Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Haldane, a prisoner at HMP Stafford, on 29 August 2022

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.

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 Steven Haldane died in the reception area of HMP Stafford on 29 August 2022, while waiting for a prison van to take him to hospital. His cause of death was toxic megacolon (extreme inflammation of the colon) caused by chronic constipation. He was 55 years old. I offer my condolences to Mr Haldane's family and friends.

The clinical reviewer found that the care Mr Haldane received up to 29 August was equivalent to that which he could have expected to receive in the community. However, she was concerned about the care Mr Haldane received on 29 August, after he told staff he felt unwell and had been unable to defecate for a month. In particular, the nurse who went to see Mr Haldane on the morning of 29 August failed to record his clinical observations in his medical record and failed to use the NEWS2 tool (used to assess clinical deterioration). Inconsistent use of NEWS2 has been a repeated failure at Stafford and is a matter that the Head of Healthcare should address without delay.

I am also concerned that there was a delay in staff starting CPR when Mr Haldane became unresponsive in reception on 29 August. CPR was not started until nurses arrived around three minutes later.

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 **May 2023**

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Summary

Events

1. On 9 April 2020, Mr Steven Haldane was recalled to prison custody after breaching his licence conditions. On 25 March 2021, he was moved to HMP Stafford.

2. On the morning of 29 August 2022, Mr Haldane's cellmate rang his emergency cell bell as Mr Haldane felt unwell and had been trying unsuccessfully to defecate throughout the night. An officer radioed for a nurse, who noted that Mr Haldane's stomach was distended, though his clinical observations were normal. The nurse gave Mr Haldane a laxative and arranged to review him later that day.

3. The nurse went back to see Mr Haldane in the early afternoon and he told her that he had vomited black vomit that morning. The nurse found that Mr Haldane was breathless and his abdomen was more taut than earlier. She asked officers to arrange his transfer to hospital, though she did not consider that it was an emergency.

4. Mr Haldane was taken by wheelchair to reception at around 3.10pm. At 3.15pm, staff noticed that he had slumped forward in his wheelchair and they struggled to find a pulse. They radioed a medical emergency code. They said they were about to move Mr Haldane from his wheelchair and start CPR when nurses arrived. Nurses arrived at 3.18pm and realised that Mr Haldane was not breathing. Staff then moved Mr Haldane to the floor and began CPR.

5. Ambulance paramedics arrived at 3.25pm and took over Mr Haldane's care. At 3.49pm, the paramedics pronounced that Mr Haldane had died.

6. A post-mortem examination found that Mr Haldane died from toxic megacolon (extreme inflammation of the colon) caused by chronic constipation.

Findings

7. The clinical reviewer concluded that the care Mr Haldane received at Stafford up to 29 August was equivalent to that which he could have expected to receive in the community.

8. However, the clinical reviewer was concerned about the care he received on 29 August. She was concerned that after the nurse checked Mr Haldane at 9.30am, she failed to note his clinical observations in his medical record. She was also concerned that the nurse did not use NEWS2 (National Early Warning Score - a tool used to assess clinical deterioration).

9. There was a delay in staff starting CPR when Mr Haldane became unresponsive in reception. We consider that staff should have started CPR as soon as the medical emergency code was called. Instead, there was a three minute delay before nurses arrived and started CPR.

Recommendations

- **The Head of Healthcare should ensure that when staff take clinical observations, they:**
    - **record the readings in the prisoner's medical record; and**
    - **calculate and record the NEWS2 score and know when to escalate care as a result.**
- **The Governor should ensure that staff start CPR without delay when a prisoner has no pulse and stops breathing.**

The Investigation Process

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

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

12. The investigator interviewed six members of staff and two prisoners from HMP Stafford. All interviews were conducted by telephone.

13. NHS England commissioned a clinical reviewer to review Mr Haldane's clinical care at the prison. The investigator and clinical reviewer conducted joint interviews with the clinical staff and with a custodial manager.

14. We informed HM Coroner for Staffordshire South of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

15. Mr Haldane had no identified next of kin so there was no family involvement in this investigation.

Background Information

HMP Stafford

16. HMP Stafford is a medium security prison in Staffordshire for adult male sex offenders. It holds around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Stafford was in January 2020. Inspectors noted that nearly half of the prisoner population at Stafford was over 50 years old. Inspectors found that an up-to-date health needs analysis informed service delivery although there was an insufficiently sharp focus on certain important patient outcomes. Inspectors found that there was a positive relationship between prison staff and local health partners. Inspectors noted that the clinical records they reviewed were professional and that arrangements to provide a rapid response to medical emergencies were sound.

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 30 April 2022, the IMB reported that in the last year they had received very few complaints about staff/prisoner relationships. The IMB noted that in the main, the healthcare provision at Stafford often received praise from prisoners and the care was equal to what could be expected in the community. However, the IMB was critical of medicines management which was not sufficiently focused on whether the patient had received the right medication at the right time and in the right dose.

Previous deaths at HMP Stafford

19. Mr Haldane was the 16th prisoner to die at Stafford since August 2020. Of these, 14 deaths were from natural causes and one was self-inflicted. We have made recommendations in three of these cases about the failure to use the NEWS2 assessment tool, most recently in February 2023 (for a death that occurred in June 2022). In response to earlier recommendations, the healthcare provider said that refresher training on NEWS2 would be delivered in early 2021.

Key Events

20. In April 2015, Mr Steven Haldane was sentenced to nine years in prison for sex offences.

21. Mr Haldane was released from prison on 17 December 2019, but on 9 April 2020 he was recalled for breaching his licence conditions.

22. On 25 March 2021, Mr Haldane was moved to HMP Stafford.

23. In July 2022, Mr Haldane asked for a meeting with his former cellmate who had moved to a different wing. It appears that Mr Haldane wanted to pursue a relationship with him. On 8 July, Mr Haldane was told that the prison would not arrange a meeting.

24. On 12 July, Mr Haldane said that he had started a hunger strike and would continue until a meeting was arranged between him and his former cellmate. Stafford began plans to start Prison Service suicide and self-harm monitoring (known as ACCT) if Mr Haldane continued with his hunger strike after 72 hours.

25. On 15 July, Mr Haldane collected his afternoon meal. Staff noted that he was in a good mood and chatted with peers and staff.

26. On 27 August, Mr Haldane's key worker met with him. Mr Haldane said that he was okay, that he was eating his meals, that he had no issues on the wing and that there was nothing that he wanted to discuss.

27. The investigator spoke to Mr Haldane's cellmate. He said that after Mr Haldane threatened a hunger strike, he then went through a period of around two weeks in August when he would collect his meals but would then dispose of them by flushing them down the toilet. However, around a week before his death, Mr Haldane began eating again, which caused him indigestion.

Events of 29 August

28. On the morning of 29 August, Mr Haldane's cellmate rang the emergency cell bell as he was concerned about Mr Haldane who was not feeling well and who had tried without success to defecate throughout the night. An officer responded to the cell bell and then radioed for a nurse.

29. A nurse saw Mr Haldane at 9.30am. Mr Haldane said that he had not been able to defecate properly for around a month and that he had vomited the previous night. The nurse noted that Mr Haldane's stomach was distended. The nurse told the investigator that she took Mr Haldane's clinical observations, which were all within the normal range. She said that she noted his observations on a piece of paper but acknowledged that she failed to enter these in his medical record. The nurse gave Mr Haldane a laxative and told him that she would review him later in the day. She told him to ask to see healthcare staff if he began to feel worse in the interim.

30. The nurse went back to see Mr Haldane between 1.30pm and 2.00pm. Mr Haldane said that he had vomited that morning and the vomit was black. She noted that Mr

Haldane had still not defecated, that his abdomen was very taut and he was also breathless. The nurse decided that Mr Haldane needed to be sent to hospital for an assessment and she arranged for him to go that afternoon by prison van or taxi, which she thought at the time was appropriate. She said that if she had been very concerned, she would have called an emergency ambulance, although she also said that transfer by prison van or taxi was often quicker than transfer by ambulance.

31. At just after 3.00pm, an officer and a prisoner, who worked as a career, went to collect Mr Haldane from his cell. His cell was one floor above reception and was close to the stairs.

32. The prisoner carer told the investigator that Mr Haldane was able to walk down the stairs without assistance and was able to talk as they went. When they reached the bottom of the stairs, Mr Haldane got into a wheelchair and the prisoner carer pushed him to reception.

33. The Orderly Officer arranged to send Mr Haldane to hospital in a prison van. After identifying officers to accompany Mr Haldane to hospital, the Orderly Officer went to reception. The Orderly Officer said that Mr Haldane did not look well when he arrived, but he was conscious, was breathing, was sitting upright in the wheelchair and was looking around.

34. A custodial manager (the CM) was also in reception. He told the investigator that Mr Haldane was grey in colour and it was clear he was not well. The Orderly Officer noticed that Mr Haldane's head had slumped forwards and when the CM asked him if he was okay, he did not respond. Neither the Orderly Officer or the CM could find a pulse so at 3.15pm, the Orderly Officer called a medical emergency code blue (to indicate that a prisoner is unconscious or having breathing difficulties). Control room staff called for an ambulance.

35. The Orderly Officer said that they were on the point of deciding to move Mr Haldane onto the floor and start CPR when nurses arrived.

36. A nurse arrived in reception at 3.18pm. She said that Mr Haldane was still in the wheelchair when she arrived. She shook his shoulder and called his name, but got no response. She asked the officers to move Mr Haldane onto the floor and as they were doing that she realised that CPR needed to be started straight away. Other nurses had arrived with the nurse and they took turns giving CPR and gave Mr Haldane oxygen. They applied a defibrillator, which advised that no shock should be given and CPR should continue.

37. Paramedics arrived at 3.25pm and took over efforts to resuscitate Mr Haldane. A second ambulance crew arrived at 3.30pm. At 3.49pm, the paramedics stopped CPR and pronounced that Mr Haldane had died.

Contact with Mr Haldane's family

38. Stafford were unable to establish whether Mr Haldane had any next of kin.

Support for prisoners and staff

39. The Stafford's Head of Reducing Reoffending debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

41. The pathologist noted that Mr Haldane's colon was markedly distended and contained abundant faeces and that there was a large amount of impacted faeces within his rectum. The pathologist gave his cause of death as toxic megacolon (extreme inflammation of the colon) caused by chronic constipation.

Findings

Clinical care

42. The clinical reviewer noted that Mr Haldane had not reported being constipated prior to 29 August and told his key worker on 27 August that he was fine and was taking his meals. The clinical reviewer concluded that the care Mr Haldane received up to 29 August was equivalent to that he could have expected to receive in the community.

43. However, the clinical reviewer found that the care Mr Haldane received on 29 August was not equivalent. She noted that the nurse failed to record Mr Haldane's clinical observations in his medical record after she examined him at 9.30am. The clinical reviewer also considered that constipation for one month with abdominal distension should have given the nurse more concern, especially the risk of sepsis, and she should have calculated a NEWS2 score. (National Early Warning Score (NEWS2) is a clinical tool used to assess clinical deterioration.)

44. The clinical reviewer noted that the nurse did not take a complete set of observations (she did not take respiratory rate) so she would have been unable to calculate a NEWS2 score. The nurse said her watch was not working properly so she could not take Mr Haldane's respiratory rate, but the Head of Healthcare said a stopwatch was always available in the healthcare visiting bag. Although the nurse said that Mr Haldane did not appear breathless, his respiratory rate should have been measured. The clinical reviewer noted that if his respiratory rate had been higher than normal, then the NEWS2 score could have indicated a medium to high risk of sepsis.

45. We have previously made recommendations to Stafford about the failure to use NEWS2 consistently and so the Head of Healthcare should address this issue urgently. We recommend:

    The Head of Healthcare should ensure that when staff take clinical observations, they:

    - **record the readings in the prisoner's medical record; and**
    - **calculate and record the NEWS2 score and know when to escalate care as a result.**

Emergency response

46. The Orderly Officer radioed a code blue emergency at 3.15pm and nurses arrived at 3.18pm. We are concerned that reception staff had not started CPR by the time nurses arrived.

47. In his statement, the Orderly Officer said that it was clear something was seriously wrong with Mr Haldane as his head had slumped forwards. He said he checked for a pulse but could not find one and then called the code blue. At interview, he said that nurses arrived very quickly which is why staff had not started CPR. However, it was around three minutes before nurses arrived so we consider that reception staff

should have started CPR in the interim and as soon as possible after the code blue was called. We recommend:

The Governor should ensure that staff start CPR without delay when a prisoner has no pulse and stops breathing.

Inquest

48. An inquest into Mr Haldane's death held on 12 June 2025 concluded that his cause of his death was toxic megacolon secondary to chronic constipation.

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