Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Stainburn a prisoner at HMP Moorland on 8 April 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 I oversee can improve their work in the future.

Mr John Stainburn died on 8 April 2018 of heart failure while in the custody of HMP Moorland. Mr Stainburn was 74 years old. I offer my condolences to Mr Stainburn's family and friends.

Mr Stainburn presented with a number of complex health conditions and, on the whole, was appropriately assessed, monitored and cared for. There were, however, some gaps in his health care relating to medication, care plans and referrals and I have made recommendations for improvements in these areas.

It is disappointing once again to find that Moorland have used restraints inappropriately when escorting an elderly, ill prisoner to hospital.

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 **April 2019**

Contents

Summary

Events

1. On 4 December 2014, Mr John Stainburn was sentenced to 11 years imprisonment for sexual offences and sent to HMP Leeds. He transferred to HMP Moorland on 19 January 2016.

2. Mr Stainburn had a number of health conditions including heart disease and diabetes, and he went on to develop chronic kidney failure. He was under the care of various hospital specialists.

3. When Mr Stainburn arrived at Moorland he was prescribed all the appropriate medication and, within a few months, was added to the complex care register, ensuring his needs were regularly discussed. He complained he was getting increasingly breathless so was assigned a buddy to help him with everyday living tasks. An echocardiogram taken in January 2017 revealed no immediate concerns.

4. In March 2017, Mr Stainburn was diagnosed with chronic kidney disease and staff monitored his kidneys' functionality from then on.

5. In December 2017, a diabetes specialist wrote to the prison recommending the prescription of a drug to help Mr Stainburn's body produce its own insulin. The correspondence was not actioned for some time and the drug was not prescribed until February 2018.

6. In March 2018, Mr Stainburn's kidney disease progressed, and he complained frequently of chest pain. On 3 April, he was admitted to hospital for further assessment after complaining of feeling particularly ill and having run out of his medication for his heart condition some days earlier. His condition deteriorated while he was in hospital and on 8 April he had a cardiac arrest. Hospital staff pronounced him dead at 11.55am.

Findings

7. The clinical reviewer was satisfied that, although some areas were in need of improvement, these did not impact on Mr Stainburn's death and overall the care he received at HMP Moorland was equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer found a need for improvement in the following areas: care plans were not reviewed at Mr Stainburn's complex care meetings; important correspondence relating to diabetes medication was not promptly actioned; Mr Stainburn was not referred to a specialist when his kidney disease progressed; he ran out of heart medication; the NEWS (National Early Warning Score) System was not employed to aid assessment and restraints were applied unjustifiably. It is not clear, to us, that electrocardiograms (ECGs) were promptly reviewed or results recorded.

9. Several of these points were identified in the review carried out by the healthcare provider after Mr Stainburn's death and action identified to address them. However, given the lack of clarity on how those actions are to be implemented, we make the following recommendations.

Recommendations

- The Head of Healthcare should ensure all relevant staff receive training in care plan completion and that plans are reviewed at complex care meetings.
- The Head of Healthcare should ensure clinical staff are aware of the NICE guidance relevant to caring for patients experiencing chronic kidney disease, and referrals for specialist assessments are made where necessary.
- The Head of Healthcare should ensure systems are in place to assign correspondence, in a timely fashion, to the appropriate individuals and that they complete any required actions.
- The Head of Healthcare should ensure all ECGs are reviewed by an appropriately qualified member of staff and the results clearly documented in the medical record.
- The Head of Healthcare should put a process in place to ensure that vulnerable patients are alerted when crucial medication awaits collection.
- The Head of Healthcare should ensure appropriate staff are trained to use the NEWS (National Early Warning Score) assessment tool and it is part of routine clinical practice.
- The Governor and Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the heath of a prisoner and are based on the actual risk the prisoner presents at the time.

The Investigation Process

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

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

12. NHS England commissioned a clinical reviewer to review Mr Stainburn's clinical care at the prison.

13. We informed HM Coroner for South Yorkshire East District of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Stainburn's wife to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Those matters she asked us to consider which were in remit, concerned whether Mr Stainburn received all his medication, if he was taken to appointments and generally if he received all other appropriate care for his conditions.

15. Mr Stainburn's wife received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Moorland

17. HMP Moorland holds up to 1,000 men. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full- time nursing cover.

18. In August 2018, the prisons minister, Rory Stewart MP, announced that Moorland would be one of the sites participating in the '10 Prisons Project'. The project (with the aid of a 10m funding injection) seeks to improve safety, security and decency at the prisons by focussing on living conditions, preventing drugs entering the establishments and enhancing leadership training available to Governors and their staff.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Moorland was conducted in February 2016. Inspectors reported that healthcare staffing levels and the skill mix were appropriate, but high demand and continuing vacancies had placed significant pressure on frontline staff. A dedicated lead for older people had recently been identified, but prisoner needs had not been fully assessed.

Independent Monitoring Board

20. 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 February 2018, the IMB reported that a successful recruitment drive had allowed prisoners to return to a full regime. There were some concerns that too many prisoners were not attending healthcare appointments and that external appointments were too often cancelled because of a lack of escorts.

Previous deaths at HMP Moorland

21. Mr Stainburn's is the eighth death from natural causes at HMP Moorland in the last five years. We have made recommendations about the excessive use of restraints following three previous investigations, most recently in a report on a death that occurred in February 2018

Key Events

22. On 4 December 2014, Mr John Stainburn was sentenced to 11 years imprisonment for sexual offences. He was sent to HMP Leeds, where he had already served time on remand, and transferred to HMP Moorland on 19 January 2016.

23. The copy of the medical record provided to the PPO begins on 19 January 2016 when Mr Stainburn transferred to HMP Moorland. However, the clinical reviewer has seen records indicating that Mr Stainburn's reception screen was conducted by a nurse on 18 January during an overnight stay at Doncaster prior to his transfer to Moorland.

24. Mr Stainburn had a history of heart disease, aortic stenosis (narrowing arteries) and angina. He also had diabetes and sleep apnoea (where normal breathing is interrupted during sleep). A nurse considered that Mr Stainburn was fit for independent living and normal location. Mr Stainburn was under the care of various specialists at a hospital for his heart, diabetes and respiratory issues.

25. Mr Stainburn was seen again by a nurse and a prison GP when he arrived at HMP Moorland on 19 January. The prison GP prescribed a number of medications for high blood pressure, angina and diabetes.

26. On 20 May 2016, an unnamed member of staff added Mr Stainburn to a 'complex care caseload' the purpose of which was to ensure his needs were assessed and addressed**.** His care was regularly discussed as part of complex care reviews, but there is no evidence that any care plans were drawn up.

27. On 16 August, a prison GP saw Mr Stainburn as he had been getting increasingly breathless. He made a non-urgent referral to the local cardiology service for an echocardiogram.

28. On 26 August, a nurse noted that Mr Stainburn had an unofficial buddy who was helping him to collect meals and taking him to visits. She planned to speak to officers about arranging a more permanent buddy who would also help Mr Stainburn clean his cell. This was arranged successfully.

2017

29. On January 2017, Mr Stainburn had the echocardiogram which did not reveal any significant concerns, and specialists considered it would be sufficient for him to have a repeat in a year's time.

30. On 24 March, a prison GP recorded that as a result of his pre-existing conditions Mr Stainburn had developed chronic kidney disease. A blood test to check how well his kidneys were working showed that their function was moderately to severely reduced. Staff regularly monitored Mr Stainburn's kidneys from this point onwards.

31. On 7 November, a nurse completed a 'Care Act Assessment' to ensure appropriate support was in place to help Mr Stainburn maintain his independence. If anything was lacking, extra publicly funded care might have been made available. Mr Stainburn did not qualify for the extra funding as it

was thought the prison could care for his needs and the buddy system provided appropriate additional support. The prison also provided back rests and reaching devices to assist his daily living.

32. On 6 December, a diabetes specialist, wrote to an unspecified doctor at Moorland (he addressed it to 'Dr Officer Medical') and advised that Mr Stainburn be prescribed dulaglutide. (This is a diabetes treatment which helps the body release its own insulin.) However, Mr Stainburn did not receive the medication until 2 February 2018 because there was no system in place to ensure such correspondence was reviewed promptly.

2018

33. On 16 March, a prison GP recorded that the dulaglutide was working well and that he would repeat blood tests the following week. He did and they were normal. However, Mr Stainburn's kidney disease had deteriorated and had now reached stage four. (There are five stages ranging from one, which is mild, to five which is complete kidney failure.)

34. On 19 March, a nurse attended the wing after reports that Mr Stainburn was not well. His blood pressure was 118/62 (partially low) and his pulse 62 bpm (at the low end of the normal range). She discussed the case with a prison GP who recommended an electrocardiogram test (ECG). The following day, a healthcare assistant performed the ECG and noted that she had passed the results to a GP. These are not recorded in the medical record and the investigator has not been able to establish whether a GP reviewed the reading or not.

35. On 26 March, a nurse recorded that prison staff brought Mr Stainburn to healthcare as he said he had pain in his chest and felt unable to breathe. A prison GP attended and another ECG was performed. No ECG results or diagnosis was recorded in the medical notes, but the GP told Mr Stainburn he might have to go to hospital if he got worse. The doctor also increased his furosemide prescription. (This is for high blood pressure, heart failure and fluid retention.) Healthcare staff informed relevant prison staff and Mr Stainburn's buddy that he was not feeling well.

36. On 28 March, a nurse went to see Mr Stainburn in his cell as he said he was unwell. His blood pressure was low but he had been using his GTN (glyceryl trinitrate) spray as an inhaler and the nurse advised him to stop this. (Glyceryl trinitrate is used for chest pain relief.) She told Mr Stainburn to alert staff if his symptoms worsened and that he would see a GP for a full review the following week. A nurse saw Mr Stainburn on 30 March and recorded that he said he felt much better and he did not seem to be short of breath.

37. On 3 April, a prison GP saw Mr Stainburn. Mr Stainburn told him he had taken the increased furosemide prescription for a few days but had stopped it. He said he had initially felt a little better but then ran out of the medication and ended up feeling as bad as, if not worse, than before. He recorded that Mr Stainburn's stomach was swollen and tense, his blood pressure was partially low, his pulse was at the lower end of the normal range and his oxygen saturation was normal. He decided that Mr Stainburn should be further

assessed in hospital and a non-urgent admission was arranged. Mr Stainburn was taken to hospital later that day.

38. A risk assessment was carried out to determine the level of restraints and number of escorts for the hospital visit. The unsigned medical portion of the risk assessment indicated that there were no medical objections to restraints, that Mr Stainburn's medical condition was likely to influence the escort and that he needed a wheelchair to mobilise. The security risk assessment stated that Mr Stainburn was a low risk of escape, of receiving outside assistance and of hostage-taking but presented a medium risk to the public. A deputy governor approved the use of single cuffs with a discretion to remove them for medical interventions.

39. On 4 April at 3.10pm, Mr Stainburn was moved to the cardiology ward and told he would be in hospital for a few days. A prison manager authorised that the restraints could be reduced to an escort chain.

40. On 5 April, a nurse telephoned the hospital for an update. She was told Mr Stainburn was unlikely to return to prison over the weekend. Mr Stainburn remained short of breath and the bedwatch logs describe him as quiet and rather restless at night but with no dramatic downturn in his health.

41. On 8 April, Mr Stainburn was about to have a bladder scan when, at 11.36am, he had a cardiac arrest. Nurses asked a senior officer to remove the escort chain from Mr Stainburn which he did immediately. Hospital staff attempted to resuscitate Mr Stainburn, but they were not successful. Mr Stainburn was pronounced dead at 11.55am.

Contact with Stainburn's family

42. On 8 April, the prison appointed a prison manager, as the family liaison officer. She visited Mr Stainburn's family on 8 April and broke the news of his death. She stayed in contact with the family to offer advice and support.

43. Mr Stainburn's funeral was held on 3 May. No representatives from the prison attended at the family's request but, in line with national policy, the prison contributed to the funeral costs.

Support for prisoners and staff

44. After Mr Stainburn's death, staff were not formally debriefed but a member of the chaplaincy and care team, arrived to offer the escort officers support. They were also given permission to go home.

45. The prison posted notices informing other prisoners of Mr Stainburn'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 Stainburn's death.

Post-mortem report

46. The coroner provided a copy of the post-mortem report. This gave Mr Stainburn's cause of death as ischaemic heart disease and aortic stenosis, with chronic kidney disease, tobacco-smoking, raised body mass index and diabetes mellitus listed as contributory conditions.

Findings

Clinical Care

47. The clinical reviewer concluded that the care Mr Stainburn received at HMP Moorland was equivalent to that he could have expected to receive in the community. She considered that, on the whole, appropriate monitoring and assessment processes were in place to manage his long-term conditions, although some areas of care did not meet expected standards.

48. On 20 May 2016, Mr Stainburn was added to the 'complex care' caseload. As a result, his progress was monitored regularly and discussed at complex care reviews. However, there is no evidence that any actual care plans were drawn up, which would have helped other staff (who might not have attended the latest review) address any specific care points.

49. The healthcare provider's 72-hour report following Mr Stainburn's death has acknowledged that care plan reviews must form part of the complex case review meetings and states its intention to deliver training sessions to all nursing staff. However, as the report does not set out an anticipated completion date, we think it necessary to formalise our concern and make the following recommendation:

    The Head of Healthcare should ensure all relevant staff receive training in care plan completion and that plans are reviewed at complex care meetings.

50. On 24 March 2017, a prison GP recorded that Mr Stainburn had been diagnosed with chronic kidney disease. Mr Stainburn was educated in the importance of controlling his blood pressure, blood sugar levels and eating a healthy diet. Unfortunately, his kidney function continued to deteriorate and by March 2018 the disease had reached stage four.

51. NICE (National Institute for Care Excellence) guidance for chronic kidney disease in adults says that patients should be referred for a specialist assessment when the disease reaches stage four or five. There is no evidence to suggest that this was done, and we make the following recommendation:

    The Head of Healthcare should ensure clinical staff are aware of the NICE guidance relevant to caring for patients experiencing chronic kidney disease, and referrals for specialist assessments are made where necessary.

52. On 6 December 2017, a diabetes specialist wrote to the prison and asked that Mr Stainburn be prescribed dulaglutide. (This is a drug which helps the body produce its own insulin.) The letter was not addressed to a specific individual and apparently did not arrive until 21 December. Regardless, the request was not processed with any immediacy and Mr Stainburn did not receive the medication until 2 February.

53. The provider's 72-hour review highlighted this issue and the fact that there was no consistent system in place to deal with correspondence of this kind. The review commits to re-examine current processes to ensure all doctors' tasks are dealt with, in a timely manner, and actions completed. Given that at the time of writing, this remains a 'plan' at the time of writing, we make the following recommendation:

The Head of Healthcare should ensure systems are in place to assign correspondence, in a timely fashion, to the appropriate individuals and that they complete any required actions.

54. On 20 and 26 March 2018, entries in the medical record confirm that ECGs were performed, and copies (of what appear to be the readings) are also filed on the record. It is not clear if the readings were reviewed by a doctor or what they mean. In the absence of that evidence, we make the following recommendation:

The Head of Healthcare should ensure all ECGs are reviewed by an appropriately qualified member of staff and the results clearly documented in the medical record.

55. On 3 April 2018, a prison GP saw Mr Stainburn. He was not feeling well and reported that he had stopped taking the increased furosemide dose because he had run out. The clinical reviewer spoke to the Head of Healthcare who said that a revised prescription was sent to the pharmacy within the correct timescale and was available for collection but Mr Stainburn had not picked it up

56. We have not been able to find out the exact reasons for this but conclude it is likely there was some confusion arising from the change in dosage rather than a fundamental problem with the prescribing system. However, Mr Stainburn's mobility was poor and furosemide was clearly an important medication for him as the hospital administered it intravenously when he was admitted. We make the following recommendation:

The Head of Healthcare should put a process in place to ensure that vulnerable patients are alerted when crucial medication awaits collection.

57. At the same appointment, a prison GP decided that Mr Stainburn should be assessed further in hospital. The clinical reviewer notes that a prison GP did not use the NEWS (National Early Warning Score) assessment tool which she feels could have helped the doctor's own assessment process. We make the following recommendation:

The Head of Healthcare should ensure appropriate staff are trained to use the NEWS (National Early Warning Score) assessment tool and it is part of routine clinical practice.

Restraints, security and escorts

58. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

59. Mr Stainburn was admitted to hospital on 3 April in single cuffs which were reduced to an escort chain the next day. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

60. We do not believe that the requirements of the high court judgement were properly fulfilled. There was no meaningful medical input to the risk assessment and there was no consideration of how his medical condition impacted on his (poorly evidenced) risk. As Mr Stainburn used a wheelchair much of the time and needed assistance with most daily living tasks and, in addition, was experiencing chest pain and shortness of breath on his planned admission to hospital, we find it very unlikely that any restraints, let alone single cuffs, were ever justifiable. We make the following recommendation:

The Governor and Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

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