

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Stephen Barton, a prisoner at HMP Dovegate, on 27 July 2019

**A report by the Prisons and Probation Ombudsman**

## 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*



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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 Stephen Barton died from sepsis caused by cholesteatoma (an ear condition) at HMP Dovegate on 27 July 2019. He was 33 years old. I offer my condolences to Mr Barton's family and friends.

Mr Barton suffered with frequent ear pain and ear infections, for which he was prescribed antibiotics. On 26 July, he told staff that he had been having dizzy spells all day and had fainted three times. He also had a rash and was worried he might have meningitis, which he had contracted before in 2014, following an ear infection. A nurse assessed him and was satisfied he did not have meningitis. The nurse told Mr Barton to let staff know if he felt unwell during the night. Nursing staff did not review him again. The next morning, Mr Barton was found dead in his cell.

The clinical reviewer found that the care Mr Barton received at Dovegate was not equivalent to that he could have expected to receive in the community. She found that Mr Barton was not adequately assessed by nursing staff on 26 July, who failed to recognise that he was acutely ill. She also found that healthcare staff had failed to put a care plan in place for Mr Barton's chronic ear condition, and that there was poor record keeping.

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 CB**  
**Prisons and Probation Ombudsman**

**January 2021**

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# Summary

## Events

1. On 23 October 2007, Mr Stephen Barton was jailed for life for murder.
2. Mr Barton had cholesteatoma (an abnormal growth of skin inside the ear), which caused frequent ear infections. In 2014, he contracted meningitis, following an ear infection, and spent four weeks in hospital.
3. Mr Barton was moved to HMP Dovegate on 8 February 2017. He continued to suffer with ear pain and ear infections. On 16 July 2019, Mr Barton complained of worsening symptoms in his right ear and a prison GP prescribed antibiotics. On 22 July, Mr Barton saw a nurse because he had a rash on his torso and was worried it could be meningitis again. The nurse assessed that he did not have meningitis but advised him to book a GP appointment.
4. At around 4.40pm on 26 July, Mr Barton told staff that he was having dizzy spells and had fainted three times. He also still had the rash on his torso. A nurse assessed him and was satisfied he did not have meningitis. The nurse advised Mr Barton to tell staff if he felt unwell overnight.
5. On 27 July at 8.12am, staff found Mr Barton unresponsive in his bed. Staff called a code blue and healthcare staff attended. Staff did not attempt cardiopulmonary resuscitation (CPR) as there were signs Mr Barton had been dead for some time. Paramedics arrived at 8.40am and confirmed Mr Barton's death shortly afterwards.
6. The post-mortem examination found no evidence of meningitis and identified no obvious cause of death. The pathologist recorded that, given Mr Barton's clinical history, his cause of death was sepsis caused by cholesteatoma.

## Findings

7. The clinical reviewer found that the standard of care Mr Barton received at Dovegate was not equivalent to that he could have expected to receive in the community.
8. Mr Barton was not appropriately assessed by healthcare staff on 26 July. Nurses failed to use the National Early Warning Score (NEWS – a tool used to assess clinical deterioration) and no one recognised that Mr Barton was acutely ill. Nurses did not review Mr Barton between 5.45pm on 26 July and when he was found dead the next morning.
9. Healthcare staff failed to put a care plan in place to manage Mr Barton's ear condition.
10. The nurse who assessed Mr Barton on the evening of 26 July, failed to update his medical record until after he had died. There were other examples of poor record keeping, including a lack of explanation for missed hospital appointments.

## Recommendations

- The Head of Healthcare should investigate the actions of nursing staff between 26 and 27 July 2019, in relation to Mr Barton's assessment and care with a view to considering whether disciplinary or other action is appropriate.
- The Head of Healthcare should ensure that all staff can use the National Early Warning Score (NEWS) tool.
- The Head of Healthcare should ensure that a care and treatment plan is set up for all prisoners with a chronic health condition, in accordance with National Institute of Clinical Excellence (NICE) guidelines.
- The Head of Healthcare should ensure that staff:
  - make accurate, timely and contemporaneous notes in prisoners' medical records; and
  - record the reasons for missed hospital appointments, including the rationale for treating appointments as non-priority.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Dovegate informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Barton's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Barton's clinical care at the prison.
14. We informed HM Coroner for Staffordshire South of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Barton's mother, sister and partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The family did not raise any concerns.
16. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies. They provided an action plan which is annexed to this report.
17. We sent copies of our initial report to Mr Barton's mother, sister and partner. They found no factual inaccuracies.

## Background Information

### HMP Dovegate

18. HMP Dovegate is a category B prison in Staffordshire, managed by Serco. The main prison holds around 930 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 220 men. Mr Barton lived in the therapeutic community. Care UK provides 24-hour healthcare services. South Staffordshire and Shropshire Foundation Trust provides mental health services.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Dovegate was in October 2019. Inspectors reported some notable improvements since their last inspection in 2017. They reported that healthcare provision was reasonably good overall. Non-attendance rates for healthcare appointments were low and waiting times were acceptable. Inspectors noted that many patients experienced delays getting medication and the in-house pharmacy service required further development.

### 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 September 2019, the IMB reported that healthcare services were good. There had been a reduction in the waiting time for dental and GP appointments and only 5% of internal appointments were missed. They also reported an increase in the availability of external escorts, resulting in very few cancellations of external hospital appointments.

### Previous deaths at HMP Dovegate

21. Mr Barton was the 10<sup>th</sup> prisoner to die at Dovegate since July 2017. Of the previous deaths, three were self-inflicted, three were drug-related and three were from natural causes. There are no similarities between our investigation findings in Mr Barton's case and the findings from our previous investigations at Dovegate.

## Key Events

22. On 23 October 2007, Mr Stephen Barton was jailed for life for murder.
23. Mr Barton had cholesteatoma in his left ear, which resulted in frequent ear infections. (Cholesteatoma is an abnormal collection of skin cells deep inside the ear. They are rare but if left untreated, they can damage the delicate structures inside the ear that are essential for hearing and balance.) In August 2014, Mr Barton had an ear infection that developed into meningitis and he spent four weeks in hospital. In October 2014, he had surgery on his left ear.
24. On 8 February 2017, Mr Barton was moved to HMP Dovegate.

### 2018

25. From February 2018, Mr Barton began experiencing symptoms of cholesteatoma in his right ear. He saw an ear, nose and throat (ENT) specialist who referred him for a CT scan to establish the extent of damage caused by the cholesteatoma.
26. Mr Barton subsequently missed four CT scan appointments on 27 February, 12 March, 12 April and 18 May. Records obtained by the clinical reviewer show that the hospital cancelled two of the appointments, the prison cancelled one because they did not have enough notice to arrange escorts, and Mr Barton refused to attend the last one on 18 May.
27. Mr Barton was seen by a prison GP on 6 November due to his ongoing ear condition. He told the prison GP that he had missed his scan appointment on 18 May as he was in too much pain at the time and 'couldn't be arsed', but he wanted it to be rearranged. The prison GP prescribed a course of antibiotics and said he would rearrange the scan appointment.

### 2019

28. Mr Barton had his CT scan on 4 January 2019.
29. On 16 January, a nurse saw Mr Barton as he was complaining of right ear pain. He was concerned that this was similar to the pain he had had in his left ear when he contracted meningitis. The nurse referred Mr Barton to the prison GP who noted that Mr Barton had an inflamed right ear canal and reported an odorous discharge from his ear for around one week. The prison GP noted that he wanted to take a swab from Mr Barton's ear but could not find a swab stick in the department. The prison GP prescribed a further course of antibiotics.
30. On 1 February, the nurse saw Mr Barton again. He was complaining of a headache due to pain in his right ear. The nurse prescribed ibuprofen for pain relief.
31. On 28 March, a nurse assessed Mr Barton as he was complaining of right ear pain. The nurse noted mild inflammation and weeping of Mr Barton's right ear and she prescribed a further course of antibiotics.

32. On 25 April, a prison GP saw Mr Barton. The prison GP assessed that Mr Barton's ear was not inflamed but he noted the presence of a creamy coloured discharge which Mr Barton said had been there for several weeks. The prison GP did not prescribe further antibiotics, but he asked the administrative team to chase up an urgent appointment with the ENT consultant. The appointment was subsequently arranged for 27 June.
33. However, Mr Barton did not attend the ENT appointment on 27 June. The Head of Healthcare told the clinical reviewer that there were ten outpatient appointments scheduled for that day but the prison was only able to provide four escorts. Healthcare staff therefore had to prioritise four prisoners to attend their appointments and the remaining six prisoners were unable to attend. Mr Barton was one of the six prisoners who was not prioritised to attend, but the reason for this decision was not recorded in his medical notes.
34. On 16 July, a prison GP saw Mr Barton after he complained of worsening symptoms in his right ear. The prison GP noted symptoms of ongoing pain and discharge from his ear, which was now accompanied by bleeding. He noted that Mr Barton had missed his ENT appointment on 27 June and asked the administrative team to chase up a further appointment. The prison GP prescribed Mr Barton a further course of antibiotics.
35. On 22 July, a nurse assessed Mr Barton as he had a rash on his torso. He was concerned it could be meningitis but the nurse assured him there were no signs of the illness. She advised him to book an appointment with the doctor but, in the meantime, to report any worsening symptoms to staff.

### **Events of 26-27 July 2019**

36. Around 4.40pm on 26 July, Mr Barton told wing staff that he had been having dizzy spells all day and had 'gone over' three times. They contacted healthcare staff and Nurse A attended shortly afterwards to assess Mr Barton. Nurse A took Mr Barton's observations and noted that his blood pressure was dropping and he had a rash on his torso. She said she would get another nurse to look at the rash later that evening.
37. Although no record was made at the time, Nurse B said that he saw Mr Barton in his cell at around 5.45pm on 26 July. He said he assessed the rash on Mr Barton's torso and was satisfied it was not a rash consistent with meningitis. He did not take any further observations, but he advised Mr Barton to try to keep cool and stay hydrated. Nurse B said that he told Mr Barton to let staff know if he felt unwell during the night. He said he would brief the night staff and arrange for Mr Barton to be seen the following day.
38. Nurse C told the clinical reviewer that Nurse B asked her to complete the written handover record as he had other duties and did not have time to do it. Nurse C wrote that Nurse B had seen Mr Barton. She wrote that Mr Barton should see healthcare the following day as he had reported dizzy spells and a rash with a previous history of meningitis. We found no evidence that Nurse B briefed night staff verbally and no one else checked on Mr Barton during the night.

39. On 27 July at around 8.12am, staff found Mr Barton unresponsive in his bed. Staff called a code blue (a medical emergency code used when a prisoner is unresponsive or is having difficulty breathing, which alerts healthcare staff and tells the control room to call an ambulance immediately) and healthcare staff attended. Mr Barton showed no visible signs of life and rigor mortis was present in parts of his body. Staff did not therefore attempt cardiopulmonary resuscitation (CPR). Paramedics arrived at 8.40am and confirmed Mr Barton's death at 8.47am.

### **Events after Mr Barton's death**

40. At around 1.20pm on 27 July, Nurse B made a retrospective note in Mr Barton's medical records. Nurse B summarised the assessment he made of Mr Barton on the evening of 26 July. He wrote that he had been unable to complete the record himself at the time as he could not access the computerised system. Nurse B noted that he had asked Nurse C to complete the handover record and that he had verbally briefed night staff.

### **Contact with Mr Barton's family**

41. At 3.00pm on 27 July, the prison's family liaison officers visited Mr Barton's mother at home to tell her that her son had died. The prison contributed to the cost of Mr Barton's funeral in line with national guidance.

### **Support for prisoners and staff**

42. After Mr Barton's death, a prison manager debriefed staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and offering support. The staff care team also offered support.
43. The prison posted notices informing other prisoners of Mr Barton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of self-harm or suicide in case they had been adversely affected by Mr Barton's death.

### **Post-mortem report**

44. The pathologist who conducted the post-mortem examination noted that there was no evidence of meningitis. The pathologist identified no obvious cause of death and so, given Mr Barton's history of cholesteatoma, concluded that Mr Barton died from sepsis due to chronic cholesteatoma disease.
45. After the post-mortem report was issued, a prison GP wrote to the Coroner to say that there was a heatwave at the time of Mr Barton's death and that the temperature inside the prison was extremely high. He suggested that Mr Barton may have died from heat stroke. The GP's letter was passed to the pathologist who considered whether heat exhaustion could have played a part in Mr Barton's death. The pathologist concluded that it did not. However, after further tissue analysis, he amended the cause of death to sepsis caused by bilateral cholesteatoma, as there was evidence of cholesteatoma in both the right and left ear.

# Findings

## Clinical care

46. The clinical reviewer concluded that aspects of Mr Barton's clinical care were not equivalent to that which he could have expected to receive in the community.

### Events of 26/27 July

47. The clinical reviewer found that nursing staff failed to properly assess Mr Barton when he became unwell on 26 July 2019. No one used the National Early Warning Score (NEWS – a tool used to assess clinical deterioration) and no one recognised that Mr Barton was acutely ill. Mr Barton was not reviewed between 5.45pm on 26 July, when Nurse B saw him, and when he was found dead the next morning. There is no record of a handover or further assessment by nursing staff during the night of 26/27 July. We recommend:

**The Head of Healthcare should investigate the actions of nursing staff between 26 and 27 July 2019, in relation to Mr Barton's assessment and care with a view to considering whether disciplinary or other action is appropriate.**

**The Head of Healthcare should ensure that all staff can use the National Early Warning Score (NEWS) tool.**

### Lack of care plan

48. The clinical reviewer found that healthcare staff had not put in place a care plan to manage Mr Barton's chronic ear condition. We recommend:

**The Head of Healthcare should ensure that a care and treatment plan is set up for all prisoners with a chronic health condition, in accordance with National Institute of Clinical Excellence (NICE) guidelines.**

### Record keeping

49. Nurse B failed to update Mr Barton's medical record with details of his assessment on 26 July, until after Mr Barton had died.
50. We also found that the reasons for Mr Barton's missed hospital appointments were not recorded. The clinical reviewer considered that given Mr Barton's worsening symptoms, the decision not to prioritise him for a hospital appointment with the ENT consultant on 27 June should have been fully documented in his medical record, but it was not. We recommend:

**The Head of Healthcare should ensure that staff:**

- **make accurate, timely and contemporaneous notes in prisoners' medical records; and**
- **record the reasons for missed hospital appointments, including the rationale for treating appointments as non-priority.**

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