Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Stanton a prisoner at HMP Garth on 14 April 2017

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr John Stanton died of a stroke on 14 April while a prisoner at HMP Garth. He was 52 years old. I offer my condolences to Mr Stanton's family and friends.

The clinical reviewer concluded that Mr Stanton's clinical care at Garth was not of the standard he could have expected to receive in the community. Mr Stanton had hypertension, which was not appropriately managed at Garth and was a contributing factor to his stroke. We are also concerned that the emergency response from healthcare was inadequate and that staff restrained Mr Stanton when he went 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 **October 2017**

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Summary

Events

1. On 13 February 2014, Mr John Stanton was sentenced to 18 years in prison for sexual offences. He moved from HMP Woodhill to HMP Garth on 21 May 2014.

2. At his initial health screen, a nurse noted Mr Stanton had a history of alcohol misuse. A prison GP prescribed medication, including ramipril to treat high blood pressure.

3. There are no significant entries in Mr Stanton's medical record until 14 February 2016, when he reported pain in his left arm, pins and needles, a numb thumb, and palpitations. A prison GP noted he had a history of hypertension and recorded that he had high blood pressure and an abnormal electrocardiogram (ECG) reading. He diagnosed hypertension and anxiety, and recommended regular reviews. He prescribed diazepam to treat anxiety and propranolol to treat high blood pressure. Mr Stanton continued weekly blood pressure monitoring.

4. On 25 May, a prison GP noted that Mr Stanton had poor vision in his left eye and abnormal blood results in line with a 'flu like bug' and stress he had been experiencing. The GP referred him to the optician and told him to book a follow-up appointment. Mr Stanton chose not to attend the appointments.

5. Mr Stanton declined an NHS Health Check on four occasions. The last appointment, which he declined, was booked for 9 November 2016. These checks were to assess whether an individual was at higher risk of having certain health problems such as heart disease, diabetes, kidney disease or a stroke.

6. On 21 March 2017, Mr Stanton told a nurse he had right-sided weakness, stress, anxiety and post-traumatic stress disorder (PTSD). His blood pressure was slightly raised at 176 / 98. A blood pressure reading greater than 140 / 90 is considered high.

7. The next day, a prison GP examined Mr Stanton's vision, co-ordination, arm and leg strength and his central nervous system response. All were within normal limits although the GP noted that Mr Stanton's blood pressure was still slightly raised and he had not had any blood tests since April 2016. He referred him to the mental health team who examined him two days later.

Events of 29 to 30 March

8. On the evening of 29 March, Mr Stanton was locked up as normal and staff had no concerns about him. At 5.58am the next morning, an officer found him on the floor, naked from the waist down and radioed a medical emergency code blue (which indicates that a prisoner is having difficulty breathing).

9. A healthcare assistant responded and took Mr Stanton's observations, which were normal. Mr Stanton appeared unsteady on his feet and fell out of bed. The healthcare assistant suspected that Mr Stanton had taken drugs and asked officers to carry out observations at 15 minute intervals and for a nurse to assess him later that morning.

10. At approximately 8.00am, three officers failed to get a response from Mr Stanton when they called his name. They went to the pharmacy to ask a nurse to assess him. At 8.08am, another officer unlocked Mr Stanton's cell and called to him three times but he did not respond. The officer radioed another code blue and a nurse responded.

11. Having dealt with another incident at the prison earlier, paramedics were on standby outside and arrived on the wing ten minutes after the code blue. They treated Mr Stanton until 9.23am, when they took him to hospital under restraint. Prison staff applied an escort chain and it was not removed until 11.35am the following day when he had surgery. Doctors unsuccessfully performed a craniotomy (an operation to remove part of the bone from Mr Stanton's skull to expose his brain). Mr Stanton was placed in an induced coma and died two weeks later.

Findings

12. We agree with the clinical reviewer that the clinical care Mr Stanton received at Garth was not equivalent to that which he could have expected to receive in the community. Although investigations at Garth into Mr Stanton's hypertension were carried out in line with the National Institute for Clinical Excellence (NICE) guidelines, his condition was not managed using the hypertension register and his medication was not adequately reviewed.

13. The healthcare assistant who responded to the first code blue emergency call did not conduct a National Early Warning Signs (NEWS) assessment of Mr Stanton and assumed he had had an adverse reaction to drugs. Although it might not have changed the outcome for Mr Stanton, the decision should have been escalated to a higher medical authority, whether a nurse or paramedic.

14. As Mr Stanton had been unwell and was on 15 minute checks, we would have expected the officers who checked on him at 8.00am to have monitored him more closely to check on his wellbeing when they did not get a response from him.

15. We are concerned that healthcare staff were not able to assess Mr Stanton's health as part of his escort risk assessment before he was restrained. Given the length of time (approximately 65 minutes) that he was treated by paramedics before he left for the hospital and his condition at the time, it is unacceptable that he was restrained without input from the healthcare team after he had had a stroke, and that the position was not reviewed sooner after he arrived at hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that:
    - Where there is only one member of healthcare staff on duty, they are adequately trained to assess a critically ill patient and determine when it is appropriate to stand down an ambulance; and

- Staff understand the purpose and outcomes of observations, and communicate appropriately with prisoners to ensure their welfare and wellbeing.

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

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Garth informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.

17. The investigator visited HMP Garth on 3 May 2017. She obtained copies of relevant extracts from Mr Stanton's prison and medical records.

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

19. We informed HM Coroner for Preston and West Lancashire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. The investigator contacted Mr Stanton's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

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

Background Information

HMP Garth

22. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Bridgewater Foundation Trust provides 24-hour healthcare cover 7 days a week. GP clinics are held between 9.00am to 12.00pm and 2.00pm to 5.00pm on weekdays. GTD health professionals provide a service outside these times.

23. At the time of Mr Stanton's death in April 2017, Bridgewater Foundation Trust provided healthcare cover overnight in the form of a healthcare assistant. We understand that the cover was reviewed in April 2017 and that at the time of writing (September 2017) the Trust is recruiting for nurses to provide overnight cover.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Garth was in January 2017. Inspectors reported that the range of primary healthcare clinics was appropriate but waiting times were unacceptably long for GP appointments, at around 5 weeks. Prisoners with urgent health needs were seen promptly and access to the community out-of-hours GP service was appropriate and prisoners with acute health needs or injuries could access daily nurse assessment clinics. Inspectors found that illicit substances were widely available at Garth, and that the situation had worsened since their last inspection in 2014. They found that the use of new psychoactive substances (NPS) was particularly problematic.

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 2016 the IMB reported that GP waiting times had reduced from 4/5 weeks to 3 weeks and that there were fewer missed hospital appointments from lack of escorts, due to the attendance at the establishment of a Medical Mobile Unit which is used for CT Scans/X Rays/MRI Scans and Ultra Sound appointments and.

Previous deaths at HMP Garth

26. Mr Stanton was the fourth prisoner to die from natural causes at Garth since January 2016. There has been one death since. There were no similarities between the circumstances of Mr Stanton's death and previous deaths at the prison.

Key Events

27. On 13 February 2014, Mr Stanton was sentenced to 18 years in prison for sexual offences. On 21 May 2014, he moved from HMP Woodhill to HMP Garth.

28. At his initial health screen, a nurse noted Mr Stanton had a history of alcohol misuse. On 23 May, a prison GP prescribed co-codamol to treat pain in his hip, citalopram to treat depression, and ramipril to treat high blood pressure.

29. There are no significant entries in Mr Stanton's medical record until 14 February 2016, when he told a prison GP that he had pain and pins and needles in his left arm, a numb thumb for two days, and had had palpitations over the last few weeks. The GP noted Mr Stanton had a history of hypertension a few years earlier but there had not been a follow-up. He noted Mr Stanton was prescribed ramipril for his high blood pressure and that he was a regular smoker.

30. On examination, Mr Stanton appeared anxious but comfortable. A prison GP noted Mr Stanton's blood pressure was high and his readings ranged from 208/82 to 220/90. A blood pressure reading greater than 140/90 is considered high. He carried out an electrocardiogram (ECG), which checks the heart's rhythm and electrical activity. It produced an abnormal reading. The GP diagnosed hypertension and anxiety. He recommended twice-daily blood pressure readings over the next three days, a 48 hour review and a repeat ECG. He recorded that if Mr Stanton's blood pressure remained high, or if he experienced chest pain or loss of function in his limbs, he should be sent to hospital. He prescribed Mr Stanton diazepam for anxiety, and changed his high blood pressure medication to propranolol.

31. Mr Stanton was seen daily by healthcare staff, but he did not attend his follow up appointment with the prison GP and it was rearranged for the next day. A prison GP was happy with his blood pressure readings but recommended weekly check-ups.

32. On 23 February, Mr Stanton started a smoking cessation clinic but continued to smoke several cigarettes a day.

33. On 25 May, a prison GP reviewed Mr Stanton who had an abnormal blood test result. Mr Stanton told him that at the time of the blood test, he had 'flu like' symptoms and had stress. During the examination, Mr Stanton said he had been experiencing poor vision in his left eye since February. The GP referred him to the optician and told him to see a GP after this review. Mr Stanton chose not to attend all subsequent appointments, including one with an ophthalmologist (an eye doctor), and he signed a disclaimer.

34. Mr Stanton declined an NHS Health Check on four occasions. The last appointment was booked for 9 November 2016. These checks were to assess whether an individual was at higher risk of having certain health problems such as heart disease, diabetes, kidney disease or a stroke.

35. On 21 March 2017, Mr Stanton told a nurse that he had right- sided weakness, similar to his previous episode of left-sided weakness in February 2016. He also said he had stress, anxiety and post-traumatic stress disorder (PTSD). She

advised him to attend work, if he could, to distract him from his stress and anxiety. His blood pressure reading was slightly raised at 176/98. She referred him to a prison GP.

36. A prison GP examined Mr Stanton the next day. He assessed his vision, co-ordination, arm and leg strength and central nervous system response. All were within normal limits although he noted that Mr Stanton's blood pressure was still slightly raised at 165/96.

37. Mr Stanton was referred to the mental health team for his PTSD. On the same day, a mental health manager tried to see Mr Stanton on the wing but he was working. A nurse assessed him two days later. He disclosed that he had been diagnosed with PTSD in 2010 after a serious work accident and as a result, he had night terrors and at times, he struggled to manage his emotions. He acknowledged that working distracted him and he denied any thoughts of suicide or self-harm. She referred him to the prison's psychological wellbeing practitioner.

Events of 29 to 30 March

38. On the evening of 29 March, Mr Stanton was locked up as normal and was reported to be his usual self. Staff had no concerns about him.

39. The cell bell system on Mr Stanton's wing was broken at this time. At 5.58am, an officer support grade found Mr Stanton on the floor, naked from the waist down. He radioed a medical emergency code blue (which indicates that a prisoner is having difficulty breathing).

40. A healthcare assistant responded as the only member of healthcare staff on duty. He took Mr Stanton's observations, which were normal. Mr Stanton appeared unsteady on his feet and fell out of bed. The healthcare assistant suspected he had taken drugs.

41. The healthcare assistant asked officers to carry out observations at 15-minute intervals and recorded a request for a nurse to assess him later that morning.

42. At 7.10am, an officer began checking Mr Stanton every 15 minutes. On each occasion, she noted that she could see him breathing and that he had been moving and changing position as he slept. At her last check, she saw that Mr Stanton was breathing but not responding to his name. At approximately 8.00am she asked two officers to check on him with her, which they did. One officer told the other officer that a nurse should examine Mr Stanton. She then went to the pharmacy and asked the nurses to examine Mr Stanton.

43. At that point, another officer unlocked Mr Stanton's cell and called to him three times with no response. He then shook Mr Stanton's leg and he lifted his arm to his head. At 8.08am, he radioed a medical emergency code blue emergency.

44. A nurse responded. When she arrived, Mr Stanton was unresponsive. She carried out his observations and moved him onto the landing, where she had space to use the emergency equipment. She noticed his left-sided weakness when she moved him. She gave him oxygen and he was in and out of consciousness.

45. After dealing with another incident at the prison earlier, paramedics were on standby outside the prison and at 8.11am, gate staff escorted the paramedics to the wing. They arrived ten minutes after the code blue was called.

46. The paramedics treated Mr Stanton and took him to hospital at 9.23am. When Mr Stanton left Garth, he was unable to walk. An escort chain was applied on the basis of a risk assessment. At hospital, he was so unwell that he was unable to speak, and doctors advised the escort officers that he had suffered a bleed to the brain. The escort chain was not removed until 11.35am the next day when Mr Stanton had a craniotomy (an operation to remove part of the bone from his skull to expose his brain). The operation was unsuccessful, and Mr Stanton was placed in an induced coma. He died two weeks later on 14 April.

Contact with Mr Stanton's family

47. When Mr Stanton was taken to hospital, the prison appointed an officer as the family liaison officer, and she notified his sister. When Mr Stanton died, a prison manager telephoned Mr Stanton's sister to let her know, and arranged for a local family liaison officer from HMP Littlehey to visit her in person. An officer telephoned her the next day to offer her condolences and ongoing support. Mr Stanton's funeral was held on 12 May. The Prison Service contributed to the costs in line with national policy.

Support for prisoners and staff

48. After Mr Stanton's death, a senior manager 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.

49. The prison posted notices informing other prisoners of Mr Stanton'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 Stanton's death.

Post-mortem report

50. The post-mortem examination concluded that Mr Stanton died of a haemorrhagic stroke. Hypertension was identified as a contributing factor.

Findings

Clinical care

51. The clinical reviewer considered that investigations into Mr Stanton's hypertension were carried out in line with the National Institute for Clinical Excellence (NICE) guidelines. Despite this, she found that his hypertension should have been formally managed using the hypertension register and that his anti-hypertensive medication had not been reviewed annually, as it should have been.

Emergency response

52. On the morning of 30 March, when the healthcare assistant responded to the first code blue emergency call, he did not conduct a National Early Warning Signs (NEWS) assessment (a simple scoring system to identify physiological deterioration) of Mr Stanton and wrongly assumed that his presentation was due to substance misuse. Mr Stanton had no history of drug misuse and no previous episodes of illicit drug use while in prison. He had in fact suffered a bleed to the brain.

53. While we recognise the widespread availability of illicit substances at Garth, which HM Inspectorate of Prisons identified in their last inspection in January 2017, we are concerned that the healthcare assistant and officers presumed, without assessing Mr Stanton appropriately, that he had taken illicit substances and required monitoring, instead of urgent medical assistance.

54. We would have expected the healthcare assistant to review Mr Stanton's medical record and seek advice from a more senior member of the healthcare team, or arranged for a paramedic to examine Mr Stanton.

55. The healthcare assistant instructed officers to observe Mr Stanton at 15 minute intervals, with a view to seeking medical assistance if he displayed signs of illness. We would have expected the officers who checked on Mr Stanton at approximately 8.00am to have gone into his cell and tried to get a response from him, as their colleague did a few minutes later when he called a code blue emergency response.

56. While we cannot say whether or not the outcome for Mr Stanton would have been different but for these deficiencies, we agree with the clinical reviewer that the care Mr Stanton received was not equivalent to that which he could have expected to receive in the community.

57. The level of healthcare cover overnight depends on the contractual agreement between the prison and healthcare provider. At the time of Mr Stanton's death Bridgewater Foundation Trust provided a healthcare assistant overnight at Garth. This was reviewed in April 2017 and at the time of writing (September 2017) Bridgewater Foundation Trust is recruiting for nurses.

58. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **Where there is only one member of healthcare staff on duty, they are adequately trained to assess a critically ill patient and determine when it is appropriate to stand down an ambulance; and**
- **Staff understand the purpose and outcomes of observations, and communicate appropriately with prisoners to ensure their welfare and wellbeing.**

Restraints, security and escorts

59. 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.

60. On 30 March, a senior manager noted in Mr Stanton's escort risk assessment that healthcare staff had not been able to assess him due to the urgency of escorting him to hospital. Yet, paramedics had been treating Mr Stanton for a lengthy period (approximately 65 minutes) before they left for the hospital. Mr Stanton had been assessed as a medium risk to the public, and a low risk to staff or of escape or external assistance. He concluded in the absence of medical input that if Mr Stanton could walk unaided, he should be double cuffed or otherwise he should be restrained by an escort chain. The latter was applied.

61. Although Mr Stanton was so unwell at hospital that he could not speak, and doctors advised the escort officers that he had suffered a bleed to the brain, the risk assessment was not reviewed and the escort chain was not removed until 11.35am the next day when Mr Stanton had surgery.

62. Given the length of time that Mr Stanton was treated by paramedics and his condition at that time, it is unacceptable that there was no medical input into the escort risk assessment, that he was restrained after he had a stroke and that the position was not reviewed sooner. We make the following recommendation:

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

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