Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Stapylton, a prisoner at HMP Holme House, on 6 March 2023

A report by the Prisons and Probation Ombudsman

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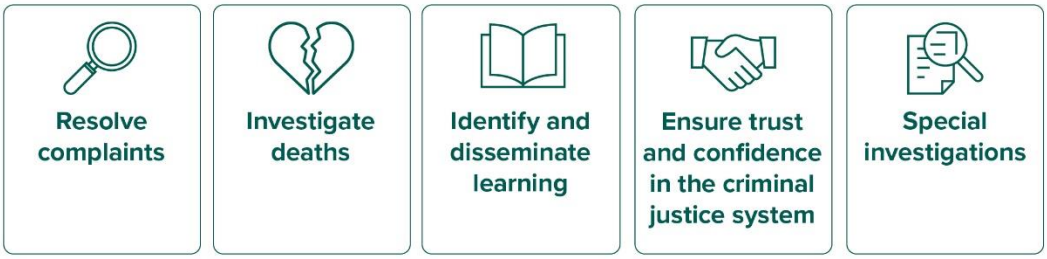
OUR VISION

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

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. 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.

3. Mr William Stapylton died of bronchopneumonia caused by gangrene in his foot on 6 March 2023, at HMP Holme House. He was 64 years old. We offer our condolences to Mr Stapylton's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Stapylton received at Holme House was of a good standard and equivalent to what he could have expected to receive in the community. She made recommendations about clinical handovers, a missed welfare check in January 2023, delays in completing a falls risk assessment and recording clinical scores and mental health capacity assessments accurately, which we do not repeat here but which the Head of Healthcare will wish to address.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Stapylton's death on 6 March 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Stapylton's clinical care at Holme House.

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

9. The PPO family liaison officer wrote to Mr Stapylton's brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. The initial report was shared with HMPPS. They did not find any factual inaccuracies.

Previous deaths at HMP Holme House

11. Mr Stapylton was the twentieth prisoner to die at Holme House since March 2020. Of the previous deaths, 15 were from natural causes, three were self-inflicted and one was drug related. Up to the end of 2023, there have been three deaths from natural causes since Mr Stapylton's death. There are no similarities between the findings in our investigation into Mr Stapylton's death and the findings from our investigations into the other deaths.

Key Events

12. On 26 November 2021, Mr William Stapylton was sentenced to 14 years in prison for sexual offences and sent to HMP Durham.

13. Mr Stapylton had a complex and long medical history of heart disease and Type 2 diabetes which were diagnosed before he went to prison. He used a walking stick and Zimmer frame to move around. For several years he had refused medical treatment and had been assessed as having the mental capacity to make such decisions. At Durham, Mr Stapylton signed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order confirming that he did not want anyone to resuscitate him if his heart or breathing stopped.

14. On 2 March 2022, Mr Stapylton was transferred to HMP Holme House.

15. During his reception health screen at Holme House, Mr Stapylton confirmed his wishes to only have medication for symptom control but not to have any regular medication, treatment and visits to hospital. Mental health staff conducted an assessment and concluded that Mr Stapylton had the mental capacity to make treatment decisions. Mr Stapylton agreed to have an allocated named nurse and to be added to the complex case register to discuss his healthcare needs. He said that he was aware that his refusal to have any treatment for his heart condition and diabetes could be detrimental. Mr Stapylton said that his preferred place of death was in prison.

16. On 3 March at Mr Stapylton's secondary health screen, a GP at the prison discussed the DNACPR order and completed an emergency health care plan (EHCP) to update Mr Stapylton's preferences for all aspects of his care and treatment. The next day, healthcare staff added Mr Stapylton to the palliative care register. However, he declined any input from the palliative care team.

17. Healthcare staff met Mr Stapylton regularly and they tried to encourage him to allow them to monitor his conditions. He refused to have any diabetic or cardiac reviews, vaccinations or medication. He stressed that he did not want to attend hospital under any circumstances. The mental health team assessed that Mr Stapylton had the mental capacity to make these decisions.

18. On 17 May, Mr Stapylton complained about a loss of sensation in his feet. Healthcare staff completed a referral to a podiatrist who diagnosed a fungal nail infection and prescribed a lacquer to treat this.

19. On 4 August, healthcare staff noted that Mr Stapylton had a toe infection. He refused oral antibiotics and agreed to topical antibiotics.

2023

20. On 20 January 2023, a GP at the prison reviewed Mr Stapylton and diagnosed possible impending sepsis. However, Mr Stapylton refused to have blood tests, referral to hospital or antibiotics and only agreed to pain relief. He was again assessed as having the capacity to make these decisions. He agreed to move to the prison's inpatient unit for closer monitoring.

21. Mr Stapylton's left foot began to deteriorate and despite frequent GP reviews, he refused any treatment or a hospital referral. His left foot became infected, and it was suspected this had caused sepsis. He was bedbound and healthcare staff arranged for his cell door to remain unlocked to allow them to attend to his needs easily.

22. On 6 March 2023, healthcare staff found Mr Stapylton unresponsive in his cell in the prison's healthcare unit. Paramedics attended and confirmed his death.

Post-mortem report

23. The post-mortem report concluded that Mr Stapylton died of bronchopneumonia caused by gangrene of the foot. Established ischaemic heart disease was also listed as a contributory factor.

Good practice

24. Prison GPs and healthcare staff ensured that Mr Stapylton was fully aware of the consequences of refusing treatment for his medical conditions. His decisions to refuse treatment limited his healthcare options. Mental health specialists assessed that he had the capacity to refuse treatment on a regular basis. Healthcare staff continued to engage with him and offered a good level of support.

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

Inquest

The inquest, held on 3 May 2024, reached the following narrative conclusion:

Mr Stapylton had been offered medical treatment and assistance on a number of occasions but refused medical treatment, he declined and died.

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