Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren Stapleton, a prisoner at HMP Peterborough, on 4 February 2025

A report by the Prisons and Probation Ombudsman

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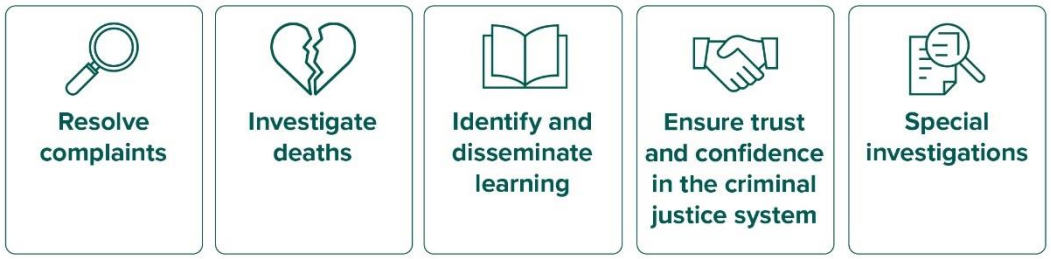
OUR VISION

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

Summary

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Darren Stapleton died from terminal lung cancer on 4 February 2025, while a prisoner at HMP Peterborough. He was 57 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Stapleton received at Peterborough was equivalent to what he could have expected to receive in the community. He made no recommendations.

5. We found that on several occasions Mr Stapleton was taken to hospital restrained with a single cuff, despite having terminal lung cancer and being on end-of-life care. Peterborough did not demonstrate that the use of restraints on Mr Stapleton was proportionate to the risks he posed.

6. We also found that there was a delay in submitting a complete Early Release on Compassionate Grounds (ERCG) application to the Public Protection Casework Section (PPCS) for consideration. The prison did not submit the application in a timely manner, and once submitted, it was returned as incomplete.

Recommendations

- The Director and Head of Healthcare should ensure that escort risk assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

The Investigation Process

7. HMPPS notified us of Mr Stapleton's death on 4 February 2025.

8. NHS England commissioned an independent clinical reviewer to review Mr Stapleton's clinical care at HMP Peterborough. The clinical review is attached as Annex 1.

9. The PPO investigator investigated the non-clinical issues relating to Mr Stapleton's care.

10. The Ombudsman's office wrote to Mr Stapleton's next of kin, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Peterborough

12. Mr Stapleton was the 22nd prisoner to die at HMP Peterborough since February 2022. Of the previous deaths,16 were from natural causes, three were drug-related, one was self-inflicted, and one was a homicide. There are no similarities between the findings in our investigation into Mr Stapleton's death and the findings from our investigations into the previous deaths.

Key Events

13. On 30 May 2024, Mr Darren Stapleton was sentenced to six years in prison for sexual offences. He was sent to HMP Peterborough.

14. At his reception health screens, the nurses noted that Mr Stapleton had been diagnosed with terminal lung cancer on 26 October 2023, was under the care of oncology (cancer) specialists at hospital and was on chemotherapy medication. Mr Stapleton had no history of mental health problems or substance misuse issues. Nursing and medical staff saw Mr Stapleton regularly to help manage his symptoms, which were predominantly rib pain and shortness of breath.

15. On 20 August, a palliative care consultant, and Nurse A, a palliative care nurse, saw Mr Stapleton for a review to manage his symptoms. The palliative consultant prescribed Mr Stapleton with a slow-release opioid patch and morphine to manage his pain.

16. On 22 August, Dr B, a consultant oncologist, had a telephone review with Mr Stapleton. He arranged for further tests to be completed due to concerns about the strain on Mr Stapleton's heart.

17. On 24 August, Mr Stapleton was moved to a cell in the male healthcare unit. Over the following weeks, Mr Stapleton's pain appeared to be managed well.

18. On 12 September, prison staff escorted Mr Stapleton to hospital for a computed tomography (CT) scan. He was restrained using a single handcuff (meaning he wore a handcuff on one wrist, attached to an officer by the other handcuff), however while having the scan prison staff removed the single handcuff and replaced it with an escort chain (where a prisoner is restrained by a single handcuff and long cable attached to an officer). They reapplied the single handcuff after Mr Stapleton's scan.

19. On 11 October, a nurse called an ambulance after Mr Stapleton had been vomiting and he appeared unwell. Paramedics attended but Mr Stapleton said he did not want to go to hospital.

20. Later that day, Dr C, a GP at the prison, met with Mr Stapleton to discuss end-of-life care as it was apparent that his health was deteriorating, and he was having more pain and nausea. Mr Stapleton decided he did not wish to be resuscitated if he stopped breathing and signed a form to confirm this.

21. Over the following weeks, Mr Stapleton's case was discussed weekly at multi-disciplinary team meetings, attended by the prison healthcare team, a representative from the prison and Mr Stapleton.

22. On 16 October, Ms D, Prison Offender Manager (POM), started an Early Release on Compassionate Grounds (ERCG) application for Mr Stapleton by completing her section. On 18 October, Dr C, completed the medical section of the application and attached a specialist letter from the prison palliative consultant. On 2 December, a senior manager completed the application and sent it to the Public Protection Casework Section (PPCS) for consideration.

23. On 28 November, prison staff escorted Mr Stapleton to a hospital appointment. He was restrained using a double handcuff (where a prisoner has their hands cuffed together with one set of handcuffs, and then another handcuff on one wrist attached to an officer).

24. On 3 December, the PPCS returned the application to the prison as it was incomplete. They noted there was no Community Offender Manager (COM) contribution, no risk management plan and no social care arrangements considered. The prison responded and said they would revisit the application and resubmit it once complete. The prison did not resubmit the application because Mr Stapleton decided that he wanted to die in prison.

25. On 10 December, prison staff escorted Mr Stapleton to a hospital appointment. He was restrained using a single handcuff.

26. Throughout the rest of the year, Mr Stapleton continued to experience pain and was seen frequently by healthcare professionals. Dr C increased his pain relief medication at appropriate intervals. The healthcare team conducted weekly palliative care reviews.

27. On 7 January 2025, the prison palliative consultant reviewed Mr Stapleton as he was becoming increasingly frail and complaining of more pain. She stopped his chemotherapy as it had become ineffective and prescribed him injectable anticipatory medicines (strong medications which are used at the end-of-life). Mr Stapleton's condition continued to deteriorate.

Events of 4 February 2025

28. On 4 February, nursing staff reviewed Mr Stapleton every two hours and prison staff checked on him four times an hour.

29. At 3.14am, a nurse checked on Mr Stapleton and found he was not breathing. Nurses assessed that he had died. They did not attempt CPR in line with his directions. Later that morning, Dr C pronounced life extinct.

Post-mortem report

30. The Coroner accepted the cause of death provided by the GP at the prison and no post-mortem examination was carried out. The GP determined that Mr Stapleton died from terminal lung cancer.

Findings

Clinical findings

31. The clinical reviewer concluded that the clinical care Mr Stapleton received at Peterborough was equivalent to what he could have expected to receive in the community. He found that Mr Stapleton had regular nursing reviews and saw the GP and palliative care consultant frequently. He concluded that Mr Stapleton received timely, holistic and multi-professional care. He made no recommendations.

Restraints, security and escorts

32. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

33. A judgment in the High Court in 2007, known as the Graham Judgment, made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when he has a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. The Prevention of Escape: External Escorts policy framework states that restraints should not routinely be used where mobility is severely limited such as in the case of advanced age and ill health.

34. On 12 September and 10 December, Mr Stapleton was taken to hospital restrained with a single cuff and on 28 November, he was taken to hospital restrained with a double cuff. Although he had terminal lung cancer and was on end-of-life care, healthcare staff did not object to restraints being used in Mr Stapleton's risk assessments. Mr Stapleton had limited mobility, had no disciplinary hearings in prison and there was no intelligence to suggest he posed a risk of escape or harm to the public. Despite this, Peterborough assessed Mr Stapleton's risk as medium and restrained him.

35. We consider that Peterborough did not demonstrate that the use of restraints on Mr Stapleton was proportionate to the risks he posed. The decision to restrain him during medical appointments in the months leading up to his death was unjustified, particularly as two escort officers escorted him. We make the following recommendation:

    The Director and Head of Healthcare should ensure that escort risk assessments fully take into account the health of a prisoner and are based on the actual risk he presents at the time.

Director to note

Compassionate release

36. On 16 October 2024, Ms D, POM, started Mr Stapleton's ERCG application which was completed and sent to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS) on 2 December. Although Mr Stapleton's application was started and compiled in a timely manner, there was a significant delay in the prison sending it to the PPCS for consideration. On 3 December, the PPCS returned the application to the prison as it was incomplete.

37. The Early Release on Compassionate Grounds Policy Framework says that when a COM is yet to be assigned to a case, a duty COM must complete the relevant section of an application. As Mr Stapleton did not have an allocated COM, we would have expected the prison to send the application to the relevant Probation Delivery Unit (PDU) for allocation to a duty COM for completion. The prison told us that they were undergoing management changes at the time, which impacted on Mr Stapleton's application. We consider that these factors contributed to the overall delay in submitting the initial application. We bring this to the Director's attention.

Staff debrief

38. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed. It also provides those directly involved with an opportunity to process events and receive support.

39. Peterborough staff told us that following Mr Stapleton's death there was no debrief. They told the investigator that there was a lack of understanding amongst new management, and as Mr Stapleton died while the prison was in night state, senior staff were not on site. We make no formal recommendation on this occasion; however the Director will wish to consider this.

Inquest

40. At the inquest held on 17 May 2025, the Coroner concluded that Mr Stapleton died of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **August 2025**

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