Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Kearns, a prisoner at HMP Stocken, on 3 October 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Stephen Kearns died on 3 October 2020 at HMP Stocken after being found unresponsive in his cell. The cause of his death is unknown. He was 37 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the care Mr Kearns received was equivalent to that which he could have expected to receive in the community.

Mr Kearns reported no significant health problems and we are satisfied that staff could not have foreseen or prevented his death.

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 **February 2022**

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Summary

Events

1. On 7 June 2020, Mr Stephen Kearns was recalled to prison custody and sent to HMP Altcourse. On 28 July, he transferred to HMP Stocken.

2. On the morning of 3 October, Mr Kearns was checked at 5.19am during the early morning roll check and again by day staff at 7.13am. Mr Kearns appeared to be asleep in bed and the officers who checked him did not notice anything untoward.

3. When officers went into Mr Kearns' cell at 9.04am, he was found unresponsive, with no pulse. An officer radioed an emergency code and another officer started cardiopulmonary resuscitation (CPR). Nurses responded and assisted with efforts to resuscitate Mr Kearns.

4. Ambulance paramedics arrived at 9.37am and they took charge of Mr Kearns' care. At 9.57am, the paramedics confirmed that Mr Kearns was dead.

5. A post-mortem was unable to determine the cause of Mr Kearns' death.

Findings

6. The clinical reviewer found that the care Mr Kearns received at Stocken was equivalent to that which he could have expected to receive in the community.

7. Mr Kearns' death is unexplained. We have found no evidence to suggest that staff could have foreseen or prevented his death and we make no recommendations.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Kearns' prison and medical records. She interviewed four members of staff at Stocken in January 2021. All of the interviews were conducted by telephone due to revised working practices during the COVID-19 crisis.

10. NHS England commissioned a clinical reviewer to review Mr Kearns' clinical care at the prison.

11. We informed HM Coroner for Rutland and North Leicestershire of the investigation. He gave us a copy of the post-mortem. We have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted Mr Kearns' next of kin, his mother, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Kearns' mother asked a number of questions. We have addressed the questions that are relevant to Mr Kearns' death in this report.

13. We shared the initial report with Mr Kearns' mother and with HM Prison and Probation Service (HMPPS). HMPPS identified the misspelling of the names of three officers and we had used the wrong job title for another officer. HMPPS also identified several other inaccuracies. We have corrected the errors, none of which affected our findings.

Background Information

HMP Stocken

14. HMP Stocken is medium security prison which holds up to 1059 men. Practice Plus Group provide primary and mental health services. Substance misuse services are provided through Midlands Partnership NHS Foundation Trust. The healthcare service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide ten GP sessions per week.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Stocken was in January and February 2019. Inspectors found that living conditions in Stocken were good and that most prisoners said that staff treated them respectfully. Stocken is a rural prison situated around midway between Nottingham and Peterborough. In response to a prisoner survey question, 88% of prisoners said that it was very difficult for family and friends to get to the prison.

Independent Monitoring Board

16. 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 April 2020, the IMB noted that, in general, prisoners at Stocken were treated fairly and humanely. However, the IMB noted that there was a need to increase prison capacity in London and the South East as too many prisoners at Stocken were a very long way from their homes and families.

Previous deaths at HMP Stocken

17. Mr Kearns was the fourth prisoner to die at Stocken since October 2018. Of the previous deaths, one was from natural causes, one was drug-related and one was self-inflicted. There are no similarities between this investigation and the previous deaths at Stocken.

Key Events

18. On 13 June 2013, Mr Stephen Kearns was convicted of conspiracy to supply class A controlled drugs and was sentenced to 15 years imprisonment. He was released on licence on 5 June 2020.

19. On 7 June, Mr Kearns was arrested for allegedly breaching his licence conditions and was sent to HMP Altcourse.

20. On 28 July, Mr Kearns transferred to HMP Stocken.

21. At his reception health assessment at Stocken, Mr Kearns said that he had no health concerns, that he did not have any current problems with alcohol or drug use and that he had no thoughts of deliberate self-harm. The nurse noted her own observation that Mr Kearns appeared fit and well.

22. On 7 August, an officer saw Mr Kearns for a welfare check as he had raised concerns with the Independent Monitoring Board. Mr Kearns said that he was unhappy that he was not receiving Kosher meals and that he had not been able to contact his legal team about his release. The officer said that he would speak to the Lead Chaplain about Mr Kearns' food and that staff would try to facilitate a telephone call for him to his lawyers. He recorded that this seemed to settle Mr Kearns.

23. On 10 August, the prison's Jewish Rabbi concluded that Mr Kearns did not qualify for Kosher meals as his records showed that he had ordered pork for one of his meals. Mr Kearns was told that the Rabbi would review the situation in a few weeks to give Mr Kearns the opportunity to demonstrate religious sincerity.

24. On 14 August, a Prison Offender Manager (POM) introduced herself to Mr Kearns as his offender supervisor. Mr Kearns asked for a transfer to a prison closer to his home in Kirby, but the POM explained that that would be difficult as prisons were not processing transfer requests at that time due to the COVID-19 pandemic.

25. On 24 August, Mr Kearns was referred to the Primary Care Mental Health Team, following mental health concerns identified by Offender Management. On the same day, he had a video call with his family and was seen by an officer for a welfare check. The officer was satisfied that Mr Kearns was coping with the restricted COVID-19 regime and told him that in future he would be checked weekly by a member of wing staff.

26. On 26 August, Mr Kearns was seen by a nurse for an asthma assessment. She identified poor inhaler technique and prescribed new inhalers. The nurse also prescribed laxatives as Mr Kearns was suffering from constipation. She noted that he said he found it difficult to urinate or open his bowels in a shared cell and she planned to raise his request for a single cell at the multi-disciplinary team meeting the following day.

27. An appointment with the mental health team was scheduled for 29 August but Mr Kearns did not attend. No reason is noted.

28. On 22 September, Mr Kearns had a three-way telephone conversation with the POM and his offender manager (probation officer). The POM told the investigator that by that time, the further charges that had led to Mr Kearns' recall to custody had been dropped. She and the offender manager told Mr Kearns that they both supported his re-release, although the decision would have to be made by the Parole Board. The POM said that she and the offender manager were hopeful that the Parole Board would be able to make a decision without the need for an oral hearing and that Mr Kearns' re-release would happen more quickly than a prison transfer.

29. On 30 September, Mr Kearns was seen again by the nursing team for the second health screening assessment. No concerns were identified.

30. On 1 October, Mr Kearns was told that the restrictions on his telephone use had been lifted. The investigator was told that prisoners could normally spend 20 minutes on the telephone, but that at that time prisoners who were failing to comply with aspects of the limited COVID-19 regime were being restricted to 10 minute calls. (Examples of poor compliance included prisoners spending more than 20 minutes on the telephone; spending too much time using the shower; and being slow to return to their cells.)

31. On 2 October, Mr Kearns moved from cell M-127, which was a double cell, to cell M-174, a single cell. Another prisoner at Stocken told the police that he went to Mr Kearns' new cell for a cup of tea that afternoon. He said that Mr Kearns was very happy to have a single cell. Mr Kearns also showed him some paperwork he had received from the Parole Board and he was very optimistic that he would soon be released.

32. Prisoners were locked in their cells at just after 5.00pm on 2 October and the final check on Mr Kearns that day was at about 8.22pm when an Operational Support Grade (OSG) completed a roll check on the wing.

Saturday 3 October 2020

33. CCTV shows that the OSG carried out a roll check on the morning of 3 October and checked Mr Kearns at 5.19am. This was a visual check to ensure that all prisoners were in their cells and apparently well. The OSG used a torch to help him check prisoners and he noticed nothing of concern with Mr Kearns.

34. CCTV shows that at 7.13am, an officer carried out a roll check. This was again a visual check to ensure all prisoners were in their cells and apparently well. Staff were not expected to gain responses from prisoners during this check.

35. At 9.04am, an officer unlocked Mr Kearns' cell and told him it was time for showers and telephone calls. The officer told the investigator that Mr Kearns did not respond so she went into the cell, tapped his bed and said again that it was time for showers and telephone calls. She then looked more closely at him and noticed his skin looked blue. Another officer wrote in a statement that he also shouted to Mr Kearns that he had only 20 minutes for a shower and phone calls and he followed the officer into the cell. The first officer said that Mr Kearns' hand was cold so she checked for a pulse and found none. She then radioed a medical emergency code

blue (to indicate a prisoner is unconscious or having breathing difficulties). The control room called an emergency ambulance immediately.

36. The officers moved Mr Kearns onto the cell floor and one of the officers started cardiopulmonary resuscitation (CPR).

37. A nurse arrived at the cell within around two minutes. She noted that Mr Kearns was blue/grey in colour, that he had no pulse and that officers were carrying out CPR. The nurse took over giving CPR and she noted that Mr Kearns was checked with a defibrillator, which advised that no shock could be given. Other nurses arrived and inserted an airway to help give oxygen. Staff continued to take it in turns to give CPR.

38. Ambulance paramedics arrived at around 9.37am, and they took charge of Mr Kearns' care. Efforts to try to resuscitate him continued for a further 20 minutes, but at around 9.57am the paramedics confirmed that Mr Kearns had died.

Contact with Mr Kearns' family

39. Mr Kearns had named his mother as his next-of-kin and given an address in Kirkby, near Liverpool. Due to the distance, Stocken contacted HMP Liverpool to ask if they could visit the family to deliver the news of Mr Kearns' death. Liverpool initially agreed but then contacted Stocken to say that they were unable to make the visit due to local COVID-19 conditions. Stocken then contacted Merseyside police who agreed to visit the family.

40. At 2.40pm, Merseyside police told Stocken that they had visited the address in Kirkby, but the family had moved away. At just after 3.00pm, Stocken found an address for Mr Kearns' sister. Merseyside police made contact with her and were able to meet all of Mr Kearns' family at just after 5.00pm.

41. Stocken contributed to the cost of Mr Kearns' funeral in line with national instructions.

Support for prisoners and staff

42. The Governor debriefed the staff who were involved when Mr Kearns' death was discovered. The staff care team also offered support.

43. The prison posted notices informing other prisoners of Mr Kearns' 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 Kearns' death.

Post-mortem report

44. The post-mortem was unable to establish the cause of Mr Kearns' death.

45. The pathologist found nothing to suggest that Mr Kearns had been assaulted or restrained before his death. The post-mortem identified some scarring to Mr Kearns' heart muscle, together with an abnormally narrowed branch of a coronary artery with enlargement of a proportion of the muscle cells. The pathologist noted

that these changes might have been linked to previous use of stimulant drugs. However, he went on to say that the pathological changes he had observed were not sufficiently severe to give this as a likely cause of death.

46. Toxicology tests found no substances to account for Mr Kearns' death.

Findings

Clinical care

47. The clinical reviewer found that Mr Kearns' care at Stocken was equivalent to that which he could have expected to receive in the community. She said that, although no cause of death had been established, from the evidence seen there had been no opportunity to save Mr Kearns' life and his death was not avoidable.

48. The clinical reviewer noted that there was a 64-day gap between Mr Kearns' initial healthcare assessment at Stocken and the second part of the assessment. (The target is for the second part to be completed within seven days of the initial assessment.) The clinical reviewer recommended that the Head of Healthcare should ensure that target times for the secondary health screen are met. However, no significant health concerns were identified at the secondary screen on 30 September and, although the delay was poor practice, it did not contribute to Mr Kearns' death.

49. The clinical reviewer made two other recommendations. As none of the recommendations were related to Mr Kearns' cause of death, we have not repeated them here.

Morning roll checks

50. The investigator observed CCTV footage for 3 October which showed that the OSG checked Mr Kearns at 5.19am for the early morning roll check and that an officer checked him again at 7.13am. Both checks were visual checks to ensure Mr Kearns was in his cell and was apparently well. Mr Kearns appeared to be asleep in bed on both occasions and neither officer noticed anything of concern. We are satisfied that both of the checks were conducted appropriately. Mr Kearns was a reasonably young man who was apparently in good health and there was no reason for the officers to have been concerned about him.

51. We found no evidence to suggest that staff could have been expected to foresee or prevent Mr Kearns' death and we make no recommendations.

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