

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr Barry Thompson, a prisoner at HMP Stafford, on 9 March 2021**

**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 Barry Thompson died on 9 March 2021 of a stroke while a prisoner at HMP Stafford. He was 54 years old. I offer my condolences to Mr Thompson's family and friends.

The clinical reviewer concluded that the clinical care Mr Thompson received at HMP Stafford was not equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned that when Mr Thompson presented with raised blood pressure and persistent headaches, healthcare staff failed to follow this up. Mr Thompson had been given paracetamol tablets for an extended period of time without being referred to an Advanced Nurse Practitioner or a prison GP to establish the cause of his continual need for pain relief.

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 2022**

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# Summary

## Events

1. On 31 August 2020, Mr Barry Thompson was remanded to HMP Dovegate charged with sexual offences. He was sentenced to two years and eight months imprisonment.
2. Mr Thompson was previously diagnosed with diverticular disease (irritated bowel). He also had a history of substance misuse.
3. On 15 January 2021, Mr Thompson transferred to HMP Stafford.
4. At his initial health screen, a prison nurse noted Mr Thompson's pre-existing conditions and previous medical history. She checked his blood pressure and noted that it was elevated. On 18 January, Mr Thompson had his secondary health screen. Healthcare staff did not recheck his blood pressure as they should have done.
5. On 22 January, Mr Thompson told a prison nurse that he had a headache. The nurse gave him two paracetamol tablets. Between 22 January and 23 February, healthcare staff gave Mr Thompson paracetamol almost every day. On each occasion, he was not referred to an Advanced Nurse Practitioner (ANP) or prison GP to establish the reason for his need for ongoing pain relief as he should have been.
6. At 11.03am on 25 January, prison staff found Mr Thompson unresponsive in his cell. Staff called a medical emergency code, and an ambulance was called immediately. Healthcare staff started cardiopulmonary resuscitation (CPR).
7. At 11.13am, paramedics arrived at the cell and took over Mr Thompson's care and treatment. Mr Thompson was then taken to Royal Stoke Hospital by emergency ambulance. He was not restrained.
8. Mr Thompson suffered a brain haemorrhage (a bleed on the brain) and was admitted to hospital as an inpatient. He underwent two surgical procedures to alleviate the pressure on his brain caused by swelling. Following the procedures, he was placed into an induced coma and moved to the hospital's intensive therapy unit (ITU).
9. Mr Thompson's condition continued to deteriorate in hospital. At 6.11am on 9 March, it was confirmed that Mr Thompson had died.
10. The post-mortem report gave Mr Thompson's cause of death as subarachnoid haemorrhage.

## Findings

11. The clinical reviewer concluded that the clinical care Mr Thompson received at Stafford was not equivalent to that which he could have expected to receive in the community.

12. She was concerned that when Mr Thompson arrived at HMP Stafford on 15 January 2021, his blood pressure was raised. Healthcare staff failed to recheck his blood pressure on 18 January during his secondary health screen.
13. She was also concerned that between 22 January and 23 February, healthcare staff prescribed Mr Thompson paracetamol almost daily. They failed to refer him to an Advanced Nurse Practitioner or prison GP to establish the reason for his need for ongoing pain relief as they should have done.

## **Recommendations**

- The Head of Healthcare must ensure that all clinical staff follow the local homely remedy policy and procedure for the safe administration of medications.
- The Head of Healthcare must ensure that all clinical staff follow the national guidance for blood pressure monitoring.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Stafford informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. Due to restrictions in response to the COVID-19 pandemic, the investigator was unable to visit Stafford. He obtained copies of relevant extracts from Mr Thompson's prison and medical records by email.
16. NHS England commissioned a clinical reviewer to review Mr Thompson's clinical care at the prison.
17. We informed HM Coroner for Staffordshire South of the investigation. The coroner gave us the results of the post-mortem examination and toxicology results. We have sent the coroner a copy of this report.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.
19. Mr Thompson's family received a copy of the initial report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## **Background Information**

### **HMP Stafford**

20. HMP Stafford is a medium security prison in Staffordshire for adult men convicted of sexual offences. It can hold around 750 prisoners. Practice Plus provides healthcare services. Nurses are on duty daily between 7.30am and 5.30pm and there is a weekday GP service with on-call doctors outside of these hours.

### **HM Inspectorate of Prisons**

21. The most recent inspection of HMP Stafford was conducted in January 2020. Inspectors found the range of primary care services available at the prison was appropriate, and access to nurses and GPs was good. Inspectors considered that the care of those prisoners who had been diagnosed with long-term conditions was well managed. Healthcare reviews were reliably scheduled, and comprehensive care plans were used to manage their care needs.

### **Independent Monitoring Board**

22. 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 report for the year to April 2021, the IMB noted that issues had been identified with medicine management. However, the IMB noted an improvement in supervision at the medication hatches by prison staff.
23. The IMB was concerned that there were difficulties in the provision of overnight care at the prison due to healthcare staff shortages. However, the difficulties were hoped to be alleviated by the recruitment of new staff.

### **Previous deaths at HMP Stafford**

24. Mr Thompson was the 11<sup>th</sup> prisoner to die at Stafford since March 2019. All the previous deaths were from natural causes. There were no similarities between Mr Thompson's death and the previous deaths.

## Key Events

25. On 31 August 2020, Mr Barry Thompson was remanded to HMP Dovegate charged with inciting a child to engage in sexual activity. On 2 October, he was sentenced to two years and eight months imprisonment.

### HMP Dovegate

26. Mr Thompson was previously diagnosed with diverticular disease (an irritated bowel). He also had a history of drug misuse and mental illness. During his initial health screen, he told a nurse that he had given up using illicit substances before being sent to prison. The nurse created a care plan to manage his diverticular disease and made a referral to the prison's mental health team.
27. On 29 December, a nurse saw Mr Thompson after he complained of having chest pains. The nurse took his observations, and they were all normal apart from his heart rate, which was slightly raised. Mr Thompson told the nurse that he had slipped while attempting to climb onto the upper bunk of the bed in his cell. She diagnosed him with sustained muscular pain following a blow to his chest.

### HMP Stafford

28. On 15 January 2021, Mr Thompson transferred to HMP Stafford.
29. A nurse carried out an initial health screen. She considered that Mr Thompson appeared anxious and agitated during the review. She checked his blood pressure, which she noted was raised. She noted his previous diagnosis of diverticular disease, his previous history of substance misuse and poor mental health. She referred Mr Thompson to the prison's mental health team and asked for full blood tests. The results of the blood tests showed that Mr Thompson had a syphilis (an infection), a low red blood cell count and abnormal liver function. She reviewed his prescribed medications and updated his care plans.
30. On 18 January, a nurse carried out a second health screen. She did not recheck Mr Thompson's blood pressure as she should have done.
31. On 21 January, a worker from the prison's mental health team saw Mr Thompson. He told her that he had been experiencing a tingling sensation in his body and that he had been hearing voices. He asked her if she could prescribe him with anti-depressants. She told him that the mental health team would continue to offer him support, and that she would review him again at a later date, with a view to prescribing him anti-depressants. She also discussed his history of substance misuse and encouraged him to engage with the prison's substance misuse service. Mr Thompson said that he would consider it.
32. On 22 January, Mr Thompson told a nurse that he had a headache. She gave him two paracetamol tablets. Between 22 January and 23 February, healthcare staff gave Mr Thompson paracetamol nearly every day. On each occasion, healthcare staff failed to refer him to an Advanced Nurse Practitioner (ANP) or prison GP in order to establish the reason for his need for ongoing pain relief.

33. On 15 February, a worker from the prison's mental health team saw Mr Thompson. He told her that he had been suffering from disturbed sleep and was feeling anxious and panicked. She considered that Mr Thompson should have a more in-depth review to see if he would benefit from other interventions.
34. On 22 February, an ANP assessed Mr Thompson's suitability to be prescribed sertraline, an anti-depressant. There is no evidence in Mr Thompson's medical records to indicate that the ANP took his previous raised blood pressure reading into account, or his continued requests for pain relief medication.

## Events of 25 February

35. On 25 February, Mr Thompson asked a medical technical officer for paracetamol. He reviewed Mr Thompson's medical records and noted that Mr Thompson had already asked for paracetamol on numerous occasions without a review by an ANP or prison GP. He told Mr Thompson that he would not issue him with any more pain relief until an ANP or prison GP saw him for review.
36. At 11.03am, staff radioed a code blue (indicating that a prisoner is unconscious or is having breathing difficulties) after they found Mr Thompson unresponsive on the floor of his cell. Staff in the prison control room telephoned for an emergency ambulance immediately.
37. A nurse responded and took with her an emergency grab bag (a bag containing lifesaving equipment). When she arrived at his cell, prison staff told her that Mr Thompson had fallen from the upper bunk bed and had hit his head. She noted that his breathing was laboured, so rolled him onto his back to open his airway. When doing so, she noted that his head felt soft.
38. An ANP arrived shortly afterwards. They moved Mr Thompson out of his cell and onto the landing. They checked him for obvious signs of injury, but there were none. The nurse took a note of his observations and they were normal, but his blood pressure was raised. She noted that Mr Thompson's breathing had deteriorated, his skin was becoming grey in colour and that his pulse was weak and irregular. She inserted a tube into his throat to prevent his tongue blocking his airway and administered oxygen therapy. She also attached a defibrillator to his chest, which advised that CPR should be commenced. The ANP started chest compressions.
39. At 11.13am, paramedics arrived at the cell and took over Mr Thompson's care and treatment. Mr Thompson was taken to Royal Stoke Hospital, by emergency ambulance.
40. In hospital, Mr Thompson was diagnosed with having a bleed on the brain and was admitted to hospital as an inpatient. The next day, he underwent a surgical procedure to relieve the pressure on his brain caused by the swelling. Following the procedure, he was placed in an induced coma and moved to the intensive therapy unit (ITU).
41. On 28 February, Mr Thompson had a second surgical procedure to further reduce the swelling to his brain. His condition continued to deteriorate in hospital, and on 5 March, hospital staff told the escort staff accompanying him that his prognosis was poor, and it was unlikely that he would survive.

42. At 6.11am on 9 March, it was confirmed that Mr Thompson had died.

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

43. On 25 February 2021, the prison appointed a prison Family Liaison Officer (FLO).

44. The FLO contacted Mr Thompson's next of kin, his ex-partner, to inform her of his admission to hospital and to offer her support. He remained in contact with her and Mr Thompson's daughter and kept them updated with his condition. When Mr Thompson died, he telephoned Mr Thompson's partner to inform her of his death and offered support.

45. The prison contributed to Mr Thompson's funeral in line with national guidance.

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

46. The prison posted notices informing other prisoners of Mr Thompson'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 his death.

47. Staff involved in the emergency response were given the opportunity to discuss any issues arising and they were also offered support by the staff care team.

### **Post-mortem report**

48. The post-mortem report gave Mr Thompson's cause of death as subarachnoid haemorrhage (a stroke caused by a bleed on the surface of the brain) caused by a giant ruptured right middle cerebral artery berry aneurysm (clipped). Also, smoking did not cause but contributed to Mr Thompson's death.

# Findings

## Clinical care

49. The clinical reviewer concluded that the care Mr Thompson received at Stafford was not equivalent to that which he could have expected to receive in the community.

## Blood pressure management

50. When Mr Thompson arrived at HMP Stafford on 15 January 2021, his blood pressure was raised. The clinical reviewer was concerned that during his secondary health screen on 18 January, his blood pressure was not rechecked as it should have been. We recommend:

**The Head of Healthcare should ensure that all clinical staff follow the national guidance for blood pressure monitoring.**

## Medication risk assessments and review

51. Healthcare staff prescribed Mr Thompson paracetamol on a number of occasions after he complained of having headaches. This was in line with the homely remedy procedure, which required them to administer low grade pain relief without the need for a prescription. However, the clinical reviewer found that this was not in line with the homely remedy policy, which says that, after training, clinicians can administer pain relief for no more than three continuous days without seeking advice from a GP or an Advanced Nurse Practitioner. We recommend:

**The Head of Healthcare should ensure that all clinical staff follow the local homely remedy policy and procedure for the safe administration of medications.**

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