Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Stanton a prisoner at HMP Holme House on 17 May 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 Paul Stanton died on 17 May 2018 of bronchopneumonia due to the combined effects of heroin, methadone and prescription drugs that had not been prescribed to him. He was 38 years old. I offer my condolences to Mr Stanton's family and friends.

The investigation found that, overall, Mr Stanton received appropriate support for his substance misuse issues. However, a nurse failed to speak to Mr Stanton when he did not collect his methadone on the morning of his death. If the nurse had checked on Mr Stanton, she might have identified that he was under the influence of drugs and he could have received medical attention sooner than he did.

Mr Stanton was found unresponsive in his cell at around 5.30pm on 17 May and an officer called a medical emergency code. There was then a delay in control room staff calling an ambulance. The delay in calling an ambulance made no difference in Mr Stanton's case but is an issue we have raised with Holme House before.

Mr Stanton was able to obtain heroin and prescription drugs that had not been prescribed to him while he was at Holme House. I am concerned that drugs are readily available and that the prison needs to do more to tackle the supply of and demand for drugs.

I also need to record that the PPO investigator encountered unacceptable delays in obtaining documentation from Holme House and in arranging interviews with relevant staff. We have had similar problems in other investigations at Holme House and the prison needs to improve its PPO liaison arrangements.

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 **August 2019**

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Summary

Events

1. On 19 April 2018, Mr Paul Stanton was sentenced to three years and nine months' imprisonment for burglary. On 26 April, he was moved to HMP Holme House.

2. Mr Stanton had a history of drug and alcohol abuse and was prescribed methadone in prison as a heroin substitute.

3. On the morning of 17 May, Mr Stanton failed to collect his methadone. At midday, a nurse asked an officer to send Mr Stanton to collect his methadone but when the officer got to Mr Stanton's cell, he found him asleep. His cellmate told him Mr Stanton had been awake in the night with toothache and had only got to sleep that morning.

4. At around 5.30pm, an officer unlocked Mr Stanton's cell, so he and his cellmate could collect their dinner. Mr Stanton's cellmate left the cell and returned with a dinner for himself and one for Mr Stanton. He told officers that Mr Stanton was ill. The officers then went to the cell and realised Mr Stanton was unresponsive on his bed.

5. Staff called a medical emergency code and a few minutes later, control room staff called an ambulance. Prison healthcare staff conducted cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived. When the paramedics arrived, they found that Mr Stanton had signs of rigor mortis and declared his death at around 6.10pm.

Findings

6. The clinical reviewer found that, overall, the care Mr Stanton received at Holme House was equivalent to that he could have expected to receive in the community. She considered, however, that the nurse should have checked on Mr Stanton herself when he failed to collect his methadone in the morning. Had she done, she might have identified that Mr Stanton was intoxicated, and he could have received medical help a lot sooner.

7. Control room staff failed to call an ambulance immediately in response to the medical emergency code. Although this made no difference in this case because Mr Stanton was already dead, it is important that control room staff follow medical emergency procedures.

8. As Mr Stanton had signs of rigor mortis, healthcare staff should not have started CPR.

9. We are concerned about the easy availability of drugs at Holme House. More needs to be done to reduce supply and demand.

10. The investigator encountered delays in obtaining documentation from Holme House and in arranging interviews with relevant staff. Holme House needs to improve its PPO liaison arrangements.

Recommendations

- The Head of Healthcare should ensure staff are reminded to speak to prisoners who do not collect their methadone and report details of any such instances at the daily handover meeting.
- The Governor should ensure control room staff are aware of their responsibilities and immediately call an ambulance when an emergency code is called.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that the key drug issues at Holme House are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.
- The Governor should ensure that staff appointed as a PPO liaison officer following a death in custody are aware of, and carry out, their duties in line with the requirements of PSI 58/2010.

The Investigation Process

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

12. The investigator interviewed nine members of staff and one prisoner at HMP Holme House on 9 and 10 January 2019.

13. NHS England commissioned a clinical reviewer to review Mr Stanton's clinical care at the prison. The clinical reviewer jointly interviewed with the investigator and conducted one telephone interview on her own.

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

15. The investigator contacted Mr Stanton's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any issues with the PPO directly but contacted the Coroner.

16. We shared our initial report with HM Prison and Probation Service (HMPPS) and Mr Stanton's family. HMPPS told us that officers at Holme House are not required to carry out a welfare check when unlocking prisoners for dinner. We have therefore removed our recommendation on this issue. HMPPS have provided an action plan which is annexed to this report.

Background Information

HMP Holme House

17. HMP Holme House is a medium security prison which holds around 1,200 convicted men. Health services at the prison are delivered by several different providers. The prison has an inpatient unit and nurses are on duty 24 hours a day.

18. HMP Holme House is part of the DRP (Drug Recovery Prison) pilot. It brings together, for the first time, health and justice funding and partnership working at a national, regional and local level to restrict the supply of drugs, reduce the demand and promote recovery from prison to release in the community.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Holme House was in July 2017. Inspectors were concerned that drugs were readily available. Nearly 11% of mandatory drugs tests were positive, and this figure rose to 36% when psychoactive substances (PS) were included. Nearly 60% of prisoners said it was easy to get drugs in the prison, with a quarter claiming they had developed a drug problem at the prison. Despite these statistics the prison did not have an integrated or effective supply reduction strategy in place.

20. Inspectors reported that the healthcare interactions that they observed between staff and prisoners were very good, but they noted that chronic staff shortages in the primary care nursing team had affected service delivery. In their survey, only 22% of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times and inspectors found that prisoners were waiting up to five weeks for routine doctor and nurse practitioner appointments. However, they found that patients with urgent needs were seen quickly.

Independent Monitoring Board

21. 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 31 December 2017, the IMB reported that plans were in place to restructure the delivery of primary care but that the plans had been compromised by significant staff shortages, including difficulties in the recruitment and retention of healthcare staff.

Previous deaths at HMP Holme House

22. Mr Stanton was the 15th prisoner to die at Holme House since May 2015. Eleven deaths were from natural causes and three prisoners took their own lives. There have been four deaths since, three from natural causes and one is awaiting classification. We have made a recommendation about delays calling an ambulance before.

Key Events

23. On 19 April 2018, Mr Paul Stanton was sentenced to three years and nine months' imprisonment for burglary. He had previously been on remand at HMP Durham and remained there until 26 April when he transferred to HMP Holme House.

24. On 26 April, a nurse conducted Mr Stanton's reception health screen. He recorded that Mr Stanton looked well and had been on methadone therapy (heroin substitution) at HMP Durham. A healthcare assistant created a methadone care plan the same day. On 27 April, a nurse recorded that Mr Stanton was awaiting a mental health assessment.

25. On 3 May, a mental health nurse assessed Mr Stanton. He told her he was stressed about the move to Holme House and that a specific prisoner wanted to harm him. He would not name the other prisoner but wanted to move to a different prison. He made references to defending himself and hurting the other prisoner if they crossed paths. He said he had been treated for mental health issues in the community but would not provide details and said he had not attended appointments. He said that no one had assessed him at Durham and said he had tried to kill himself. (There are no records to substantiate this.)

26. The nurse concluded that there was no evidence Mr Stanton displayed psychotic symptoms or had an affective disorder. She considered he was able to weigh up information and make informed decisions and that no further input from the mental health team was necessary.

27. On 12 May, a nurse noted Mr Stanton wanted to stay on methadone therapy – 25 millilitres a day for four weeks. On 14 May, a pharmacy technician and a nurse noted the same. Mr Stanton collected and took his methadone every morning.

28. Mr Stanton's cellmate told the investigator that on the afternoon of 16 May, Mr Stanton took alprazolam (also known as Xanax, an anti-anxiety medication that is similar to diazepam (Valium) but far stronger, which can be lethal when taken in a large quantity or mixed with other drugs). He said that Mr Stanton had obtained this from a newly arrived prisoner, but he did not know who. He said that at approximately 8.30am on 17 May, Mr Stanton had grunted at him.

29. Mr Stanton did not attend the medicine hatch to collect his methadone that morning.

30. Mr Stanton's cellmate told the investigator that he was feeling drowsy himself that morning and that Mr Stanton was very drowsy. He said he asked Mr Stanton if he wanted him to get a nurse, but Mr Stanton declined.

31. Mr Stanton's cellmate said that at approximately 11.30am, he asked Mr Stanton if he wanted his lunch. Mr Stanton did not respond, and Mr his cellmate noticed a small amount of something brown around his mouth. He said Mr Stanton was lying at a 'dodgy angle'. The investigator asked him if Mr Stanton was breathing, but he did not give a clear answer and just said that Mr Stanton had sleep apnoea and sometimes went for long periods making no sound. He decided not to get lunch and went back to sleep.

32. At approximately midday, while he was unlocking prisoners' cells for lunch, an officer was asked by a nurse to send Mr Stanton to collect his methadone. He unlocked Mr Stanton's cell but found him asleep. Mr Stanton's cellmate told him that Mr Stanton had been up all night with toothache and had only managed to get to sleep earlier that morning. The officer told the investigator that Mr Stanton was snoring very loudly.

33. At approximately 5.30pm, two officers were unlocking prisoners' cells, so they could collect their evening meal. One officer unlocked Mr Stanton's cell. He then went back along the landing to chase up the prisoners and when he returned to Mr Stanton's cell, his cellmate was putting his socks on and Mr Stanton appeared to be asleep.

34. Shortly afterwards, the two officers saw Mr Stanton's cellmate returning to his cell with a servery worker who was carrying Mr Stanton's meal. They thought this was strange as prisoners are expected to collect their own meals. When they asked the cellmate what was going on, he said Mr Stanton was not very well.

35. One officer put his head into the cell and shouted at Mr Stanton to try to get a response but got no reply. The other officer entered the cell. Mr Stanton's cellmate, shook Mr Stanton, got no reply and then rolled him onto his back. One officer realised Mr Stanton was not breathing and asked the other to call a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties). The other officer called a code blue at approximately 5.42pm. The control room log says that an ambulance was called at 5.44pm, but North-East Ambulance Service records show that the call was made at 5.48pm.

36. A nurse responded immediately to the code blue and arrived in approximately two minutes. He said Mr Stanton's right arm was mottled, his lips were blue, he looked ashen and his arm was 'coolish'. The duty governor arrived at the cell with a Custodial Manager (CM). The nurse could find no evidence of a pulse and he and the duty governor put Mr Stanton on the floor and started cardiopulmonary resuscitation (CPR).

37. At approximately 5.45pm, another nurse arrived at the cell and attempted to insert different models of airways. Mr Stanton's jaw was clamped tightly shut so she administered air via an airbag. She asked an officer to get a defibrillator which he collected from the Senior Officer's office. He estimated it took him less than a minute to get there and back. The defibrillator advised 'no shock' and staff carried on with CPR.

38. A healthcare assistant arrived at the cell and one of the nurses asked her to go and get oxygen from the treatment room in the centre of the house block. She returned to the cell within a couple of minutes with another nurse. The three nurses carried out life support.

39. Paramedics arrived at 5.54pm. They found that Mr Stanton had signs of rigor mortis (they could not insert an airway as Mr Stanton's jaw was clamped shut). They declared Mr Stanton's death at approximately 6.10pm.

Contact with Mr Stanton's family

40. The prison appointed a prison manager as the prison's family liaison officer at 6.20pm on 17 May and she reported into the prison at 7.10pm. She spoke to Mr Stanton's cellmate to see if he had any helpful information she could give to the family. As she was about to leave the prison to tell the family, they arrived at the prison. It seems that they had been told about Mr Stanton's death by other prisoners. She offered the family support and information, which continued up to Mr Stanton's funeral.

41. Mr Stanton's funeral was on 1 June 2018. The prison's family liaison officer, an officer and CM attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

42. After Mr Stanton's death, the Duty Governor 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.

43. 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

44. The post-mortem report states that Mr Stanton died from bronchopneumonia due to the combined effects of heroin, methadone, alprazolam, diazepam, mirtazapine and pregabalin.

Findings

Clinical care

Substance misuse management

45. Mr Stanton had a long history of drug and alcohol misuse. These problems were identified on his arrival to both HMP Durham and HMP Holme House. At Durham he was appropriately assessed and his withdrawal from substances monitored. When he arrived at Holme House his methadone therapy was continued and a care plan created.

46. On 17 May 2018, Mr Stanton did not collect his methadone. A nurse was on dispensing duties that day. The clinical reviewer and the investigator asked staff how unusual a 'no show' for methadone was. A pharmacy technician and a nurse, senior nurse with the Drug and Alcohol Recovery Team said that it would be highly unusual for a prisoner not to collect his methadone. Mr Stanton's dose was 25 millilitres a day which, while not one of the highest, was still a moderately high dose.

47. The clinical reviewer asked the pharmacy technician and a nurse what action they would take if a prisoner did not attend to collect their methadone. Both said that they would ask an officer to go and find the prisoner and report back why they had missed their methadone dose. They also said if the officer did not give a satisfactory answer or return with the prisoner, they would physically check on the prisoner themselves. They said that the level of the prescribed dose, no matter how low, would not impact on this decision.

48. The clinical reviewer asked the Head of Healthcare and the Deputy Head of Healthcare for their views. They agreed with the nurse and the pharmacy technician and said while this approach was not enshrined in policy, it was an expectation.

49. The nurse was off sick when the interviews took place, but the clinical reviewer spoke to her later by telephone. She said that she could not recall the events of 17 May. She said that normally at the end of methadone administration she would report any prisoners who had not collected their methadone to prison officers and ask them to find out why. She said she would not always go and speak to the prisoners herself if she was given a reasonable explanation, they were not known to be low in mood and/or they were not on a high dose of methadone (she cited 65 millilitres or above as a high dose). She said she would always take a list of any prisoners who had not received their methadone to the healthcare handover meeting (at the time this was held at lunchtime).

50. An officer said that when he went to tell Mr Stanton to collect his methadone, Mr Stanton's cellmate told him that Mr Stanton was asleep because he had been awake in the night with toothache. We consider this was not a satisfactory explanation for a prisoner failing to collect their methadone and warranted further investigation by the officer and the nurse. We make the following recommendation:

The Head of Healthcare should ensure staff are reminded to speak to prisoners who do not collect their methadone and report details of any such instances at the daily handover meeting.

Mental health

51. When Mr Stanton transferred to Holme House on 26 April 2018, he had an outstanding mental health assessment. On 3 May 2018, a nurse completed the assessment at Holme House and, having not found any evidence of affective disorder or psychosis and as he was able to make balanced judgements, she discharged him from the service.

52. The clinical reviewer concluded that the care Mr Stanton received in respect of his mental health at Holme House was equivalent to that he could have expected to receive in the community.

Emergency response

53. Prison Service Instruction (PSI) 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency code is called. There should be no requirement for control room staff to check with managers, healthcare staff or others at the scene before calling an ambulance. The PSI says that it is better to act with caution and request an ambulance that can be cancelled later if it is not needed.

54. The prison's local policy is in line with these guidelines and an officer called a code blue immediately when it became apparent that Mr Stanton was unresponsive. The control room log records that the code blue was called at 5.42pm and an ambulance requested at 5.44pm, although this has been overwritten to read 5.47pm. North-East Ambulance Service records show that the call was made at 5.48pm (almost 5.49pm) and a second call, to give more information was made at 5.52pm. The time, therefore, between the code blue and an ambulance being called was approximately six minutes. We make the following recommendation:

The Governor should ensure control room staff are aware of their responsibilities and immediately call an ambulance when a medical emergency code is called.

55. The clinical reviewer considered that Mr Stanton presented with signs of rigor mortis when he was found. Despite this, healthcare staff started CPR. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, say that, "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The examples given of when resuscitation will be futile include the presence of rigor mortis. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

Drug strategy

56. Mr Stanton died as a result of taking heroin, methadone, alprazolam, diazepam (anti-anxiety medication), mirtazapine (antidepressant) and pregabalin (used to treat epilepsy and nerve pain). Alprazolam, diazepam, mirtazapine and pregabalin are all prescription drugs, but are widely abused and traded in prison. None were prescribed to Mr Stanton.

57. HMP Holme House has a drug strategy for 2017-2020. It gives detailed objectives for reducing supply including: improving search facilities for incoming drugs, securing the infrastructure of 'the gate', evaluating new scanning technologies, searching staff, employing drugs dogs, sharing and collecting intelligence and better multidisciplinary working.

58. It is clear, however, that Mr Stanton was still able to obtain heroin and prescription drugs that were not prescribed to him at Holme House. Holme House is not alone in facing this problem – drug use is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

59. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We, therefore, recommend:

The Governor should ensure that the key drug issues at Holme House are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

Liaison with the PPO

60. The prison's liaison with the PPO was poor from the start. The most basic paperwork (such as the control room log) took months to arrive despite numerous requests.

61. Liaison duties were eventually transferred to a prison manager and matters improved. However, staff failed to turn up for interviews as expected because they had changed shifts, gone to work at other prisons or been sent on escort duties. This also happened in a subsequent investigation at Holme House.

62. PSI 58/2010, *Prisons and Probation Ombudsman*, makes it clear that access to all documentation will be facilitated by the designated liaison officer. We also expect that the same liaison officer will take responsibility for arranging all interviews requested by the Ombudsman's investigator, including interviews with prison and healthcare staff and contractors' staff. Interviews should be arranged at times that suit the shift arrangements of different staff in consultation with their managers. We make the following recommendation:

The Governor should ensure that staff appointed as a PPO liaison officer following a death in custody are aware of, and carry out, their duties in line with the requirements of PSI 58/2010.

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