Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Holland, a prisoner at HMP Peterborough, on 4 July 2024

A report by the Prisons and Probation Ombudsman

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

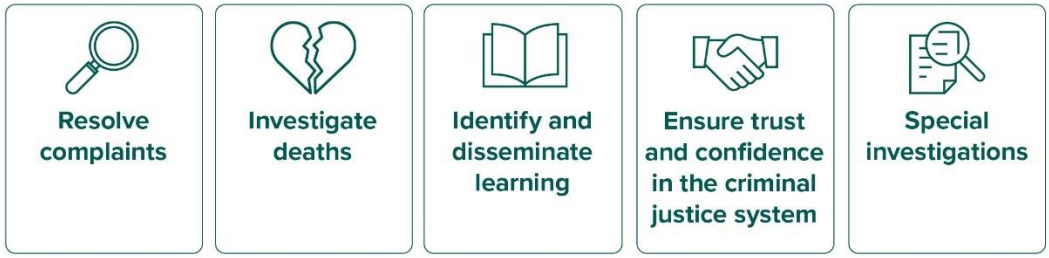
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

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.

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.

Mr Geoffrey Holland died of infective exacerbation of chronic obstructive pulmonary disease on 4 July 2024 at HMP Peterborough. He was 65 years old. I offer my condolences to Mr Holland's family and friends.

The clinical reviewer concluded that the clinical care Mr Holland received at Peterborough was partially equivalent to what he could have expected to receive in the community. Mr Holland had an active Do Not Resuscitate (DNACPR) order in place, however staff commenced resuscitation because they were unaware of the DNACPR.

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

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

Contents

Summary

Events

1. On 16 February 2024, Mr Geoffrey Holland was remanded to prison, charged with having a bladed article in a public place. He was sent to HMP Peterborough. Mr Holland had not been sentenced when he died.

2. Mr Holland had a significant medical history and two days prior to his death, completed a ReSPECT form, including a Do Not Attempt Cardiopulmonary Resuscitation order (DNACPR - if a person has a cardiac arrest or stops breathing suddenly then CPR should not be performed).

3. On 14 May, Mr Holland was admitted to hospital and was told that he needed dialysis because his kidneys were not functioning properly. He was also seen by the heart failure team at the hospital.

4. On 4 June, Mr Holland was discharged from hospital and transferred back to Peterborough. When he returned, healthcare staff completed daily welfare checks and took full clinical observations.

5. On 4 July, at approximately 7.45am, a prisoner found Mr Holland unresponsive in his cell and alerted staff. Staff radioed a medical emergency code at approximately 7.52am. Prison and healthcare staff attended immediately and started cardiopulmonary resuscitation (CPR).

6. At approximately 8.00am, the paramedics arrived, and the long-term conditions nurse arrived with Mr Holland's DNACPR order. The paramedics advised to stop CPR.

7. At approximately 8.30am, the paramedics confirmed that Mr Holland had died.

Findings

8. The clinical reviewer concluded that the clinical care Mr Holland received at Peterborough was partially equivalent to what he could have expected to receive in the community.

9. She found a disconnect in communication between staff because a ReSPECT form was put in place two days prior to Mr Holland's death, but there was no record of this on the wing, which resulted in prison staff performing CPR. The clinical reviewer found this was undignified and not in Mr Holland's best interest.

The Investigation Process

10. HMPPS notified us of Mr Holland's death on 4 July 2024.

11. 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. One prisoner responded and she addressed his concerns in a separate letter.

12. The investigator obtained copies of relevant extracts from Mr Holland's prison and medical records.

13. The investigator interviewed four members of staff on 13 September 2024.

14. NHS England commissioned a clinical reviewer to review Mr Holland's clinical care at the prison. She conducted joint interviews with the investigator on 13 September 2024.

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

16. The Ombudsman's office contacted Mr Holland's family to explain the investigation and to ask if they had any matters they wanted us to consider. They did not respond.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS and Northamptonshire Healthcare NHS Foundation Trust pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Peterborough

18. HMP/YOI Peterborough is a category B local and resettlement prison, managed by Sodexo. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. Northamptonshire NHS Healthcare Foundation Trust (NHFT) provides health services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Peterborough was in January 2024. Inspectors reported interactions between healthcare staff and prisoners were courteous and respectful, and staff were working diligently to make sure care was being delivered. They found the management of patients with long-term conditions had improved; all had a care plan that was reviewed regularly. NHFT had recently rolled out the use of a clear template for care, using best national guidance, and there were plans to help staff improve their use of them.

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 2023, the IMB reported that prisoners were treated with respect, care, and compassion. Prisoners were often critical of health services, and communication about health matters were weak, which led to misunderstandings and unrealistic expectations.

Previous deaths at HMP Peterborough (male side)

21. Mr Holland was the 17th prisoner to die at Peterborough since July 2021. Of the previous deaths, 14 were from natural causes, one was self-inflicted, and one was drug related. There are no similarities between our findings in the investigation into Mr Holland’s death and the investigation findings for the other deaths.

Key Events

22. On 16 February 2024, Mr Geoffrey Holland was remanded to HMP Peterborough charged with having a bladed article in a public place. Mr Holland had not been sentenced prior to his death.

23. Mr Holland was in poor health when he arrived at Peterborough and had pre-existing health issues, including acute kidney injury (AKI), myocardial infarction (heart attack), chronic obstructive pulmonary disease (COPD - a group of lung conditions that cause breathing difficulties), oesophageal varices, and alcoholic liver disease and cirrhosis.

24. Mr Holland was admitted to hospital from 14 March until 22 March, when he was treated for sepsis and AKI.

25. On 25 March, a GP at the prison discussed a ReSPECT (Recommended Summary Plan for Emergency Care and Treatment) form. Mr Holland said that he did not want to be resuscitated if staff found him unresponsive. Healthcare staff did not hold a follow up review for the ReSPECT form, and one was not activated at that time.

26. Mr Holland was admitted to hospital for a second time from 27 March to 4 June, when he was treated for low haemoglobin levels, an elevated CRP (C-Reactive Protein - increases when there is inflammation in the body) and deranged kidney function. While in hospital, Mr Holland acquired pneumonia and needed intravenous (IV) antibiotics. (The hospital twice discharged him to Peterborough during this period, but, on both occasions, healthcare staff at the prison concluded that he was too poorly to return to the prison and transferred him directly back to hospital.)

27. When Mr Holland returned to Peterborough, a nurse completed a full set of physical observations, and they were all within an acceptable range and did not indicate any concerns. Healthcare staff had put a plan in place to change Mr Holland's medication and to complete daily physical observations. Mr Holland was not able to return to the healthcare inpatient unit due to it being closed for refurbishment, so he returned to the safeguarding unit, and a plan was made for healthcare staff and prison staff to complete daily welfare checks.

28. On 2 July, a palliative care consultant held a care review with Mr Holland and the chronic disease nurse. During this review, they discussed whether Mr Holland wanted staff to attempt to resuscitate him if he stopped breathing and Mr Holland agreed to a DNACPR. The consultant completed a ReSPECT form with DNACPR instructions. However, the nurse did not pass this information on to the prison staff on Mr Holland's wing or scan it on his medical records. Prison staff were not aware that the DNACPR was in place.

Events of 4 July 2024

29. At approximately 7.45am, an officer unlocked the prisoners for breakfast, this included Mr Holland's cell. He then went into the office for the morning briefing.

30. In a statement, a prisoner said that he went to Mr Holland's cell, but he did not get a response from him so thought he was sleeping. He went to collect Mr Holland's

breakfast pack. When he returned, he realised Mr Holland had not moved at all and he tried to wake him up. He then checked to see if Mr Holland had a pulse but could not detect one and found that Mr Holland felt cold. He alerted an officer and told him that Mr Holland needed medical attention because he was not breathing, and he could not feel a pulse.

31. At about 7.52, the officer attended Mr Holland's cell with another officer, who radioed an emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties) while an officer checked for his vital signs.

32. Both officers started CPR. The duty SPCO attended and radioed the control room informing them an ambulance was required and healthcare staff needed to attend. The SPCO and one officer moved Mr Holland to the floor to provide more room and continued with CPR. A nurse was already on the wing and was first on scene. She brought the oxygen and took over CPR. None of the staff who were first on scene were aware of Mr Holland's DNACPR order. At interview, the SPCO said that prison staff rely on healthcare staff to inform them that these are in place.

33. At approximately 7.56am, the ambulance paramedics arrived and continued CPR. At 8.00am, a nurse arrived with Mr Holland's ReSPECT form. The paramedics advised that resuscitation should stop. At approximately 8.30am, the paramedics confirmed that Mr Holland had died.

Events following Mr Holland's death

34. Following Mr Holland's death, the prison opened an internal investigation into the actions of one of the officers involved. They were concerned that he did not conduct a welfare check and assure himself that Mr Holland was alive and well when he unlocked him for breakfast. The officer was suspended pending the outcome of the investigation. The prison told us that the officer left Sodexo employment before the investigation was completed.

Contact with Mr Holland's family

35. While Mr Holland was in hospital for the second time, the prison appointed a family liaison officer (FLO) due to the decline in Mr Holland's health.

36. Mr Holland did not have any next of kin details on his record, so the FLO visited Mr Holland in hospital to ask him for any family members' contact details. Mr Holland gave the name of his brother-in-law but was unable to provide an address or phone number.

37. Following Mr Holland's death, the FLO checked with numerous other stakeholders to see if any next of kin details had been recorded but nothing had been. He exhausted all avenues to try and locate any family members, but he was unsuccessful.

38. The prison contributed towards funeral costs in line with policy.

Support for prisoners and staff

39. After Mr Holland's death, two senior managers 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.

40. The prison posted notices informing other prisoners of Mr Holland'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 Holland's death.

Post-mortem report

41. The post-mortem report gave Mr Holland's cause of death as infective exacerbation of chronic obstructive pulmonary disease. Hepatic cirrhosis (severe scarring of the liver) and left ventricular hypertrophy (thickening of the heart muscle) were contributing factors but did not directly cause his death.

Findings

Clinical care

42. The clinical reviewer concluded that the clinical care Mr Holland received at Peterborough was partially equivalent to that which he could have expected to receive in the community.

Emergency response and delivery of CPR

43. Two days before Mr Holland died, he agreed to a ReSPECT form being completed, including a DNACPR. The clinical reviewer found a disconnect in communication between staff because there was no record of this on the wing or in his medical records, which resulted in CPR being commenced against his wishes. She found this was undignified and not in Mr Holland's best interest.

44. During interviews, staff told us that all DNACPR paperwork was kept in the wing office, and it was also displayed on a board in the office. However, Mr Holland's ReSPECT form was not scanned onto his medical records and a copy was not sent to the wing. The ReSPECT form was not added to Mr Holland's medical records until after he died.

45. At interview, the Head of Healthcare said the chronic disease nurse was new to the prison at the time of Mr Holland's death and was unaware a copy of the ReSPECT form should have been given to wing staff. She spoke to the nurse after Mr Holland's death. The nurse said that she did give someone a copy of the ReSPECT form, but she could not remember who, and she also did not share that information with the other nurses. Since Mr Holland's death, the Head of Healthcare confirmed that she had introduced a new process to ensure information is shared effectively. In light of this, we make no recommendation.

46. The clinical reviewer made recommendations relating to other aspects of Mr Holland's care, not directly related to his cause of death, which the Head of Healthcare will wish address.

Inquest

47. At the inquest held on 31 January 2025 the coroner concluded Mr Geoffrey Holland died of natural causes.

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