

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Stokes a prisoner at HMP Lindholme on 30 November 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Daniel Stokes was found having a seizure in his cell at HMP Lindholme on 30 November 2015. Paramedics were called but Mr Stokes died later that evening. He was 34 years old. I offer my condolences to Mr Stokes' family and friends.

On 3 April 2017, Mr Stokes' partner pleaded guilty to supplying Class A drugs to him while in prison. On 11 May, she was sentenced to 4 years in custody.

The investigation found no evidence that Mr Stokes' death was intentional and it appears to have been caused by an accidental overdose of illicit drugs. I am concerned at the evident availability of, and access to, illicit drugs at Lindholme and share the concerns of HM Inspectorate of Prisons and the Independent Monitoring Board about this issue. There were also serious deficiencies in the emergency response.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2017

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Summary

Events

1. On 4 June 2014, Mr Daniel Stokes was remanded into custody at HMP Leeds charged with burglary and theft. He had been in prison before and, since 1997, had served several custodial sentences. On 6 November, Mr Stokes was convicted and sentenced to five years, 6 months imprisonment. He was transferred to HMP Lindholme on 2 December 2014.
2. Mr Stokes had settled well at Lindholme, had a job in the workshops and was on the enhanced regime level. He had no significant health problems. He had never self-harmed while in prison and no one had ever considered him to be at risk of suicide. He had never been made subject to an adjudication hearing (an enquiry into a breach of prison rules) nor had he ever failed a mandatory drugs test (MDT).
3. On 30 November, at 6.35pm, a prisoner on the same wing told an officer that he was concerned Mr Stokes was unwell. Staff arrived at Mr Stokes' cell at 6.37pm, called an emergency code and began cardiopulmonary resuscitation until paramedics arrived. The paramedics took over emergency treatment but at 8.05pm pronounced Mr Stokes dead.

Findings

Assessment of risk

4. There is no evidence that Mr Stokes' death was intentional but was caused by an overdose of illicit drugs. Mr Stokes told a fellow prisoner that he had swallowed a packet of drugs which he had trafficked into the prison and this was borne out by the findings of the post-mortem examination.

Access to illicit substances

5. We are concerned at the availability of, and access to, illicit drugs at Lindholme. There was no intelligence to suggest that Mr Stokes himself used illicit drugs in prison, however, his partner pleaded guilty to supplying Class A drugs to him while he was there. It is now clear from Mr Stokes' actions that, in collusion with her, he intended to bring illicit drugs into the prison.

Emergency response

6. We are concerned about the prison's emergency response. After officers called an emergency code it took ten minutes before support staff called an ambulance. It then took a further 28 minutes before paramedics arrived at the prison. While a quicker response may not have saved Mr Stokes it may be critical in other emergencies in the future.

Actions following a death in custody

7. No members of staff were asked to complete Incident Report forms after the initial emergency incident or after Mr Stokes' death, although it is mandatory for them to do so.

Recommendations

- The Governor should ensure that there are effective supply and demand reduction strategies within the prison to help reduce the availability of illicit drugs, including the appropriate assessment of security intelligence and application of sanctions to prisoners and visitors.
- The Governor should ensure that all prison staff are made aware of and understand Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, and their responsibilities during medical emergencies which:
 - Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;
 - Ensures that an emergency response protocol is in place with the ambulance service;
 - Ensures that all emergency equipment, including radios, is in good working order.
- The Governor should ensure that all relevant mandatory actions in PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* are completed after a prisoner's death.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact him. Nobody came forward.
9. The investigator visited Lindholme on 8 December. He obtained copies of relevant extracts from Mr Stokes' prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Stokes' clinical care at the prison.
11. The investigator interviewed six members of staff and one prisoner at Lindholme in December. Of these, six were interviewed jointly with the clinical reviewer.
12. On 10 October 2016, in line with the Ombudsman's terms of reference, we suspended our investigation while the police carried out a criminal investigation. Mr Stokes' partner pleaded guilty to supplying Class A drugs to Mr Stokes and, on 11 May 2017, was sentenced to 4 years in custody. Our investigation resumed on the conclusion of the criminal trial.
13. We informed HM Coroner for South East Yorkshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Stokes' family to explain the investigation and to ask whether there were any matters they wanted the investigation to consider. The family wanted to know whether Mr Stokes had used drugs in prison and what was the level of regime on his wing. The family raised concerns about the security arrangements at the prison in relation to drugs and mobile phones, and also asked whether Mr Stokes had been on closed visits with his partner in the past. If so, why were they stopped if there were known concerns in respect of these visits? Mr Stokes' family received a copy of the initial report. They did not make any comments.

Background Information

HMP Lindholme

15. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic, some specialist services and out-of-hours GPs.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Lindholme was carried out in March 2016. Inspectors found very high levels of victimisation and incidents of self-harm. These were linked to an influx of illicit drugs, in particular new psychoactive substances (NPS), which has destabilised the prison. Inspectors noted that although Lindholme had seized considerable amounts of such drugs, they still remained readily available. Inspectors found that security was well-managed and focused on the significant threats from prisoners associated with organised crime groups and their links to violence and drug-related activity. The quality of relationships between staff and prisoners was found to be good. Health services were reasonably good overall.

Independent Monitoring Board

17. 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 most recently published report for the year to January 2016, the IMB commented that a major concern at Lindholme is the supply and use of illicit drugs, particularly NPS. It had been the cause of some disturbing incidents for a number of prisoners and was rife throughout the prison. The IMB were concerned that there does not appear to be a realistic plan in place to combat the use of drugs.

Previous deaths at HMP Lindholme

18. Mr Stokes' death was the third at Lindholme since December 2013. The previous two deaths were both from natural causes. There are no similarities between these deaths and that of Mr Stokes.

Key Events

19. Mr Stokes had a custodial history dating back to 1997. On 12 March 2014, he was released on licence from HMP Humber. On 4 June, Mr Stokes had his licence revoked and was remanded in custody to HMP Leeds on new offences of burglary and theft. On 6 November, Mr Stokes was convicted and sentenced to five years, six months imprisonment. On 12 December, he was transferred to HMP Lindholme. Throughout Mr Stokes' entire time in custody he never self-harmed and no one ever assessed him as being at risk of suicide or self-harm.
20. At Lindholme, Mr Stokes lived in a single cell on Spur Eight of C Wing. Each spur had eight cells and each prisoner had his own key. There is a shared communal area on each wing and, additionally, each cell has its own television. The spurs are locked at night but prisoners still have access to all the communal facilities on their spur.
21. Mr Stokes was on the enhanced level of the Incentives and Earned Privileges scheme which rewards good behaviour with additional privileges. He was employed in the workshops. Officers described Mr Stokes as polite and courteous and as someone who never gave staff any trouble or concerns.
22. Mr Stokes' medical records show that, while he was in prison he had a long-standing diagnosis of asthma and was prescribed an inhaler. He received no other medication. He had no recorded mental health problems and there was no information whatsoever to indicate that he used drugs or alcohol.
23. Although he was never made the subject of an adjudication hearing (an enquiry into a breach of prison rules), Mr Stokes' security records disclose that there was intelligence to suggest he wanted to become involved in the drug sub-culture within the prison by becoming employed in waste management. This would give him the opportunity to collect packages thrown over the perimeter fence. Intelligence also suggested that he used mobile phones, possession and use of which within prison is unlawful and a breach of prison regulations. Mr Stokes' family have told us that he contacted them using a mobile phone.
24. There was a marker on Mr Stokes' Mercury print file (a prisoner's security record) indicating that West Yorkshire Police Organised Crime Unit was to be informed whenever he was transferred between establishments.
25. On 23 October 2015, a general allegation made against a number of prisoners, including Mr Stokes, suggested involvement in the prison's drug-subculture. However, there was no evidence at that time to substantiate this allegation. From the point at which Mr Stokes entered custody on 4 June 2014, prison records show that he did not fail any drug tests.
26. Mr Stokes was visited regularly by his partner. On 31 May 2015, when he was visited by her, staff witnessed her pass two gold-coloured hinges to Mr Stokes. The hinges were confiscated and returned to Mr Stokes' partner after the visit had ended. Mr Stokes' prison records show that he had made a box in the carpentry workshop and he explained that this was why he wanted the hinges. As a consequence, Lindholme put Mr Stokes and his partner on closed visits for

a period of three months. (This meant that visits were conducted with a glass screen between the visitor and prisoner, preventing any physical contact.)

27. On 9 August, security staff received an intelligence report from another prisoner suggesting that Mr Stokes was planning to obtain drugs passed by his partner after the period of closed visits had ended. The deputy governor told the investigator that the information given by the prisoner could not be corroborated. He said that, based on this single piece of intelligence alone, there were insufficient grounds to place Mr Stokes and his partner on further closed visits.
28. Prison phone records show that between 12 November and 22 November, Mr Stokes made nine calls to his partner and one call to his aunt. Mr Stokes made no phone calls after 22 November.
29. On 22 November, the Governor of Lindholme allowed Mr Stokes to visit his terminally ill father in hospital. Later that evening, Mr Stokes' father died. Permission was subsequently granted for Mr Stokes to attend his father's funeral, which was arranged for 3 December. Following the death of his father, Mr Stokes gave no indication to anyone that he had any thoughts of suicide or self-harm.
30. On 29 November, Mr Stokes was visited by his partner. Examination of the CCTV footage shows them in close contact with one another on frequent occasions throughout the visit. On two occasions, Mr Stokes appears to have swallowed something, then appear to choke and take a drink from a soft drink bottle.
31. On 30 November, at approximately 6.35pm, a prisoner on C Wing, and the same spur as Mr Stokes, shouted to an officer to come onto Spur 8. She went onto Spur 8 and he directed her to Mr Stokes' cell. She told the investigator that when she entered Mr Stokes' cell she saw him lying on his bed. Another prisoner from Spur 8 was with him. He told her to call an ambulance but he would not say why.
32. The officer said that as soon as she saw Mr Stokes she knew something was wrong. She tried to use her radio but found that the battery was flat. She told another prisoner to find an officer and tell him to call an ambulance. This officer used his radio to call a code blue emergency.
33. The prison communications log shows that the code blue radio call was made at 6.37pm. Two operational support grade staff were on duty in the communications room. Both told the investigator that it had been the practice at Lindholme for some time that, when an emergency call was made, they would not immediately call an ambulance but wait until a nurse specifically requested one. This is contrary to Lindholme's policy for emergency incidents, which states that an emergency ambulance should be called as soon as an emergency code is used. The communications log shows that requests to call an ambulance were made at 6.43pm and 6.45pm, and the officer made the 999 call at 6.47pm.
34. Other staff responded to the emergency, including three nurses. Mr Stokes was, by this time, on his bed in a distressed state and appeared to be having a seizure, thrashing out with his arms and legs. A nurse told the investigator that Mr Stokes was conscious but, due to his arms thrashing about, nurses were unable to take

his blood pressure and oxygen levels. She said she asked a prisoner whether he knew what Mr Stokes had taken but he refused to say.

35. The nurse said that after several minutes Mr Stokes suddenly vomited and stopped breathing. She immediately started cardiopulmonary resuscitation (CPR). At this point the prisoner told her that Mr Stokes had consumed MDMA (methylenedioxy-methamphetamine – a pure form of ecstasy). She said she had just started the second cycle of cardiac compressions when the paramedics arrived.
36. Ambulance service records confirm that the 999 call was made at 6.47pm. Paramedics arrived at the prison at 7.15pm and reached Mr Stokes' cell at 7.20pm. The paramedics took over resuscitation. However, at 8.05pm, they pronounced Mr Stokes dead.
37. The prisoner told the investigator that he and Mr Stokes had been friends for 20 years. He said that before evening meal time, Mr Stokes had told him that he had swallowed some drugs and thought that the package had burst inside him. He wanted to call for help but Mr Stokes had told him not to. He said that initially Mr Stokes had appeared to be his usual self. Suddenly, his physical condition began to deteriorate rapidly and he began to twitch. At that point, he had told another prisoner to call a member of staff.

Contact with Mr Stokes' family

38. The prison Governor and a prison family liaison officer visited Mr Stokes' aunt at home at 11.00pm. They broke the news that Mr Stokes had died and offered their condolences. The prison subsequently liaised with Mr Stokes' mother, who took over as next of kin. In line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

39. The Head of Safety and Equality debriefed the staff who had been involved in the emergency response. However, staff members were not asked to complete incident report forms, as Prison Service instructions require. Staff members were offered the support of the prison's care team.
40. The prison posted notices informing other prisoners of Mr Stokes' death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Stokes' death. The prisoner who had raised the alarm said staff and the mental health team supported him.

Post-mortem report

41. A post-mortem examination, conducted by a Home Office Forensic Pathologist, confirmed that the cause of Mr Stokes' death was mixed drug toxicity. He commented on the toxicology results which found the presence of 4-chloromethcathinone (commonly known as 4-CMC or clephdrone), a Class B drug; methylenedioxy-methamphetamine (commonly known as ecstasy), a Class A drug; and benzylpiperazine (commonly known as BZP), a Class C drug. All of these drugs are designer recreational psychoactive substances. He concluded

that, based on the level of drugs found, Mr Stokes was under the influence of stimulant drugs at the time of his death.

Findings

Assessment of Risk

42. Mr Stokes had been in prison several times before. He had no history of suicide attempts or self-harm, and at no time during his current sentence was he considered as being in need of monitoring and support using Prison Service suicide and self-harm prevention procedures.
43. We do not consider that Mr Stokes intended to take his own life. Mr Stokes' death was not intentional and was caused by an accidental overdose of illicit drugs. In August 2015, Lindholme had received an uncorroborated allegation from another prisoner that Mr Stokes intended to introduce illicit drugs into the prison through visits and, on the day of his death, he told a fellow prisoner that he had swallowed a package of drugs which had burst inside him. This was confirmed by the findings of the post-mortem examination.

Access to illicit substances

44. The presence and use of illicit drugs is a major problem across the prison estate. Besides dangers to both physical and mental health, it poses a threat to an establishment's good order and the trade in illicit drugs can lead to debt, violence and intimidation.
45. Mr Rayner told the investigator that there was no evidence or intelligence indicating that Mr Stokes was a user of illicit drugs while in prison. However, there was intelligence from previous establishments which alleged Mr Stokes had links with, and was part of, an organised crime group from the Bradford area and received drugs from his partner Ms Holian.
46. While Mr Stokes was at Lindholme, intelligence suggested he posed a risk of trafficking drugs and was in possession of a mobile phone. Mr Raynor explained that there were a range of sanctions that were considered, including closed visits, intelligence-led monitoring, targeted searches and transfer to another prison.
47. The deputy Governor said because of a lack of corroborated intelligence, Lindholme could not justify applying any sanctions to Mr Stokes in the period leading up to his death. Additionally, all visitors, and their possessions, are individually searched on each occasion they visit, before they enter a prison. While all visitors are subject to a rub-down search, some can hide illicit items in their underwear or secreted about their bodies. He explained that the prison was able to detect heroin and other opiates but was unable to detect new psychoactive substances, known as 'Spice' or 'Mamba'.
48. It is now clear from Mr Stokes' actions that, in collusion with his partner, he intended to traffic illicit substances into the prison and use them to trade on his own account or to supply to others. We make the following recommendation

The Governor should ensure that there are effective supply and demand reduction strategies within the prison to help reduce the availability of illicit drugs, including the appropriate assessment of security intelligence and application of sanctions to prisoners and visitors.

Clinical Care

49. The clinical reviewer considered that the standard of healthcare Mr Stokes received at Lindholme was appropriate and equivalent to that he could have expected in the community. Over the period from December 2014 to the day of his death, Mr Stokes saw healthcare staff on only five occasions. These visits were for minor illnesses and, once, to have a wound dressed following a minor accident in the prison workshop.

Emergency Response

50. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies. The PSI also includes a mandatory instruction that the terms of the medical emergency response protocols must be written, and agreed, in conjunction with the local healthcare commissioner at the prison and the local ambulance trust.
51. When the officer found Mr Stokes in a distressed state in his cell, she could not use her radio as the battery was flat. It was fortunate that another officer happened to be on the wing at the time.
52. The officer did use an emergency code as required by the local emergency protocol. However, the staff in the control room did not call an ambulance immediately. This led to a ten minute delay before an emergency ambulance was called. As soon as Mr Stokes stopped breathing CPR was started immediately.
53. Yorkshire Ambulance Service received the 999 call at 6.47pm. However, it took 28 minutes for paramedics to arrive at Lindholme. This was an unacceptable delay. The clinical reviewer commented that the emergency standard for a Red 1 emergency call (a respiratory issue or cardiac arrest) is 8 minutes. This incident was investigated by Yorkshire Ambulance Service who confirmed that the nearest ambulance crew had been dispatched to the call. We cannot know whether earlier intervention might have affected the outcome for Mr Stokes, however, in future emergencies such a delay may be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, *Medical Emergency Response Codes* and their responsibilities during medical emergencies which:

- Ensures staff immediately call for an emergency ambulance when a medical emergency code is used;
- Ensures that an emergency response protocol is in place with the ambulance service;
- Ensures that all emergency equipment, including radios, is in good working order.

Actions following a death in custody

54. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, sets out the actions that prisons should undertake after a prisoner's death. Chapter 12 of the PSI contains a mandatory action that staff directly involved, particularly those who were first on scene, must complete Incident Report Forms as soon as is practicable. No members of staff were asked to complete the forms after the initial emergency incident or after Mr Stokes died. We make the following recommendation:

The Governor should ensure that all relevant mandatory actions in PSI 64/2011 are completed after a prisoner's death.

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