

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Baby D, the child of a prisoner at HMP Peterborough, on 30 May 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



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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. The PPO also has discretion to investigate neonatal deaths and stillbirths that occur in hospital following transfer from prison.
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. Baby D died at Peterborough City Hospital on 30 May 2025 shortly after being born. The baby's mother, Ms D, was admitted to hospital from HMP Peterborough on 26 May due to medical concerns. I offer my condolences to Ms D, her partner and family.
4. The clinical reviewer concluded that the clinical care Ms D received at HMP Peterborough was of a very good standard and was equivalent to that which she could have expected to receive in the community.
5. We found that the prison's approach to looking after Ms D was caring and compassionate.

The Investigation Process

6. HMPPS notified us of Baby D's death on 3 June 2025.
7. NHS England commissioned an independent clinical reviewer to review the clinical care provided to Ms D at HMP Peterborough. The clinical review is attached as Annex 1.
8. The PPO investigators investigated the non-clinical issues relating to Ms D's care. They visited Peterborough on 17 June and introduced themselves to Ms D and explained the remit of the investigation. Ms D had no specific questions that she wanted us to investigate but asked for a copy of our report.
9. The investigators obtained copies of relevant extracts from Ms D's prison and medical records along with a copy of HMPPS' Early Learning review.
10. The investigators carried out one interview by video conference on 4 August.
11. Baby D's family received a copy of the draft report. The solicitor representing them provided us with some clarification relating to three paragraphs within the report. However, this has not changed our findings.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Peterborough

13. HMP Peterborough is operated by Sodexo Justice Services. It holds adult men and women in separate sides of the prison. The women's side of the prison includes a separate Mother and Baby Unit which can accommodate twelve mothers. There is also a wing which is predominantly for pregnant women and long-term prisoners.

HMP Inspectorate of Prisons

14. The most recent inspection of HMP Peterborough (women) was in November 2023. The Chief Inspector concluded that overall the prison continued to be a competent and capable institution and it was generally safe.
15. They noted that relationships between staff and prisoners were supportive. Most officers working regularly on the women's site knew prisoners in their care well and showed a good level of compassion and respect when dealing with complex emotional issues.
16. Inspectors recorded that antenatal and postnatal care reflected what is offered in the community and that the multi-agency partnership worked well and delivered good quality care. Pregnant women had access to a 24-hour midwifery advice line and there were a number of professionals' meetings which provided oversight and a coordinated approach to the care of women with pregnancy related issues.

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 latest annual report for the year to 31 March 2024, the IMB reported that their principal concern was the impact on prisoners of population pressures, staff shortages, management changes and poor-quality purposeful activity. They said that as well as planned regime restrictions, exercise and time out of the cell was curtailed at short notice, which was affecting prisoners' morale.

Key Events

18. On 1 April 2025, Ms D was sentenced to 2 years and 6 months in prison for fraud by abuse of position and she was sent to HMP Peterborough. She had not been in prison before.
19. Ms D was approximately 12 weeks pregnant with an estimated delivery date of 13 October 2025.
20. On arrival Ms D was seen by a nurse for an initial health check. Ms D told the nurse that she had been having scans every two weeks in the community due to a sub chronic hematoma (a pooling of blood between the membrane surrounding the embryo and the uterine wall). As a result, Ms D was initially located in the female healthcare unit.
21. The nurse contacted Ms D's maternity team in the community to get more information. She also notified all relevant colleagues within the prison about Ms D's circumstances.
22. On 2 April, a nurse spoke to the community maternity team, who said that Ms D was due to have a 12-week scan that day. It was agreed that a Specialist Prison Midwife would arrange for Ms D's maternity care to be transferred to Peterborough City Hospital.
23. On the same day, a Perinatal and Mother and Baby Unit and Families Lead and a Pregnancy and Mother and Baby Liaison Officer met with Ms D and they started a pregnancy care and management plan (a joint record for operational and healthcare staff to use and refer to).
24. On 4 April, Ms D went to Peterborough Hospital for her 12-week scan. The scan showed that the sub chronic hematoma had reduced in size and there were no other concerns.
25. On 7 April, Ms D moved to D1, which is a wing for pregnant prisoners.
26. On 17 April, the Perinatal Review Board (a fortnightly multi-disciplinary meeting to discuss the care and management of pregnant prisoners) took place. Ms D's care was reviewed.
27. At 8.20am on 18 May, a nurse visited Ms D as part of her daily pregnancy welfare check. Ms D reported that she had seen a dark blood clot when using the toilet. Ms D was told to use a pad so that they could monitor if there was any further blood loss and to let them know. The nurse wrote in the medical record that she told wing staff to contact healthcare staff if support was required.
28. At 5.20pm, the nurse saw Ms D on the wing. Ms D reported further bleeding and said she had experienced some stomach cramps.
29. At 6.30pm, the nurse spoke to the maternity unit at Peterborough Hospital who told her that Ms D should attend hospital for an examination. The nurse recorded that she would speak to the duty officer to arrange for Ms D to be escorted to hospital. Ms D left for hospital at 9.37pm.

30. At 00.05am on 19 May, Ms D returned to prison. An officer recorded in her prison file that there were no concerns for either Ms D or her baby.
31. At 8.18am, a nurse went to see Ms D as she had reported more blood loss. Following a discussion with the midwife and the hospital maternity team it was decided that Ms D should return to hospital for an assessment. She left the prison at 11.35am.
32. Ms D returned later the same day. The hospital told the healthcare team that they had carried out tests and the baby's heartbeat was fine.
33. On 21 May, Ms D attended hospital for the 20-week scan accompanied by a nurse. The results from the scan were satisfactory.
34. At 10.13pm, Ms D used her cell call bell. She said that she had called the hospital's maternity line, using her in-cell telephone, about some further blood loss and they told her to attend hospital. Ms D was escorted to hospital at 11.50pm.
35. On 23 May, a Release on Temporary Licence (ROTL) Board meeting took place. They agreed that Ms D would be given ROTL using a special purpose licence (SPL) which would allow her to attend hospital unescorted for the next six days.
36. On 25 May, Ms D returned to prison and was seen by healthcare staff. She told them that both she and baby were well.
37. At 8.39am on 26 May, Ms D used her cell call bell to ask for healthcare staff, because of new blood loss. A nurse attended and examined Ms D and agreed that she would speak to the hospital maternity team. Approximately 10 minutes later Ms D reported a further and more significant blood loss and the decision was made that she should go to hospital. Ms D left the prison unescorted around 9.30am. Ms D was provided with a mobile phone so that the prison and healthcare team could remain in contact with her. There were no restrictions on her partner or family being with her to provide support at the hospital.
38. On 28 May, the Pregnancy and Mother and Baby Liaison Officer and the Perinatal and Mother and Baby Unit and Families Lead visited Ms D in hospital. They provided her with a new SPL which allowed her to remain in hospital unescorted until 3 June.

30 May

39. At around 12.30pm on 30 May, Ms D's mother contacted the prison and informed them that Ms D had given birth to her baby at 8.20am but the baby had died a short while later. The baby was born at 21 weeks and two days. Healthcare staff immediately contacted the hospital for further information and were told that Ms D was not well enough to be moved to the ward and remained in the delivery suite.
40. Following the call from Ms D's mother, a Safer Custody Manager for the female estate, a Prison Custody Officer from the Safer Custody Team for the female estate, and a Senior Prison Custody Officer made their way to the hospital. The Perinatal and Mother and Baby Unit and Families Lead told us that a further two operational staff also attended to provide additional support for Ms D. (This was

later reduced to one as it was felt that two were not required.) The Perinatal and Mother and Baby Unit and Families Lead said that she believed that only the Senior Prison Custody Officer entered the room where Ms D was located.

41. Ms D told the investigators that while she was in the recovery suite she was made aware that a number of prison staff had arrived. On reflection she said that this had felt overwhelming at the time.
42. The Head of Female Prison Peterborough told the investigators that she was made aware that hospital staff had queried why so many staff had arrived at the prison.
43. The Deputy Director of Peterborough told the investigators that on being notified of the death of Baby D he made the decision to change Ms D's SPL to an escorted SPL and asked for two officers to be sent to the hospital to provide Ms D with support. The Deputy Director said that he when he made the decision he was not aware if any officers were already there. The Deputy Director said that there was no requirement for the change of licence to be documented outside of the actual licence paperwork itself.
44. At approximately 2.45pm, the Prison Offender Manager attended the hospital to change the licence.

Care for Ms D following Baby D's death

45. While Ms D was in hospital she received support from family members. As well as the support provided by the escort officer, healthcare staff regularly contacted Ms D by phone. The Pregnancy and Mother and Baby Liaison Officer and the Perinatal and Mother and Baby Unit and Families Lead also visited her.
46. The Senior Prison Custody Officer was appointed as the family liaison officer, for continuity and in recognition of the positive relationship that already existed between him and Ms D. A referral was also made to the Perinatal Mental Health Lead to initiate support for Ms D.
47. The prison arranged for Baby D's birth and death to be registered, with Ms D and her partner both present. They also spoke to her about where she would like to be located once she returned to prison.
48. On 5 June, a ROTL board meeting took place and Ms D was given a four-night resettlement licence allowing her to return to her home. Ms D was discharged from hospital.
49. Later the same day, the Prison Offender Manager moved all of Ms D's possessions to a cell on a different wing. She made the bed and took care to unpack her possessions so that Ms D did not have to do this when she returned to prison on 9 June.

Support for prisoners and staff

50. On the 30 May, the Head of Female Prison Peterborough carried out a hot de-brief with staff who were involved in the care of Ms D. Support was made available through the staff care team and the trauma risk management team. A cold de-brief

was scheduled after fourteen days and was also carried out by the Head of Female Prison Peterborough.

Post-mortem report

51. Ms D opted not to have a full post-mortem examination of Baby D.

Findings

Clinical findings

52. The clinical reviewer concluded that the clinical care extended to Ms D was of a very good standard and equivalent to that she would have received in the wider community. She identified a number of areas of good practice.

Non-clinical findings

53. From the outset, Ms D was managed in line with the prison's perinatal pathway. The pathway, which is very comprehensive and aims to meet the specific needs of women who are pregnant in prison, outlines the process which should be followed to ensure there is a safe and holistic approach to care and risk management for pregnant prisoners.
54. When Ms D began to have episodes of blood loss she was able to liaise directly with the hospital maternity unit. The prison arranged for her to attend hospital as and when required.
55. When it became apparent that Ms D may need to remain in hospital the prison arranged ROTL so that Ms D was able to remain in hospital, where she could be supported by her partner and family, without a prison officer being present. She was provided with a phone which allowed her and the prison to keep in touch.
56. When the prison were notified of the death of Baby D they immediately deployed a number of officers to the hospital to provide support to Ms D. Her licence was changed to ensure that an officer was present to provide support if and when required.
57. While we commend the prison in seeking to provide support quickly, it is evident that while Ms D appreciated prison staff's presence and support, the number of staff that initially went to the hospital was excessive and potentially overwhelming.

Director to note

58. The reasons for changing the special licence on 30 May were not documented in Ms D's prison records.

Good practice

59. The investigators noted several actions that clearly demonstrated that the staff involved with Ms D treated her in a caring and compassionate way. A good example of this was when the prison asked Ms D where she wanted to be located when she returned to prison and the subsequent moving and unpacking of her belongings, including making up her bed ahead of her return.

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April 2026

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