Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Stenning a prisoner at HMP Frankland on 26 February 2018

A report by the Prisons and Probation Ombudsman

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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*

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 David Stenning died of heart failure on 26 February 2018 at HMP Frankland. He was 61 years old. I offer my condolences to his family and friends.

I am satisfied that the healthcare that Mr Stenning received at Frankland was good and equivalent to that which he could have expected to receive in the community.

However, I am concerned that the officers who went to Mr Stenning's cell did not try to find a pulse or check whether he was breathing and that the prison did not have up to date details of his next of kin.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

Contents

Summary

Events

1. On 14 October 1994, Mr David Stenning was sentenced to life in prison for sexual offences. He was transferred to HMP Frankland on 1 July 2009. He had a complex medical history, including heart problems, Type 2 diabetes, high cholesterol and chronic leg ulcers.

2. A diabetes consultant reviewed Mr Stenning through the telemedicine clinic and adjusted his insulin prescription. In July 2017, a prison GP found that Mr Stenning had cellulitis (a bacterial infection under the skin) and prescribed him antibiotics.

3. On 14 October, a healthcare administrator weighed Mr Stenning. He was obese. A prison GP asked him to improve his diet and referred him to a dietician. Mr Stenning missed two appointments with the dietician through the telemedicine service.

4. On 15 February 2018, a nurse saw that Mr Stenning's legs were red and inflamed. A prison GP sent Mr Stenning to hospital to have an ultrasound of his legs to test for deep vein thrombosis (DVT) and to have a chest x-ray. He returned to prison the next day with a diagnosis of cellulitis.

5. On 20 February, Mr Stenning had an electrocardiogram (ECG, a test to check the heart's rhythm and electrical activity). A prison GP reviewed the result and referred him to a consultant cardiologist who asked for Mr Stenning to have a myocardial perfusion scan (a scan that looks at the pumping action of the heart to identify heart failure). Mr Stenning died before this scan took place.

6. On 24 February, when a nurse changed the dressings on Mr Stenning's leg ulcers, she noted that he had sacral oedema (fluid in the tissues around the lower back) which can indicate heart failure. A prison GP reviewed Mr Stenning and increased his diuretic (water tablet).

7. At 12.05pm on 26 February, a prisoner who was Mr Stenning's prison buddy (a prisoner who assists another prisoner in their daily life) got his lunch and put it in his cell. He then took Mr Stenning to the medication hatch to collect his medication. At 12.10pm, officers locked the prisoners in their cells and completed a roll check.

8. At about 2.00pm, an officer unlocked Mr Stenning's cell door and saw Mr Stenning sitting in his chair, apparently asleep. At about 2.10pm, his prison buddy returned to Mr Stenning's cell. He could not wake him, so went to the wing office and told an officer.

9. The officer, who was not first aid trained, thought that Mr Stenning was dead. Another officer went to the cell and immediately radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing). He too was not first aid trained and thought that Mr Stenning was dead.

10. A nurse promptly went to Mr Stenning's cell but could not find a pulse or a heartbeat. Mr Stenning was icy cold and appeared to have been dead for some time. The nurse said that it would have been disrespectful to have started cardiopulmonary resuscitation (CPR). Paramedics went to the cell and confirmed that Mr Stenning was dead.

Findings

Clinical care

11. Healthcare staff frequently spoke to specialists through the telemedicine clinic. Despite attempts by healthcare staff to improve his diet, Mr Stenning bought numerous sugary drinks every week. Mr Stenning's leg ulcers an indication of heart failure, made him less mobile. Healthcare staff created care plans to manage his ulcers. His wound care was difficult because he had cellulitis, tissue breakdown and did not keep his legs raised. Healthcare staff frequently spoke to tissue viability nurses for help through the telemedicine link.

12. We are satisfied that the healthcare that Mr Stenning received at Frankland was good and equivalent to that which he could have expected to receive in the community. Mr Stenning was prescribed medication for heart failure, his blood pressure was frequently checked, he had monthly Doppler studies (a measure of the amount of blood flow through the arteries and veins in the legs) and received advice about obesity and heart disease.

Emergency response

13. Mr Stenning died during the lunchtime period when prisoners are locked up. When his prison buddy realised something was wrong, he went to the office and asked an officer for help. Prison officers do not receive mandatory first aid or life support training. Prison Service Instruction 29/2015 requires the Governor to ensure that suitably trained first aiders are always available to provide first aid if someone becomes ill or injured. The two officers believed that Mr Stenning was dead without touching him, trying to find a pulse or find out if he was breathing. Although it appears that Mr Stenning had probably been dead for some time, in any medical emergency checking for a pulse and determining that a prisoner is breathing is critical in considering whether a life can be saved.

Contact with Mr Stenning's family

14. Prison records named Mr Stenning's father as his next of kin even though he had died some years previously. Although the prison could not find her contact details, Mr Stenning's mother became aware of his death when the Probation Service rang to speak to Mr Stenning's sister; she then rang the prison.

15. We are concerned that the absence of up to date details of next of kin risks creating delay in contacting them and note the potential for distress and confusion if news of a prisoner's death becomes available before the next of kin is formally informed.

Recommendations

- The Governor should ensure that all staff are made aware that if a prisoner is unresponsive, they should check for a pulse and determine whether he is breathing.
- The Governor should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, ensure that the prisoner's family is informed as soon as possible in line with national guidance.

The Investigation Process

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

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

18. The investigator interviewed a prisoner at HMP Littlehey, who was transferred from Frankland on 9 April.

19. NHS England commissioned a clinical reviewer to review Mr Stenning's clinical care at the prison. The investigator jointly interviewed six members of staff with the clinical reviewer at Frankland on 26 April.

20. We informed HM Coroner for Durham and South Darlington 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 investigator wrote to Mr Stenning's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

22. We shared the initial report with the Prison Service. There were no reported factual inaccuracies.

Background Information

HMP Frankland

23. HMP Frankland is one of eight high security prisons in England and Wales. It holds up to 844 men. There is 24-hour inpatient care. G4S Forensic & Medical Services provide general nursing services and substance misuse services. Spectrum Healthcare provides GP and pharmacy services.

HM Inspectorate of prisons

24. The most recent inspection of HMP Frankland was in March 2016. Inspectors reported that while healthcare provision was reasonably good, staffing issues were impacting on care delivery. They noted that prisoners had access to a range of primary care services and visiting specialists, and that appropriately trained staff regularly reviewed prisoners with long-term conditions.

Independent Monitoring Board

25. 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 November 2017, the IMB noted that the appointment of a new Head of Healthcare and Clinical Lead had seen innovation and consolidation of service and clinical practice.

26. They found that recruitment of nursing staff continued to be a challenge. They noted that education and professional development for the nursing team had seen a job role-specific training programme developed to enhance the nurses' skill base and to improve the quality of patient care. This included suturing, wound care, ECG, immunisation and vaccination training, as well as emergency response.

Previous deaths at HMP Frankland

27. Mr Stenning was the eleventh person to die at Frankland since January 2015, all of whom had died from natural causes. There were no significant similarities with the circumstances of the previous deaths.

Key Events

Clinical care

28. On 14 October 1994, Mr David Stenning was sentenced to life in prison for sexual offences. He was transferred to HMP Frankland on 1 July 2009.

29. Mr Stenning had a complex medical history which included a coronary artery bypass after a heart attack in 2002, Type 2 diabetes, high blood pressure, obesity, hyperlipidaemia (an abnormally high level of cholesterol in the blood, a significant risk factor for heart disease), chronic leg ulcers, asthma and he was an ex-smoker. He was prescribed a number of medications for high blood pressure, cholesterol, diabetes, pain relief and to prevent blood clots and lower fat levels in the blood.

30. Healthcare staff reviewed Mr Stenning's blood pressure on a regular basis and carried out monthly Doppler studies.

31. By October 2016, Mr Stenning's leg ulcers were worsening. Healthcare staff frequently spoke to the tissue viability nursing service through the telemedicine clinic. On 20 March 2017, a nurse noted that Mr Stenning's ulcers on both of his legs were infected. He was prescribed flucloxacillin for the infection and tramadol for pain relief.

32. On 21 June, a diabetes consultant reviewed Mr Stenning through the telemedicine clinic. He adjusted Mr Stenning's insulin prescription.

33. On 10 July, a prison GP reviewed Mr Stenning. She saw that he had a swollen leg. She asked for blood tests to see if he had deep vein thrombosis (DVT). The blood tests showed that he did not have DVT but had cellulitis. She prescribed antibiotics.

34. On 20 July 2017, Mr Stenning had a chest x-ray, which showed that his lungs were clear and his heart was normal.

35. On 7 August 2017, a prison GP saw Mr Stenning and told him about the risks of obesity and how it affects blood circulation. Healthcare staff weighed Mr Stenning regularly as part of his heart failure care.

36. On 16 August, a prison GP reviewed Mr Stenning. She asked for a blood test to measure the levels of protein made by the heart and blood vessels. Such levels are higher when a patient has heart failure. On 6 September, she noted that Mr Stenning's protein level indicated that heart failure was unlikely. However, she referred Mr Stenning for an echocardiogram (a test for heart disease). There is no record that Mr Stenning had this test.

37. On 16 September, Mr Stenning told a nurse that he would not go to healthcare unit for his wound care dressing. On 18 September, a nurse noted that his legs were very red and his wounds were weeping, with dry skin around the ulcers. In October, healthcare staff spoke to tissue viability nurses through the telemedicine

clinic. On 11 October, a nurse noted that Mr Stenning's wounds were much better.

38. On 14 October, a healthcare administrator weighed Mr Stenning. She noted his weight as 130 kilograms and body mass index (BMI) as 42.3, which meant that Mr Stenning was obese. A prison GP asked him to improve his diet and referred him to a dietician. He did not attend two appointments with the dietician through the telemedicine service. Mr Stenning's weight continued to increase. A prisoner who was Mr Stenning's prison buddy said that Mr Stenning had four bottles of fizzy pop and six bottles of diluted juice drink each week.

39. On 28 December, a nurse noted that Mr Stenning's legs had healed, he had no open wounds and he no longer had any pain. However, when another nurse saw him on 23 January, she noted that his leg ulcers had got worse. She noted that his dressings should be reviewed daily.

40. On 15 February 2018, a nurse saw Mr Stenning and noted that his legs were red and inflamed. She noted a National Early Warning (NEW) score of 3 (which suggests that a patient should be monitored every 4 hours).

41. A prison GP reviewed Mr Stenning and sent him to hospital to have an ultrasound of his legs to test for DVT and to have a chest x-ray. He also prescribed him apixaban to thin his blood.

42. The next day, Mr Stenning was sent back to Frankland. Hospital staff said that he did not have DVT but that he had cellulitis again. Hospital staff stopped his apixaban and replaced it with aspirin.

43. On 19 February, a nurse noted that Mr Stenning's legs continued to weep and that he now had macerated feet (soft skin due to in a liquid).

44. On 20 February, Mr Stenning had an ECG. A prison GP reviewed the result and then referred him to a consultant cardiologist. The consultant asked for Mr Stenning to have a myocardial perfusion scan.

45. On 24 February, a nurse changed Mr Stenning's dressings. She noted that he had sacral oedema, which can indicate heart failure. A prison GP reviewed Mr Stenning at this time and his diuretic prescription was increased.

Emergency response

46. At 12.05pm on 26 February, the prison buddy collected Mr Stenning's lunch from the servery and put it in his cell. He then used a wheelchair to take Mr Stenning to the medication hatch to collect his insulin pens and tramadol medication. At 12.10pm, two officers locked the prisoners, including Mr Stenning, in their cells and completed a roll check.

47. At about 2.00pm, Officer A unlocked Mr Stenning's cell door. He said that he opened the observation panel and saw Mr Stenning sitting in his chair. He thought that he was asleep.

48. At about 2.10pm, the prison buddy returned to Mr Stenning's cell to take him to the healthcare department. He saw Mr Stenning sitting in his chair. He also

thought that he was asleep. He tried but was unable to wake him. He went to the wing office and told Officer A. They returned to the cell together and tried to wake him. The prison buddy called his name and clapped his hands in front of his face.

49. Officer A, who is not trained in first aid, did not touch Mr Stenning or try to find a pulse. He said that Mr Stenning was a blue grey colour, was unresponsive, not moving and there were no sounds of breathing. He thought that he was dead.

50. Prison Service Instruction 29/2015 requires the Governor to ensure that suitably trained first aiders are always available to provide first aid if someone becomes ill or injured. The prison's first aid risk assessment states that during the lunchtime patrol state, there must be at least one first aid trained member of staff, who should be the Orderly Officer.

51. The acting Head of Safer Custody said that there was a rota of prison staff, trained in first aid. On 26 February, during the lunchtime period, there was a duty first aider but they did not attend the incident as healthcare staff were already present.

52. Officer B heard clapping and someone calling the name, 'Dave'. He went to the cell and saw that Mr Stenning was ashen white in colour, slumped in his chair, with his head to one side. He immediately radioed a code blue (which indicates that a prisoner is unconscious or not breathing).

53. Officer B did not touch Mr Stenning either and asked the prison buddy to leave the cell. The officer, who is not first aid trained, thought that Mr Stenning was dead.

54. A Nurse heard the code blue on his radio and promptly went to Mr Stenning's cell. The nurse said that Mr Stenning was slumped in his chair, did not move, was grey in colour and his hands were mottled because the blood was starting to pool (visible within a couple of hours of death). He was unresponsive and there was no reaction in his pupils to light.

55. The nurse said that he could not find a pulse. He used a stethoscope but there was no heartbeat. Mr Stenning was icy cold and appeared to have been dead for quite a while. The nurse said that it would have been disrespectful to have started CPR.

56. Paramedics went to the cell and confirmed that Mr Stenning was dead. The nurse said that nursing staff were not allowed to confirm a death, and there were no prison GPs on duty at that time.

Contact with Mr Stenning's family

57. On 26 February, the Head of Business appointed a family liaison officer. Mr Stenning's father was listed as his next of kin but the family liaison officer found out that he had died. She continued to look for contact details for a next of kin for Mr Stenning.

58. Frankland told the Probation Service that Mr Stenning had died so that they could inform the victim of Mr Stenning's offence of his death. One of the victims

was Mr Stenning's sister. When the Probation Service called her number, they spoke to Mr Stenning's mother.

59. On 1 March, the Probation Service told the Head of Business that Mr Stenning's mother wanted to speak to the prison. On 2 March, she spoke to Mr Stenning's mother and offered her condolences. Mr Stenning's mother asked her to speak to her daughter (Mr Stenning's sister), which she did. Mr Stenning's sister agreed to act as Mr Stenning's next of kin.

60. The family liaison officer remained in regular contact with Mr Stenning's sister to arrange the funeral. Mr Stenning's funeral took place on 3 April 2018. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

61. After Mr Stenning's death the prison did not debrief the staff involved in the emergency response, but the staff care team spoke to both officers and offered support, as did the healthcare team with the nurse.

62. The prison posted notices informing other prisoners of Mr Stenning'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 Stenning's death.

Post-mortem report

63. A post-mortem examination found that the cause of Mr Stenning's death was acute left ventricular heart disease (which is the medical term for heart failure). This was caused by ischaemic and hypertensive heart disease.

Findings

Clinical care

64. We are satisfied that the healthcare that Mr Stenning received at Frankland was good and equivalent to that which he could have expected to receive in the community. Mr Stenning was prescribed medication for heart failure, his blood pressure was frequently checked, he had monthly Doppler studies (a measure of the amount of blood flow through the arteries and veins in the legs) and received advice about obesity and heart disease.

65. Mr Stenning had a complex medical history. A consultant cardiologist asked for a myocardial perfusion scan because he thought he might have heart failure. He died before the scan could take place.

66. Healthcare staff used the telemedicine clinic link for a diabetes consultant to review Mr Stenning's diabetes. He was frequently reviewed by a dietician through the same service.

67. Despite receiving advice and information from a dietician, Mr Stenning, who was obese, had a poor diet. He consumed unhealthy food and drinks, high in sugar.

68. Mr Stenning had leg ulcers which made him less mobile. Healthcare staff created care plans to manage his ulcers. His wound care was difficult because he had cellulitis, tissue breakdown and did not keep his legs raised. Healthcare staff frequently spoke to tissue viability nurses through the telemedicine link.

Emergency response

69. At 2.10pm, when Mr Stenning's buddy went to collect him to take him to the healthcare department, he found him unresponsive. Two officers promptly went to his cell. An officer radioed the correct emergency response and an ambulance was called immediately.

70. There is no mandatory first aid or life support training for prison officers, and the officers who responded to Mr Stenning had not been trained. Both officers believed that Mr Stenning was dead without touching him, trying to find a pulse or determine if he was breathing. While the clinical reviewer is satisfied that in Mr Stenning's circumstances resuscitation would have been inappropriate (as the nurse was clear that he was dead), in any medical emergency checking for a pulse and determining if a prisoner is breathing is critical to determine whether a life can be saved. We make the following recommendation:

    The Governor should ensure that all staff are made aware that if a prisoner is unresponsive, they should check for a pulse and determine whether he is breathing.

Contact with Mr Stenning's family

71. When the family liaison officer tried to contact Mr Stenning's father who was listed in the prison record as his next of kin, she saw that he had died in 2014. The family liaison officer continued to look for details of someone to act as a next of kin.

72. The Probation Service was obliged to inform Mr Stenning's victim, his sister, of his death. They telephoned the number they had for her, which turned out to be that of Mr Stenning's mother, and told her that he had died.

73. Prisoners' next of kin details must be updated regularly. We are concerned that the contact details for Mr Stenning's next of kin were not up to date. As a result, there was a delay in informing his next of kin, and they were not informed appropriately by prison staff.

The Governor should ensure that emergency contact details for prisoners' next of kin are accurate and kept up to date and, in the event of a death, ensure that the prisoner's family is informed as soon as possible in line with national guidance.

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