Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Stokes, a prisoner at HMP Littlehey, on 21 August 2021

A report by the Prisons and Probation Ombudsman

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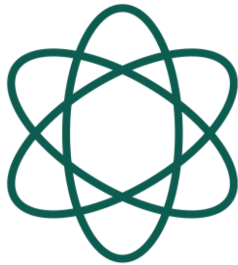
Our vision

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

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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 John Stokes died of bronchopneumonia (a lung infection) as a result of chronic obstructive pulmonary disease (COPD, a lung disease) on 21 August 2021 at HMP Littlehey. He also had Type 2 diabetes which contributed to but did not cause his death. He was 76 years old. I offer my condolences to his family and friends.

The clinical reviewer found that the clinical care that Mr Stokes received at Littlehey was equivalent to that which 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 CB
Prisons and Probation Ombudsman **April 2022**

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Summary

Events

1. In June 2016, Mr John Stokes was sentenced to 25 years in prison for sex offences. On 25 August 2017, he was transferred to HMP Littlehey. He had many long-term conditions: Type 2 diabetes, chronic obstructive pulmonary disease (COPD, a lung disease), high blood pressure, high cholesterol, heart failure and chronic kidney disease. He had poor mobility and was overweight.

2. On 31 March 2020, Mr Stokes told a palliative care consultant that he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect. On 22 April, a healthcare administrator gave Mr Stokes a wristband to confirm that he did not want to be resuscitated. He agreed to wear it.

Events of 21 August 2021

3. At 11.42am on 21 August 2021, an officer unlocked Mr Stokes' cell door for lunch and saw that he was slumped on his bed, snoring. The officer called to Mr Stokes but he did not respond. The officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or not breathing).

4. A nurse went into the cell and saw that Mr Stokes' breathing was laboured. Two officers lifted Mr Stokes to the floor and put him in the recovery position. He was shaking, having seizures and breathing poorly.

5. The nurse saw that Mr Stokes had blue lips, a blue face and was unresponsive. She noted that he had a high pulse rate and low blood oxygen saturation (75%). Two more nurses went to Mr Stokes' cell with an emergency bag, oxygen and a defibrillator. The nurse asked the officers if there was an order in place not to resuscitate Mr Stokes. The officers told her that there was but that he was not wearing his wristband.

6. A nurse gave Mr Stokes oxygen. Another nurse asked to see the order not to resuscitate but it was not available on the wing. Nurses started chest compressions and used a defibrillator which stopped working.

7. Officers brought another defibrillator which a nurse applied and advised no shock. Mr Stokes' condition deteriorated rapidly. A nurse arrived with a copy of the order not to resuscitate and the nurse stopped chest compressions.

8. At 12.08pm, ambulance paramedics were at Mr Stokes' side and at 12.20pm, confirmed that he had died.

Findings

Clinical care

9. The clinical reviewer found that the clinical care that Mr Stokes received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community.

10. The clinical reviewer has made two recommendations which are not directly related to Mr Stokes' death but which the Head of Healthcare will need to address.

Emergency response

11. The clinical reviewer found that healthcare staff responded appropriately to the emergency response, and even though the defibrillator stopped working, it was beyond the control of healthcare staff. The emergency response was initially complicated by the inability to locate the order not to resuscitate Mr Stokes but this was remedied when a nurse brought a copy of it to Mr Stokes' cell. We understand that healthcare staff have since put in measures to address this issue.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Stokes' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Stokes' clinical care at the prison.

15. We informed HM Coroner for Cambridgeshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer wrote to Mr Stokes' wife to explain our investigation. She had no specific questions.

17. We shared the initial report with Mr Stokes' wife. She did not respond.

18. We shared the initial report with the prison service. There were no factual inaccuracies.

Background Information

HMP Littlehey

19. HMP Littlehey is a medium security prison, housing approximately 1,200 prisoners. A high proportion of the prison's population are men convicted of sexual offences. There is a substantial elderly population and nearly half of the prisoners are aged over 50.

20. Northamptonshire Healthcare NHS Foundation Trust provides healthcare services at the prison. The prison healthcare centre is open on weekdays from 7.30am to 7.30pm, and at weekends from 8.00am to 5.30pm. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

21. The most recent full inspection of HMP Littlehey was in August 2019. Inspectors reported that the healthcare team provided prompt access to a range of primary care clinics, and referrals to secondary care were well managed. They said that the patient records that they sampled were informative and demonstrated patients' involvement in their care. The records also demonstrated good care plans for long-term conditions. They said there was good health promotion at the prison.

22. Inspectors carried out a short scrutiny visit of HMP Littlehey in June 2020, focussing on key issues for prisoners during the COVID-19 pandemic. Inspectors reported that Littlehey had been declared an official COVID-19 outbreak site in March 2020 and that the prison, in conjunction with Public Health England (PHE), took swift action to control the spread of the virus. They found a strong emphasis on shielding vulnerable prisoners.

Independent Monitoring Board

23. 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 January 2021, the IMB reported that Littlehey continued to be a safe and secure prison. The IMB reported that the COVID-19 pandemic had significantly impacted on the health and wellbeing needs of the prisoners and that the prison had managed the challenges provided by the pandemic well, with protocols to protect all prisoners.

Previous deaths at HMP Littlehey

24. There were 27 deaths from natural causes (eight of which were as a result of COVID-19) and one self-inflicted death at HMP Littlehey in the two years before Mr Stokes' death. Two prisoners have died from natural causes at Littlehey since Mr Stokes' death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. In June 2016, Mr John Stokes was sentenced to 25 years in prison for sex offences. On 25 August 2017, he was transferred to HMP Littlehey.

26. Mr Stokes had many long-term conditions: Type 2 diabetes, COPD, high blood pressure, high cholesterol, heart failure and chronic kidney disease. He had poor mobility and was overweight. At his initial health screen, a nurse referred Mr Stokes to the clinic for long-term conditions.

27. On 31 March 2020, a palliative care consultant reviewed Mr Stokes who said that he could walk very short distances but needed a wheelchair to get to the healthcare unit. Mr Stokes told the consultant that he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect.

28. On 22 April, a healthcare administrator gave Mr Stokes a wristband to confirm that he did not want to be resuscitated which he signed and agreed to wear.

29. On 28 April, a nurse offered Mr Stokes rehabilitation and exercise for his COPD. He declined to take part.

30. On 13 March 2021, a prison GP sent Mr Stokes to hospital because she thought that he had an acute lower respiratory tract infection. Mr Stokes returned to Littlehey with antibiotics the same day. On 15 March, Mr Stokes told the prison GP that he was feeling better but that he was still a bit shaky.

31. On 19 July, Mr Stokes told a nurse that his COPD was causing him problems and he was using his inhalers frequently.

Events of 21 August

32. At 11.42am on 21 August 2021, an officer unlocked Mr Stokes' cell door for lunch and saw that he was slumped on his bed, snoring. The officer called to Mr Stokes but he did not respond. She entered the cell and noticed that he had urinated. The officer shook Mr Stokes' knee and shoulder but he did not respond. She radioed a medical emergency code blue.

33. A nurse went into the cell and found that the room was very hot and that his fan heater was at maximum temperature. She saw that Mr Stokes was slumped against the wall, with his legs dangling off the bed, that his breathing was very laboured as if he was snoring and that his eyes were closed.

34. Two officers went into Mr Stokes' cell. They lifted him to the floor and helped to put him into the recovery position, supporting his head with a pillow. An officer saw that Mr Stokes was shaking, having seizures and breathing poorly.

35. A nurse saw that Mr Stokes had blue lips and a blue face and was unresponsive. She noted that he had a high pulse rate and low blood oxygen saturation (75%). Two more nurses went to Mr Stokes' cell with an emergency bag, oxygen and a defibrillator. The nurse asked the officers if there was an order not to resuscitate him in place. The officers told the nurse that there was, but that Mr Stokes was not wearing a wristband to confirm the position.

36. A second nurse gave him oxygen. Mr Stokes vomited, and the nurse put him on his side. A third nurse asked to see the order not to be resuscitated but it was not available on the wing. The second nurse started chest compressions and used the defibrillator which stopped working. The second nurse continued with chest compressions.

37. Officers brought another defibrillator. The first nurse applied the defibrillator and no shock was advised. Mr Stokes' condition deteriorated rapidly. She arrived with a copy of the order not to resuscitate Mr Stokes and the nurse stopped chest compressions.

38. At 12.08pm, ambulance paramedics were at Mr Stokes' side and at 12.20pm, confirmed that he had died.

Contact with Mr Stokes' family

39. On 21 August, the Acting Head of Safer Custody, appointed Custodial Manager (CM) as the family liaison officer and a Supervising Officer (SO) as the deputy family liaison officer. After Mr Stokes died, the SO telephoned Mr Stokes' wife (in line with COVID-19 policy), told her that he had died and offered her condolences.

40. Mr Stokes' funeral took place on 24 September. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

41. After Mr Stokes' death, the Head of Residence, 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.

42. The Governor posted notices informing other prisoners of Mr Stokes' 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 Stokes' death.

Post-mortem report

43. A post-mortem examination established that Mr Stokes died of bronchopneumonia (a lung infection) caused by chronic obstructive pulmonary disease (COPD, a lung disease). He also had Type 2 diabetes which contributed to but did not cause his death.

Findings

Clinical care

44. The clinical reviewer found that the clinical care that Mr Stokes received at Littlehey was of a good standard and was equivalent to that which he could have expected to receive in the community. His underlying health needs were appropriately monitored and he was referred to hospital when he needed further assessment. The clinical reviewer made two recommendations which are not directly related to Mr Stokes' death but which the Head of Healthcare will need to address.

Emergency response

45. The clinical reviewer found that healthcare staff responded appropriately to the emergency response. She found that even though the defibrillator stopped working, it was beyond the control of healthcare staff. She noted that the emergency response was complicated when the order not to be resuscitated could initially not be found but this was remedied when a nurse brought a copy to Mr Stokes' cell.

46. The Head of Healthcare told the clinical reviewer that wristbands to confirm whether prisoners should be resuscitated were available and that all prisoners who had signed an order not to be resuscitated had a copy in their cell. He did not know why a copy was not available in the wing office in Mr Stokes' case because he said that healthcare staff always provided a copy for the wing.

47. A business administrator told the investigator that a copy of the order should have been available in the wing office. She said that after Mr Stokes' death, a review was carried out of orders for prisoners who should not be resuscitated. She said that paramedics had told them that copies of an order were not valid and that they would only accept an original document, and prisoners now sign four orders. We therefore do not make any recommendations.

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