had limited understanding of safeguarding practice and procedures.

109. A manager told us that The Verne's safeguarding policy had been updated in March 2023. He shared a copy with us and set out that following actions had been taken:

- The prison meets monthly with the local NHS provider (Oxleas) about all aspects of operational delivery, care and strategy;
- healthcare staff attend the prison's daily morning meetings where operational and management issues are discussed. These include discussing specific prisoners and any issues requiring further action which are then followed up by the relevant staff member;
- the prison is represented on the local authority's adult safeguarding board;

- a weekly safety intervention meeting (SIM) is held between prison and healthcare staff to discuss issues (including care needs and safeguarding);
- there is a log for safeguarding concerns and all actions are completed immediately on referral. Any follow-up actions are recorded and escalated;
- all new prison officers receive adult safeguarding training during the basic training; and
- The Verne is creating a training plan, including online training on adult safeguarding for all staff.

110. We are satisfied that the prison now has in place processes which, if followed, should ensure that any safeguarding issue will be dealt with swiftly and there will be a record of what action has been taken and by whom. We make the following recommendation:

The Governor should ensure that all staff understand and follow the safeguarding policy, particularly with regard to the division of responsibilities for action to be taken.

Compassionate release

111. Release on compassionate grounds enables prisoners who are seriously ill, usually with a life expectancy of less than three months, to be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release are set out in the Early Release on Compassionate Grounds Policy Framework. This includes that the risk of reoffending is minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of HMPPS.

112. The Deputy Governor started an application for early release on 7 April 2021 as both the prison doctor and the hospital consultant had concluded that Mr Stephens had less than three months to live. Mr Stephens' wishes at this time were not captured. Between 13 April and 20 April, there was an exchange of emails between the Head of Healthcare, the OMH manager and probation. The Head of Healthcare said she had spoken to the local authority about a place in a care home and if an address was needed, she could go back to the local authority to see what bed spaces were available. The OMH manager told us that the application was not progressed because an address could not be provided.

113. The investigator asked PPCS if an ERCG application could be submitted without a release address, especially if a prisoner needed to move to a care/nursing home, where the location of vacancies changed daily. They said that while an address was needed to enable probation to complete the required checks and vetting, they recommended that an application should be submitted in these circumstances. If the application was declined on the basis that there was no release address, the prison could try to progress this issue and reapply again in the future. We therefore make the following recommendation:

The Governor should ensure that applications for early release on compassionate grounds for prisoners who meet the criteria are progressed and if in doubt staff should seek advice from HMPPS' Public Protection Casework Section (PPCS)

Communication

114. Good communication and liaison between prison and healthcare staff is critical, especially when prisons do not have 24-hour healthcare provision. There were issues with the flow of information between the disciplines involved in Mr Stephens' care. The RSAs complained that they were not updated about important issues and we were told that the activity sheets they completed were not shared. The Head of Healthcare told the investigator that she had not been made aware of the RSAs' concerns about Mr Stephens' deteriorating health and the impact on them.

115. The paramedics' advice on 20 May was not recorded in Mr Stephens' medical records which indicates that it may not have been shared with healthcare staff. The Head of Healthcare said that the healthcare team had not always been involved in decisions about Mr Stephens' location. It was clear that healthcare staff had clinical concerns which should have been considered.

116. In his email to the investigator on 9 May, a manager said that there were now daily operational meetings between prison staff and a senior representative from the healthcare team. He said that they discussed concerns about specific prisoners and notes were shared with the attendees. This and the weekly SIM created the opportunity for information to be shared and promoted a joined-up approach to dealing with complex issues. We therefore make no recommendations.

Governor to note

117. The investigators noted references to MDT meetings taking place, but these were not consistently recorded in Mr Stephens' prison records. In the instances where there were records, they did not always include who had attended the meeting.

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