Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Stroud a prisoner at HMP Stafford on 17 February 2019

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 Peter Stroud died in hospital on 17 February 2019 of a stroke while a prisoner at HMP Stafford. He was 71 years old. I offer my condolences to Mr Stroud's family and friends.

I am satisfied that the standard of care Mr Stroud received at Stafford was equivalent to that he could have expected to receive in the community.

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

Sue McAllister
Prisons and Probation Ombudsman **August 2019**

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Summary

Events

1. On 7 December 2016, Mr Peter Stroud was sentenced to five years in prison for sexual offences. He was sent to HMP Stafford on 7 August 2018.

1. Mr Stroud had several long-term health conditions including heart disease, high blood pressure and bladder cancer.

2. On 16 February 2019, Mr Stroud had a stroke and was taken to hospital. He was not restrained. The hospital found that he had a blood clot on the brain and operated on him immediately.

3. The operation was successful, but Mr Stroud developed a chest infection overnight. He quickly deteriorated and died on 17 February.

Findings

4. We are satisfied that Mr Stroud received appropriate care and treatment for his health conditions. The clinical reviewer considered that the standard of care he received at Stafford was equivalent to that he could have expected in the community.

5. We make no recommendations.

The Investigation Process

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

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

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

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

10. One of the Ombudsman's family liaison officers contacted Mr Stroud's wife, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not raise any issues.

11. Mr Stroud's wife received a copy of the initial report. She wrote to us raising concerns about factual inaccuracies in the clinical review. The clinical review has now been amended and reissued.

12. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Stafford

13. HMP Stafford is a medium security prison in Staffordshire for adult sex offenders. It can hold around 750 prisoners across seven wings. Care UK provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service, with on-call doctors outside these hours.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Stafford was in February 2016. Inspectors found that the range of primary care services was appropriate and access to nurses and GPs was good. However, health provision was not consistently meeting the needs of the ageing population. There was a very high need for hospital appointments and, at times, over a quarter of appointments were cancelled or rescheduled because there were not enough escort staff. Prisoners over 65 and those with mobility problems were not routinely handcuffed for external hospital appointments except when a specific risk had been identified. Governance was reasonable overall, with effective working between providers and the prison.

Independent Monitoring Board

15. 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 2018, the IMB reported that the healthcare service was generally working well. Waiting times for appointments had reduced and were comparable to, or better than those in the community. If a waiting list became too long, the healthcare manager paid for additional sessions. The Board noted the additional demands on resources for hospital visits and lengthy admissions, as well as social care, because of the prison's ageing population. Although external carers provided care for some prisoners, the Board felt that in the community some of them would have been admitted to a care home for 24-hour support.

Previous deaths at HMP Stafford

16. Mr Stroud was the 11th person to die at Stafford since February 2017. All the previous deaths were from natural causes. There were no similarities between Mr Stroud's death and the previous deaths at Stafford.

Key Events

17. On 7 December 2016, Mr Peter Stroud was sentenced to five years in prison for sexual offences and sent to HMP Nottingham. He was moved to HMP Stafford on 7 August 2018.

18. Mr Stroud had several long-term health conditions including heart disease and high blood pressure. A prison GP prescribed him the same medication he had been taking in the community.

19. On 3 January 2017, Mr Stroud had a cardiovascular check-up and a care plan was created. He had blood tests at appropriate intervals, and his blood pressure and cholesterol levels were well controlled with medication.

20. On 11 January 2018, a prison paramedic saw Mr Stroud because he was complaining of passing blood in his urine. The following day he was referred to the hospital urology department under the suspected cancer pathway (for an appointment in two weeks).

21. In May 2018, after scans and biopsies, Mr Stroud was diagnosed with bladder cancer. Between 2 July and 30 July, he was seen regularly at the hospital for treatment which included 20 sessions of radiotherapy. Over the next seven months, Mr Stroud's health was well managed.

22. On 16 February 2019 at 7.20am, an officer was completing the early morning wing count when she saw that Mr Stroud was lying on his cell floor and struggling to get up. She immediately called for health care assistance.

23. A nurse attended and noted that Mr Stroud was conscious but unable to speak due to right sided weakness of his facial muscles. He also had weakness in his right arm. The nurse suspected that Mr Stroud had had a stroke. She asked for an ambulance to be called immediately.

24. At 7.43am, the ambulance arrived at the prison and Mr Stroud was seen by paramedics who decided that he needed to go to hospital. He was escorted by two officers and no restraints were used.

25. The ambulance left the prison at 8.17am and Mr Stroud was taken to Royal Stoke University Hospital. On further investigation, it was found that Mr Stroud had a blood clot on the brain which had caused the stroke. Doctors decided that he would need an operation to remove the clot.

26. Later that day, Mr Stroud had emergency surgery. The operation appeared to be successful. However, during that night he developed a chest infection and his health rapidly deteriorated. At 10.50pm on 17 February, Mr Stroud died.

Contact with Mr Stroud's family

27. On 16 February, when Mr Stroud was taken to hospital, the prison appointed an officer as the family liaison officer (FLO). He immediately contacted Mr Stroud's wife to let her know that he had been taken to hospital. On 17 February, the FLO was sent to work in another area of the prison so the FLO role was taken over by another officer.

28. Mrs Stroud made her way to the hospital straightaway, and their son also attended. The prompt allocation of the FLO meant that Mr Stroud's family was able to see him before he died, and allowed his wife to be at his bedside until his death.

29. The second FLO offered ongoing support to Mrs Stroud at the hospital, and after Mr Stroud's death. The prison paid for the funeral in line with national guidelines.

Support for prisoners and staff

30. After Mr Stroud's death, a prison manager debriefed the staff involved in Mr Stroud's care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Cause of death

32. There was no post-mortem examination as the coroner accepted the cause of death provided by the hospital. The hospital recorded that Mr Stroud died from aspiration of gastric contents (where food is inhaled into the lungs), which had been caused by a stroke. Acute kidney injury (kidney failure) was listed as a contributory factor.

Findings

Clinical care

33. Mr Stroud had several health conditions including heart disease, high blood pressure and bladder cancer. Mr Stroud already had heart disease when he was sent to prison. His medication was continued, he had appropriate blood tests and nursing follow up. His blood pressure and his cholesterol levels were kept under control with medication. The prison also made sure that appropriate care plans were in place.

34. We are satisfied that Mr Stroud received appropriate care and treatment at Stafford. The clinical reviewer considered the standard of care was equivalent to that he could have expected to receive in the community.

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