

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Stainton, a prisoner at HMP Peterborough, on 4 September 2019

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 Daniel Stainton died on 4 September 2019 of heart disease at HMP Peterborough. He was 46 years old. I offer my condolences to Mr Stainton's family and friends.

The clinical reviewer found that the care Mr Stainton received at Peterborough was equivalent to that he could have expected to receive in the community. However, she found that the reception health screen carried out when Mr Stainton arrived at Peterborough on 20 August, was not as comprehensive as it should have been. He was also not offered a secondary health screen. She was satisfied, however, that Mr Stainton's death could not have been prevented during the two weeks he spent at Peterborough.

The investigation also found a short delay in the emergency response when Mr Stainton was discovered unresponsive in his cell.

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

March 2020

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Summary

Events

1. On 20 August 2019, Mr Daniel Stainton was remanded in custody, charged with theft, and sent to HMP Peterborough.
2. A nurse carried out Mr Stainton's reception health screen. Mr Stainton told the nurse that he injected illicit drugs daily and the nurse noted mild withdrawal symptoms. A prison GP started Mr Stainton on a methadone (opiate substitute) programme.
3. On 3 September, an operational support grade (OSG) carried out a roll check at 4.09am. He noticed Mr Stainton's cell light was on and his observation panel was covered. He looked through a gap at the side of the cell door and saw that Mr Stainton was lying on the floor. He took no further action.
4. At around 7.30am the next morning, an officer unlocked Mr Stainton's cell and saw he was lying on a mattress on the floor. (His observation panel was no longer covered.) He thought Mr Stainton looked pale and may have taken illicit drugs, so he called to a colleague. Another officer arrived and said Mr Stainton was breathing and had a faint pulse. The first officer remained concerned and asked another colleague to radio for healthcare staff to attend. A senior officer arrived and thought Mr Stainton felt cold. He radioed a medical emergency code.
5. Staff responded and started cardiopulmonary resuscitation (CPR). Ambulance paramedics arrived at 7.49am and took over CPR. They were unable to resuscitate Mr Stainton and pronounced his death at 8.28am.
6. The post-mortem examination found that Mr Stainton died from heart disease.

Findings

7. The clinical reviewer found that the care Mr Stainton received at Peterborough was equivalent to that he could have expected to receive in the community. However, she noted that Mr Stainton's initial health screen at Peterborough was not as comprehensive as it should have been, and he was not offered a secondary health screen, which would have provided an opportunity to discuss his medical issues in more detail. She was satisfied, however, that his death could not have been prevented during his time at Peterborough.
8. The OSG who found that Mr Stainton's observation panel was covered during a roll check, did not follow prison policy as he did not ask him to remove the obstruction. We note, however, that the observation panel was not covered when Mr Stainton's cell was unlocked two hours later.
9. There was a short delay in staff calling a medical emergency code. We consider that the code should have been called when Mr Stainton's cell was unlocked and it became clear that he was unresponsive.

Recommendations

- The Head of Healthcare should ensure that all relevant health data is recorded during the initial health screen.
- The Head of Healthcare should ensure that in accordance with NG (Nice Guidance) 57 'Physical health of people in prison' all prisoners are offered a secondary health screen within a week of their initial reception.
- The Director should ensure that all staff follow the correct procedures, as set out in IFC 030/2017, for dealing with prisoners who have covered their observation panel.
- The Director should ensure that a copy of this report is shared with the OSG and that a senior manager discusses our findings with him.
- The Director should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Peterborough on 11 September 2019. She obtained copies of relevant extracts from Mr Stainton's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Stainton's clinical care at the prison.
13. The investigator interviewed eight members of staff at Peterborough on 8 October 2019. She and the clinical reviewer jointly interviewed staff.
14. We informed HM Coroner for Cambridgeshire and Peterborough 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. One of the Ombudsman's family liaison officers contacted Mr Stainton's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They asked:
 - Was Mr Stainton admitted to the healthcare unit when he was sent to HMP Peterborough?
 - Did he know he had a heart condition?
 - Mr Stainton told his family he had cancer - was this true?
 - What happened during an incident when he collapsed in front of staff?
 - Why did Mr Stainton press his cell bell during the night?
 - Was he checked throughout the night?

We have addressed these issues in our report.
16. We shared our initial report with HM Prison and Probation Service (HMPPS). They raised some factual inaccuracies which have been amended in this report.
17. We provided Mr Stainton's next of kin with a copy of our initial report. She identified no factual inaccuracies. She raised several issues about her son's healthcare, which have been addressed in separate correspondence.

Background Information

HMP/YOI Peterborough

18. HMP/YOI Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

19. The most recent inspection of HMP/YOI Peterborough men's prison was in July 2018. Inspectors reported that access to healthcare was good for all prisoners. There was an appropriate range of primary care services. All prisoners were seen by a registered nurse on arrival and received a comprehensive health screen. However, there was a large backlog of people who had not received their secondary health screen.

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 March 2019, the IMB reported that they were concerned about the availability of illicit drugs. The IMB noted an improvement in the governance and delivery of healthcare services and there was no waiting list to see a doctor.

Previous deaths at HMP/YOI Peterborough

21. Mr Stainton was the second male prisoner to die at Peterborough since September 2017. The previous death was due to natural causes. There are no similarities between Mr Stainton's death and the previous death.

Key Events

22. On 20 August 2019, Mr Daniel Stainton was remanded in custody, charged with theft, and sent to HMP Peterborough. This was not his first time in prison. (He had been released from Peterborough in November 2018.)
23. A nurse carried out Mr Stainton's reception health screen. They discussed his alcohol and drug use and he said he injected illicit drugs daily. His urine tested positive for cocaine. The nurse assessed Mr Stainton's level of drug withdrawal using COWS (Clinical Opiate Withdrawal Scale) and noted he had mild withdrawal symptoms.
24. A prison GP saw Mr Stainton within the hour. Mr Stainton said he injected heroin and cocaine daily, and was also using diazepam. The GP started Mr Stainton on a standard titration methadone programme (opiate substitute), to be monitored by COWS for five days on the Integrated Drug Therapy Unit, X1.
25. Several healthcare assistants assessed Mr Stainton over the next five days. His withdrawal level remained within the mild category (a score of between five and 12 is considered mild withdrawal) and his methadone doses were titrated accordingly throughout. Mr Stainton was moved from X1 to X2 on Houseblock 4 on 3 September. He continued his methadone medication. During the move Mr Stainton fell over, picked himself up, but stumbled and fell again in his new cell. There is no evidence that Mr Stainton or staff had any concerns about this, and healthcare staff were not involved.
26. Also on 3 September, Mr Stainton met his key worker. Mr Stainton said he had settled into the prison well, and found wing staff helpful and supportive. Mr Stainton mentioned that his feet were swollen. He had applied to see a doctor and the key worker advised him to speak to wing or healthcare staff if he experienced pain or discomfort before he saw the doctor. (Mr Stainton did not see a doctor before he died.)
27. An operational support grade (OSG) started work on Houseblock 4 at 8.00pm, on 3 September. He carried out a roll check (count of prisoners) between 9.00pm and 9.15pm.
28. Mr Stainton pressed his cell bell twice that night, at 10.55pm and 11.00pm. He asked the OSG for a mattress as there was not one in his cell. At that time Mr Stainton was sitting on his bed frame using a vape machine. An officer gave Mr Stainton a mattress approximately ten minutes later. Mr Stainton was sitting in the dark but told the officer that he was alright. Mr Stainton then asked for a pillow and duvet, as these were also missing from his cell. The officer took them to Mr Stainton, who was still sitting in the dark and vaping, and who thanked him.
29. The OSG carried out a second roll check at 4.09am. He noticed Mr Stainton's cell light was on and his observation panel was covered. He looked through the gap at the side of the cell door and saw Mr Stainton's hand. Mr Stainton appeared to be lying on the floor. He took no action in response to the obscured panel.
30. At approximately 7.30am the next morning, Officer A assisted unlocking prisoners on Houseblock 4. Mr Stainton's observation panel was no longer covered. He unlocked Mr Stainton's cell and saw he was lying on a mattress on the floor. He

said he initially thought Mr Stainton may have taken psychoactive substances (PS). He thought Mr Stainton looked pale and noticed he had a swollen leg, so he called a colleague and asked him to check Mr Stainton's pulse as he was concerned about him. Officer B told him that Mr Stainton was breathing and that he thought there was a faint pulse. Officer A remained concerned and asked Officer C to radio for healthcare assistance. He then left the cell and went to the wing office to complete some paperwork.

31. A senior officer (SO) heard the radio call for healthcare and went to Mr Stainton's cell, although he said he did not rush as the call did not sound urgent. He saw Officer B, who was checking Mr Stainton for a pulse and said he was breathing. The SO radioed for healthcare assistance, but the duty nurse replied saying she was dispensing medication to prisoners in another part of the prison and asked for another nurse to attend instead.
32. The SO felt Mr Stainton and noticed he felt cold. Realising something was not right, he radioed a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). Staff in the control room telephoned for an ambulance immediately. Staff did nothing further, as they believed Mr Stainton was breathing. The SO said staff did not want to move Mr Stainton in case he had a back injury.
33. The duty manager heard the code blue call at 7.35am. He also heard the SO ask for healthcare staff to go to the cell and for staff to bring healthcare bags containing emergency equipment. He made his way to Mr Stainton's cell.
34. The first nurse arrived at Mr Stainton's cell at 7.37am. She saw Mr Stainton lying on his back on a mattress on the floor. She noted no signs of breathing or pulse, and when she opened Mr Stainton's eyes, she noted his pupils were fully dilated. His body was stiff, pale and cold. She started cardiopulmonary resuscitation (CPR) and, simultaneously, an officer asked whether Mr Stainton had died, but she said she needed to wait for other healthcare staff to arrive before she could say.
35. At 7.39am, Officer D arrived with a healthcare emergency grab bag containing breathing equipment and a defibrillator. The duty manager arrived at Mr Stainton's cell and saw nurses carrying out CPR. He arranged for paramedics to enter the prison, for prisoners already unlocked to return to their cells, and completed paperwork in case Mr Stainton went to hospital.
36. At 7.44am, another nurse arrived at the cell and, seeing that the cell was very crowded, asked for Mr Stainton to be brought out onto the landing. She noticed that Mr Stainton's fingers, toes and lips were blue. She took over chest compressions and a colleague, who had responded to the emergency call, inserted an airway into Mr Stainton's mouth. She found it difficult, because his jaw was stiff. The defibrillator instructed staff to shock him on one occasion, which they did.
37. Paramedics arrived at 7.54am. Healthcare staff briefed them and they took over CPR until 8.28am, when they pronounced Mr Stainton's death.

Contact with Mr Stainton's family

38. A prison manager was appointed deputy family liaison officer. Mr Stainton had not recorded a next of kin when he arrived at Peterborough, so the manager looked

through Mr Stainton's previous approved telephone numbers. He managed to call Mr Stainton's next of kin. He told her that Mr Stainton had been discovered unresponsive in his cell, and he would call back with an update. He telephoned again once Mr Stainton's death had been confirmed, and broke the news of his death. He and an officer visited the next of kin the next day.

39. The prison contributed to Mr Stainton's funeral in line with national guidelines.

Support for prisoners and staff

40. After Mr Stainton's death, a SO 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.
41. The prison posted notices informing other prisoners of Mr Stainton'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 Stainton's death.

Post-mortem report

42. Mr Stainton's post-mortem report concluded that he died from ischaemic heart disease, caused by atheromatous coronary artery disease (narrowing of the arteries that supply the heart, caused by a build-up of plaque deposits).

Findings

Mr Stainton's healthcare

43. Mr Stainton died from heart disease. The post-mortem report noted that he had critical narrowing of the right coronary artery and his heart had scar tissue consistent with a previous heart attack. It is unclear whether Mr Stainton was aware of this.
44. The clinical reviewer was satisfied that the care Mr Stainton received at Peterborough was equivalent to that he could have expected to receive in the community. She considered that Mr Stainton's death could not have been prevented during his time at Peterborough. However, she identified two issues of concern.
45. Mr Stainton had an initial health screen when he arrived at Peterborough, but the clinical reviewer noted that several questions were not asked, including whether he had a history of chest pain or heart disease. We make the following recommendation:

The Head of Healthcare should ensure that all relevant health data is recorded during the initial health screen.

46. There is no evidence that Mr Stainton was offered a secondary health screen. A secondary screening would have provided an opportunity to discuss Mr Stainton's health in more detail. We make the following recommendation:

The Head of Healthcare should ensure that in accordance with NG (Nice Guidance) 57 'Physical health of people in prison' all prisoners are offered a secondary health screen within a week of their initial reception.

Obscured observation panel

47. The OSG found Mr Stainton's observation panel covered when he carried out a roll check at 4.09am. He looked through a gap at the side of the door and saw Mr Stainton's hand and that he appeared to be lying on the floor. He took no further action.
48. Peterborough issued an information notice for all staff in March 2017 (IFC 030/2017) setting out the procedure to be followed if a prisoner has covered their observation panel. It says that the prisoner must be asked to clear their observation panel and if they refuse, they should be warned that it may affect their level of privileges or they may face a disciplinary charge. If they still refuse, staff should either enter the cell if safe to do so and remove the items obscuring the panel, or ask for assistance to enter the cell. The notice says, "Under no circumstances is the panel to be left obscured". The OSG did not follow the procedure and we make the following recommendations:

The Director should ensure that all staff follow the correct procedures, as set out in IFC030/2017, for dealing with prisoners who have covered their observation panel.

The Director should ensure that a copy of this report is shared with the OSG and that a senior manager discusses our findings with him.

Emergency response

Delay in calling code blue

49. When Officer A unlocked Mr Stainton's cell, he saw Mr Stainton lying on a mattress on the floor and thought he was under the influence of PS. He asked Officer B to check his pulse. Officer B said he felt a faint pulse and that Mr Stainton was breathing. Officer A remained concerned and so he asked another officer to call for a nurse and the SO. When the SO arrived, he realised Mr Stainton was cold and called a medical emergency code.
50. The first nurse to arrive found no signs of breathing or pulse and described Mr Stainton's body as pale, stiff and cold. We consider that staff should have called a medical emergency code as soon as they unlocked Mr Stainton's cell and realised he was unresponsive. We recognise that Officer A was concerned about Mr Stainton, that he asked a colleague to call for a nurse and that there was only a short delay before the SO arrived and called a code blue. Nevertheless, we know that in an emergency situation a delay of a few minutes may be critical. We consider that as Mr Stainton was unresponsive when he was unlocked, a code blue should have been called at that point, which would have triggered an emergency response from healthcare staff and an ambulance being called.
51. We make the following recommendation:

The Director should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

Resuscitation attempt

52. Some staff said that Mr Stainton was stiff and blue when he was found, both indications that he had been dead some time. Guidelines say that CPR should not be attempted where it would be futile. However, some staff thought Mr Stainton was breathing when he was found, and when the defibrillator was attached to him, it advised a single shock, which could have indicated that there was still some electrical activity in the heart. We also note that ambulance paramedics continued with the resuscitation attempt when they arrived. We accept that it was unclear whether resuscitation would be futile and we do not criticise the CPR attempt by prison healthcare staff.

Inquest

53. The inquest, held on 13 November 2023, concluded that Mr Stainton died from natural causes.

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

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

T | 020 7633 4100