Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Collyer, a prisoner at HMP Peterborough, on 14 January 2023

A report by the Prisons and Probation Ombudsman

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

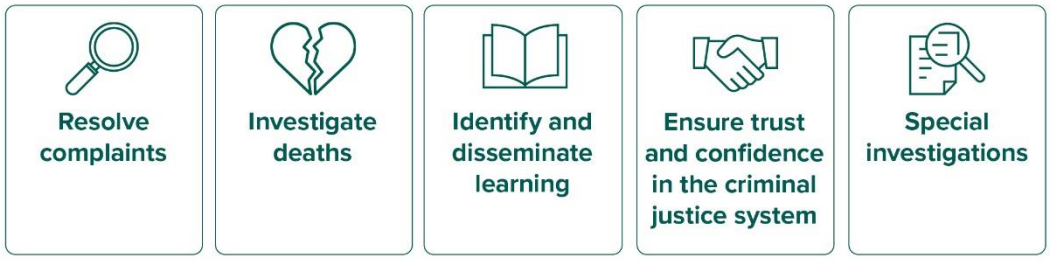
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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 HM Prison and Probation Service in ensuring the standard of care received by those within the 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 John Collyer, a prisoner at HMP Peterborough, died of a heart attack, in hospital, on 14 January 2023. He was 54 years old. I offer my condolences to Mr Collyer's family and friends.

I am satisfied that Mr Collyer's clinical care was equivalent to that which he could have expected to receive in the community and that resuscitation attempts were managed appropriately after he was found unresponsive in his cell, the day before his death.

I commend the prison's family liaison officers for immediately notifying Mr Collyer's partner that he was undergoing a medical emergency, and for their visible and consistent support while Mr Collyer was in hospital.

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 **December 2024**

Contents

Summary

Events

1. Mr John Collyer was remanded to HMP Peterborough on 13 May 2022, charged with harassment and breaching a restraining order. Over the next few months, he had no significant physical health problems.

2. In November, Mr Collyer's mental health began to deteriorate and he was diagnosed with persistent delusional disorder. After damaging his cell on 21 December, he was forcibly moved to the segregation unit. He was admitted to the healthcare inpatient unit the next day and monitored hourly.

3. At around 3.25pm on 13 January 2023, a prison custody officer found Mr Collyer unresponsive in his cell in the inpatient unit. Prison staff and paramedics performed cardiopulmonary resuscitation. Mr Collyer was then taken to hospital, where he had surgery and was placed on a ventilator in the intensive care unit.

4. On 14 January, the hospital withdrew Mr Collyer's treatment and he died at 2.47pm.

Findings

5. The clinical reviewer considered that Mr Collyer's clinical care was reasonable and the emergency response was appropriate. She concluded that his care was equivalent to that which he could have expected to receive in the community. The clinical reviewer made one recommendation about mental health referrals, which the Head of Healthcare will need to consider.

6. The investigation found no non-clinical issues of concern.

7. We commend the family liaison officers for immediately notifying Mr Collyer's partner of the emergency while he was receiving cardiopulmonary resuscitation and for the high level of support while Mr Collyer was in hospital.

The Investigation Process

8. The PPO was notified of Mr Collyer's death on 14 January 2022. 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.

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

10. NHS England commissioned an independent clinical reviewer to review Mr Collyer's clinical care at the prison.

11. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

12. The Ombudsman's family liaison officer contacted Mr Collyer's partner to explain the investigation. Mr Collyer's partner asked for several matters to be considered, which are addressed in this report and the clinical review report, including:

    - Mr Collyer had lost a lot of weight since May 2022 and he was concerned that this might have been due to malnutrition, or ill treatment.
    - Had Mr Collyer been deprived of exercise outside, as his skin was very pale?
    - Mr Collyer had unhealed wounds, including one on his foot.
    - Was the correct medication prescribed for depression?
    - Had Mr Collyer taken illicit substances?
    - Were the resuscitation attempts prompt and appropriate?

13. We shared our initial report with HMPPS. They found no factual inaccuracies.

14. We sent a copy of our initial report to Mr Collyer's partner. They did not notify us of any factual inaccuracies.

Background Information

HMP Peterborough

15. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in separate parts of the prison. Healthcare services are available 24 hours a day, under the provisions of Sodexo's contract with the Ministry of Justice.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Peterborough was in November 2020. Inspectors reported that several aspects of the healthcare service had improved since the previous inspection. The healthcare department had maintained strong clinical leadership, with adequate staffing levels and effective nurse triage.

17. Inspectors also found that the healthcare inpatient unit had a more clinical focus. Care plans were in place and prisoners were admitted to the unit for clinical rather than operational reasons. Some mental health referrals had not been followed up, but there was prompt access to a psychiatrist.

Independent Monitoring Board

18. 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 31 March 2022, the IMB reported that healthcare staff did their best to provide the full range of services, but many prisoners reported dissatisfaction with healthcare services. The healthcare department had continued the new process of triaging requests for GP and nurse appointments. This enabled them to find out more about specific needs and take action on simple requests. This had reduced the number of cancellations and non-attendance of appointments.

19. Inspectors also noted that several prisoners required a place in a mental health hospital and the shortage of such places had put additional pressure on mental health staff in dealing with increasingly unwell patients.

Previous deaths at HMP Peterborough

20. Mr Collyer was the 15th prisoner at Peterborough to die since January 2020. Ten of the previous deaths were from natural causes, two were self-inflicted and two due to substance misuse. There have been two further deaths, one was from natural causes and the cause of the other has yet to be determined. There are no significant similarities between the circumstances of Mr Collyer's death and those previously investigated.

Key Events

21. Mr John Collyer was remanded to HMP Peterborough on 13 May 2022, charged with harassment and breaching a restraining order. It was not his first time in prison.

22. Mr Collyer's initial and secondary health screens were held on 13 and 17 May, respectively. Healthcare staff identified no chronic physical health conditions. However, he had been diagnosed with depression and had a history of substance misuse. Mr Collyer declined referrals to the substance misuse service and a specialist alcohol treatment service. Over the following months, Mr Collyer had minimal contact with healthcare staff.

23. On 8 November, Mr Collyer was examined by a nurse after an assault in which he sustained bruising to his left forehead and left ribcage. No other wounds were recorded.

24. After an assessment on 24 November, two forensic psychiatrists diagnosed that Mr Collyer had persistent delusional disorder. They concluded that he was unfit to plead at court and recommended detention under section 36 of the Mental Health Act 1983 (the provision to admit a remand prisoner to hospital to treat a mental health disorder). The transfer was being pursued at the time of Mr Collyer's death.

25. From the beginning of December, Mr Collyer became paranoid and increasingly agitated. On 21 December, due to threatening behaviour and damaging his cell, he was forcibly taken to the separation and care unit (also known as segregation). A nurse noted red marks on his wrists, caused by handcuffs, but no other injuries were recorded.

26. On 22 December, Mr Collyer was moved to the healthcare inpatient unit, where he was monitored hourly. He remained unsettled and refused to engage with operational, healthcare or chaplaincy staff. Three staff were required to be present to unlock his cell. Mr Collyer often declined medication, clinical observations, food, showers and time in the open air.

Events of 13 and 14 January 2023

27. On 13 January 2023, Mr Collyer's mood varied. A nurse noted that when he checked him through the cell hatch during the morning ward round, Mr Collyer did not engage with him. At 10.50am, Mr Collyer refused clinical observations and he declined his medication and meals. At 2.15pm, he was agitated and refused a blood test.

28. Just after 3.25pm, a senior prison custody officer (SPCO) conducted Mr Collyer's hourly check. He looked through the cell hatch and Mr Collyer was lying on his back, with his arms on his chest and his mouth open. The SPCO beckoned a prison custody officer (PCO) to the cell to ask if this was Mr Collyer's normal sleeping position and the PCO said no. Both officers went into the cell and there was no response when they tried to rouse him. The SPCO began chest compressions, while the PCO radioed a code blue emergency (which indicates that a prisoner has breathing difficulties or is unresponsive).

29. Shortly afterwards, two nurses attended with a defibrillator and oxygen. Additional nurses followed. During the resuscitation attempt, Mr Collyer had a cardiac arrest and a shock was given.

30. The first paramedic crew arrived at 4.38pm and further shocks were given. At 4.42pm, the paramedics took Mr Collyer to Royal Papworth Hospital, escorted by two prison custody officers, with no restraints applied. During the journey, he had another cardiac arrest.

31. Hospital staff performed emergency surgery to insert a stent in an artery. He was then admitted to the intensive care unit and placed on a ventilator.

32. On 14 January, the hospital withdrew Mr Collyer's life support and he died at 2.47pm that day.

Contact with Mr Collyer's family

33. During the medical emergency on 13 January, the prison's family liaison officer informed Mr Collyer's partner that Mr Collyer had been found unresponsive and that paramedics were trying to resuscitate him. The family liaison officer and their deputy agreed to meet Mr Collyer's partner at the hospital. They arrived shortly after 5.00pm and stayed with him to provide support until visiting time ended at 10.00pm.

34. The next morning, the family liaison officer informed Mr Collyer's partner that Mr Collyer had deteriorated and was unlikely to survive. The family liaison officer and their deputy met him at the hospital, arriving well in advance to prepare him for what to expect and help him to understand the information given by the medical staff. They remained with him until after Mr Collyer had died and explained the processes to be followed.

35. The prison arranged and paid for Mr Collyer's funeral, which was held on 9 February.

Support for prisoners and staff

36. After the emergency response, the Director and other prison managers debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support.

37. The prison posted notices to inform other staff and prisoners of Mr Collyer's death, as well as offering support.

Post-mortem report

38. The post-mortem report concluded that Mr Collyer died from a myocardial infarction (heart attack) caused by coronary atherosclerosis - stented (coronary heart disease).

39. The inquest, held on 7 August 2023, concluded that Mr Collyer died from natural causes.

Findings

Clinical care

40. The clinical reviewer concluded that Mr Collyer's clinical care at Peterborough was of a reasonable standard and equivalent to that which he could have expected to receive in the community. She also considered the actions taken during the emergency response were appropriate.

41. The clinical reviewer made a recommendation about mental health referrals, which the Head of Healthcare will need to consider. As it was unrelated to Mr Collyer's cause of death, we have not repeated it in this report.

Non-clinical findings

42. There were no non-clinical findings of concern.

Good practice

43. We commend the prison and the family liaison officers for giving priority to informing Mr Collyer's partner that Mr Collyer was undergoing cardiopulmonary resuscitation in the prison and would be taken to hospital. This allowed his partner to go to the hospital at an early stage to spend time with Mr Collyer before he died. The family liaison officers also provided an exceptional standard of face-to-face support throughout the period that Mr Collyer was in hospital, to help ensure that Mr Collyer's partner understood and was able to cope with the gravity of the illness and the likely outcome. The Director will want to share our commendation with the staff involved.

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