# Investigation into the circumstances surrounding the death of a man at HMP Peterborough in January 2012

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man at HMP Peterborough in January 2012. He died of a heart attack. He was 63 years old. I offer my condolences to his family and friends.

The investigation was carried out by an investigator with the full co-operation of Peterborough Prison. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's clinical care.

The man was in prison for only a week before he died. After his death it was established that he had been assessed as being at high risk of heart disease seven months earlier. However, he had declined to attend appointments and tests to follow this up and had not collected any of his prescribed medications. He did not disclose any of this previous medical history and presented as fit and well during his initial and secondary health screens. He told the prison that he did not know his GP details and his community health records were not obtained.

One morning in January, the man suddenly became unwell and, despite significant efforts by staff and paramedics to revive him, he was pronounced dead at 7.34am. I am satisfied that his death could not have been foreseen by the prison. After his death the prison responded effectively and sympathetically to the needs of his family. Well organised post incident reviews were held which are noted as an area of good practice.

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

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**Prisons and Probation Ombudsman** **July 2012**

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## SUMMARY


1. The man appeared at Crown Court on 20 January 2012 and was sentenced to 18 months imprisonment. On arrival at HMP Peterborough, he had a first reception health screen with a nurse and the next day he was examined by a prison doctor. He did not disclose any significant medical history at either of these screens. Basic observations were taken and were within normal ranges. He was located initially on the induction wing and then moved to residential wing, where he shared a cell with a close family friend, whom he regarded as his nephew.

2. One morning in January, the man woke up feeling unwell. He pressed his cell bell to alert staff. Assistance was requested from healthcare and a nurse examined and treated him in his cell, before he was moved to the healthcare centre. Initially, he was able to walk unaided, but his condition quickly worsened and he was taken to the healthcare centre using a wheelchair.

3. Following his admission to the healthcare centre, the man's condition rapidly deteriorated. He became unconscious and healthcare staff and paramedics unsuccessfully attempted to revive him for over an hour. A prison doctor pronounced death at 7.34am.

4. The prison appointed a family liaison officer (FLO), to break the news to the man's next of kin. A Duty Governor spoke to the man's son and 'nephew' in the chapel to tell them of his death, while the appointed FLO travelled to the family home. His family had already been told that he was not well and were on their way to the local hospital as they thought he had been taken there. When the family returned home, the FLO broke the news of his death and support was offered to them in line with prison policy.

5. The clinical reviewer concludes that the emergency care the man received was of a very high standard. No recommendations are made as a result of this investigation. The standard of the post incident reviews are noted as good practice.

## THE INVESTIGATION PROCESS

6. The investigation was opened on 6 February 2012 by an Assistant Ombudsman who visited HMP Peterborough on behalf of the lead investigator. She met the liaison officer for the investigation and was given all of the man's records. In addition, she met the Director, the Deputy Controller, the Head of Healthcare, nursing staff who responded to the medical emergency and the family liaison officers. She visited the healthcare centre and walked the same route the man took from the wing on the morning that he became unwell. In advance of this visit, notices were issued announcing the investigation to staff and prisoners. No staff or prisoners came forward in response to the notices of the investigation.

7. The lead investigator returned to Peterborough with another investigator, on 23 February. During this visit, they viewed closed-circuit television (CCTV) footage of the man leaving his cell and being escorted to the healthcare centre. The investigators also interviewed five members of staff and four prisoners, two of whom were relatives of his. Both investigators met the Director of the prison immediately after the interviews to give preliminary feedback, which was confirmed in writing to the Director on 28 February 2012.

8. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care. He was provided with all relevant documentation to assist this review and visited Peterborough on 28 February to speak to healthcare staff.

9. The lead investigator contacted the Ambulance Service who provided verification of the contact they had with Peterborough when an ambulance was requested on 27 January.

10. The investigator contacted Her Majesty's Coroner for Peterborough to inform him of the investigation and request a copy of the post-mortem report. The investigation report will be sent to the Coroner to assist his enquiries.

11. One of the office's family liaison officers contacted the man's wife and daughter on 17 February to inform them about the investigation and to allow the family to raise any concerns about his care while he was at Peterborough. The family did not raise any issues with the family liaison officer, but asked the prison FLO why he had a cut on his head when they saw him after his death. The post-mortem report commented on the scratch on his head, but the investigation has been unable to identify the cause of this injury. It is possible that he sustained this injury during resuscitation attempts. The family received copies of the draft report as part of the consultation period. Having considered the investigation findings, no further representations were made in response to the findings.

## HMP Peterborough

12. HMP Peterborough opened in March 2005 and is run by Sodexo Justice Services (SJS). It houses both male and female prisoners in separate sides of the prison. For male prisoners the establishment serves as a category B local (a prison that sends and receives prisoners directly to and from the courts) and holds up to 624 men.

13. The male population is accommodated in two house blocks, each comprising of four wings and each wing has two landings. The accommodation is a mix of single cells and double cells. All cells have integral sanitation. New prisoners stay on an induction wing for the first week.

14. The prison has 24 hour healthcare cover, and clinical staff at the establishment are employed directly by SJS, although there is collaboration with Cambridgeshire and Peterborough NHS Trusts. General Practice (GP) services are commissioned via an agency called Cimarron.

## HM Inspectorate of Prisons

15. HM Chief Inspector of Prisons last conducted an announced inspection of the prison in April 2011. The Chief Inspector concluded that:

> "Overall, it is clear that Peterborough men's prison is an improving institution that has made commendable progress. The good environment and staff-prisoner relationships create the necessary foundation for further development."

In respect to healthcare:

> "New arrivals were given a comprehensive initial health care screening in reception. A GP was usually available to see new arrivals when required. All prisoners also had a secondary screening the following day and were given the opportunity to see the GP.
>
> " … Emergency resuscitation equipment and automated defibrillators were available in the healthcare centre and on each of the house blocks. The equipment was checked daily and all nursing staff were in date for mandatory training in basic life support, including the use of defibrillators."

## Previous deaths in custody at Peterborough

16. There has been one previous natural cause death at Peterborough in the past year. The investigator reviewed the Ombudsman's report into this death and noted that a recommendation was made relating to the inclusion of clinical staff in debrief meetings. Following the man's

death, post incident support and debriefs were held and included relevant clinical staff, as outlined at paragraph 60 of the report.

## KEY EVENTS

17. The man was born in 1948 and lived in the Peterborough area of Cambridgeshire. He appeared at Crown Court on 20 January 2012. He was sentenced to 18 months imprisonment for an offence of attempted theft and was taken to HMP Peterborough. He had previously served a number of custodial sentences.

18. The person escort record completed at court did not note any significant risk issues (a person escort record (PER) is a form that accompanies prisoners on all journeys from and between prisons, police and hospital. It serves as a communication tool about risks a prisoner poses on escort or transfer.) On arrival at Peterborough, the man had an initial health screen, during which he told a nurse that he was not currently prescribed medication, he had no concerns about his physical health and did not provide details of his GP which were recorded as unknown. Although it was not recorded in the electronic medical records, the person who he regarded as his nephew told the investigator that the man was a non-smoker.

19. Initially the man was located on the induction wing. Induction is the process of introducing newly sentenced prisoners into custody. It is designed to explain the immediate consequences of being in custody and explain the regime and rules of the prison. He had disclosed that he was not able to read or write so he was assisted by wing staff, Connections workers (prisoners who provide peer support) and his nephew, with whom he shared a cell.

20. The man was seen by a doctor the following day for his secondary health screen. His blood pressure was recorded as normal at 130/80 (the normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low). He confirmed that he had no physical or mental health problems and no history of substance misuse.

21. On 26 January, the man moved from the induction wing to a residential wing where he continued to share a cell with his nephew. The investigator viewed CCTV during her visit. In this, he was observed to be socialising on his wing that evening, and did not appear to be unwell.

22. According to the cell bell records, the man pressed his cell bell at 5.43am. CCTV footage shows that a Prison Custody Officer (PCO) went to his cell and spoke to him for about a minute through the flap in the cell door. He did not open the cell. During the night state there are only a small number of staff on duty and most do not have a full set of keys to move around the prison. There is a set protocol for opening cells to minimise the potential for security breaches. A cell will only be

opened once a senior manager has given authority unless the situation is assessed as imminently life threatening (during the night the most senior manager is known as Oscar 1).

23. The PCO did not assess the situation as life-threatening but acted promptly and immediately telephoned to request healthcare assistance. He went straight back to the cell at 5.46 and talked to the man until the nurse arrived.

24. As soon as the nurse received the PCO's call she asked for her keys to be brought over from the main gate as she did not have them in her possession. As the prison was moving towards being in daytime state, she was aware that this was the quickest means of assisting the man; otherwise she would have to wait to be escorted. In interview, the nurse said:

> "… I made sure everything is together because if it's chest pain obviously in the morning usually it's cardiac events they come mostly in the morning so while I was waiting for my keys I went to the pharmacy, got some aspirin and GTN spray [glyceryl trinitrate for the management of angina, muscle pain in the heart] and put them in the bag and just waited and then thankfully one of the officers he came very quick, brought my keys and then together we went to the house block… [I] asked a PCO if possible that he can contact the Oscar because I need to go in the cell and check on him."

25. The nurse arrived at the cell quickly at 5.52 and spoke to the man. A Senior PCO (SPCO 1), who was Oscar 1, gave permission for them to enter the cell and at 5.54am the cell door was opened and the nurse went in. The PCO remained outside the cell.

26. The nurse completed some basic observations and the man told her that it felt like he had "swallowed a thousand razor blades". She recorded his blood pressure as normal (120/80) but that he had a low pulse of 48 beats per minute (bpm - normal range is between 60 – 80 bpm). She gave him an aspirin and a GTN spray.

27. The nurse wanted to undertake a full assessment of the man in the healthcare centre due to his symptoms. The healthcare treatment room has an electrocardiogram machine (ECG - measures the electrical activity of the heart to help with diagnosis) and the decision was made to move him.

28. The CCTV footage showed that the man left the cell at 6.01am, put on his t-shirt and walked the length of the wing unaided, escorted by the nurse and PCO. He did not appear to be in any significant distress. The CCTV footage does not cover the entire wing. When he reached the end of the wing, the nurse noticed that he was growing pale. He then leant on the wall, slid down and sat on the floor. She placed an

oxygen mask on his face to assist his breathing and checked his pulse which had increased significantly. She stayed with him and asked the PCO to contact healthcare to get a wheelchair to transfer him to the healthcare centre.

29. SPCO 2, an assistant night manager in healthcare, quickly arrived with a wheelchair and the man was taken to a treatment room in the healthcare centre, arriving at 6.10am. He was assisted onto the medical examination bed. He was still receiving oxygen and his observations were being taken by the nurse. The ECG indicated that there was a problem with his heart, although he was still conscious. She asked SPCO 2 to request an emergency ambulance. The Ambulance Service confirmed this request was made at 6.22am.

30. The nurse began to take some blood for further tests when the man collapsed at 6.25am. During interview she explained that after the ECG test she had considered telephoning the on-call doctor but then decided, very quickly, that an ambulance was needed. A medical emergency alert was called over the radio at 6.25am. She was very quickly joined by two PCOs who were on duty in the healthcare centre and they started cardiopulmonary resuscitation (CPR, an emergency procedure to assist someone who has suffered cardiac arrest). They were joined by SPCO 1 who attached the defibrillator to the man (a portable electronic device that diagnoses heart rhythms after cardiac arrest). The defibrillator indicated that he should be shocked, and the first shock was administered by the machine.

31. The Clinical Lead at Peterborough got to the prison at about 6.30am that morning. She noticed an ambulance going into the prison, confirmed with the gate where it was going and made her way to the healthcare centre. When she got there, she assisted her colleagues and paramedics in administering CPR.

32. Paramedics arrived at Peterborough at 6.28am and at 6.30am began their assessment of the man. A second paramedic team arrived at 6.40am. They completed observations on him while prison staff continued to administer CPR. The paramedics attached their own defibrillator and he received two further shocks. Paramedics administered adrenalin and fluids in an attempt to revive him, but despite their efforts he did not respond and did not regain consciousness.

33. The on call prison doctor arrived at the healthcare centre in Peterborough at 7.30am. He said he went directly to the male healthcare unit and observed that the paramedics were there with nursing staff and officers and that active resuscitation was being carried out. He discussed how long the resuscitation attempt had been happening and discovered it was over an hour. He then examined the man and decided with the agreement of all present that the

resuscitation had failed. The man was pronounced dead by the doctor at 7.34am.

34. A letter was received by Peterborough from the Duty Operations Manager for the Ambulance Service which stated:

> "Staff who attended the incident would like to pass on their appreciation of the efforts of HMP Peterborough staff. This included HMP Peterborough healthcare professionals and prison officers. Together paramedics and HMP Peterborough staff gave the patient [the man] the best chance of survival. Resuscitation efforts are vigorous, intrusive and highly emotional events. The efforts of all attempting to save life should not go unrecognised. Staff should know their efforts assisted to give the patient the best chance of survival."

**Liaison with the man's family**

35. The prison chaplain arrived at Peterborough at 7.43am. He was told that the man had died and he was appointed as the prison family liaison officer (FLO). He was aware that relatives of the man, his son and his 'nephew' were also at Peterborough and another son had recently been transferred to HMP Nottingham. The chaplaincy at Nottingham was contacted and they agreed to break the news to his son. The chaplain arranged for the man's son and 'nephew' to be taken to the chapel so they could be told of his death and he made arrangements to visit the family home.

36. The man's son and 'nephew' were told the news by the Duty Governor and both men were allowed to make a telephone call home and spoke to their respective families. They were joined a short while later by their closest friends in the chapel and they were allowed to spend some time together. After they had been told the news, the 'nephew' was moved to a wing where his closest friend lived to ensure he was well supported. His son was already sharing a cell with a friend.

37. The man listed his wife as his next of kin. Following routine risk assessments the chaplain and an operational manager and a member of the care team (trained staff who have the skills to support others at difficult times), left the prison to go and break the news. They arrived at the family home at 9.30am. However, the man's wife was not present and had in fact driven past them as they approached the address, with the intention of driving to the local hospital because they had been told he had been taken out of the prison in an ambulance. Once the prison representatives arrived at the family home, the man's wife was contacted by a family member and she returned home within a few minutes. The chaplain confirmed that her husband had died and the family were given the prison contact details and explained that Peterborough would facilitate a visit to the prison if the family thought this would be helpful.

38. Later that day, both the man's son and 'nephew' received a visit in the chapel area from their partners and children. In interview, in response to how the prison had responded following the man's death, his son said:

> "they'd [Peterborough] do anything. I got a visit straightaway from my missus. Had no time. I said how long have I got to visit. He said as long as you want. They were marvellous, they were all good really."

39. The prison FLOs maintained contact with the man's family over the subsequent days and additional family visits were arranged in the chapel for his son. One of the prison FLOs visited the man's wife and daughter on 30 January to answer any questions the family had. The prison offered financial assistance with the funeral costs, which was accepted, and ensured that all of his property was returned.

40. The funeral was held on 7 February. The man's son and 'nephew' were given permission to attend and were escorted to the funeral, and the prison FLOs also attended. Support was ongoing for the man's family at Peterborough prison and the prison FLOs continued to have regular contact with his wife and daughter.

### Support for prisoners

41. The man was a well known member of the travelling community and staff at Peterborough were aware that his death would have a significant impact on those prisoners who knew him. Listeners (prisoners trained by Samaritans to offer confidential support to their peers) were briefed at 10.44am to ensure that they were present on the wings and able to provide immediate support. In addition, six prisoners who were subject to ACCT procedures (Assessment, Care in Custody and Teamwork procedures which are pivotal in the management of at-risk prisoners thought to present a risk of self-harm or suicide) were reviewed and monitored. A notice to prisoners was issued by the Director the same day which announced the man's death and expressed condolences. This notice reminded them of the available support, via wing staff, the prison chaplaincy and the Listeners. A memorial service was held in the chapel on 28 January, for all those who wished to attend.

### Support for staff

42. The duty director held a hot debrief with all staff who were involved with the man when he died (a hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support). Ongoing support was made available to staff via the care team and chaplaincy. During interview, staff confirmed that they were contacted

by a member of the care team and were aware that, if they chose to, they could contact them at any point for ongoing support.

**Post-mortem report**

43. A post-mortem examination was undertaken on 31 January. The pathologist concluded the cause of death was due to myocardial ischaemia (when heart tissue is slowly or suddenly starved of oxygen and when blood flow is completely blocked to the heart, ischemia can lead to a heart attack) and coronary artery atheroma (narrowing of the arteries to the heart resulting in reduced blood flow and causing a heart attack). There were no significant findings in the toxicology report. It is noted in the post-mortem report that “there was a very fine scratch on the central part of the forehead”. There is no indication how the man came to have this mark, although it is possible that it occurred during resuscitation attempts.

## ISSUES

### Clinical care

44. A clinical reviewer was appointed by the local Primary Care Trust to review the medical care that the man received while in prison custody. His clinical review looks at the care and treatment the man received at Peterborough and considers whether it was appropriate and equivalent to the care available in the community.

45. When the man entered Peterborough he underwent an initial health screen and subsequent assessment by a prison doctor. In PSO 3050 Continuity of Healthcare for Prisoners, Chapter 2, 2.1 notes “efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he/she has recently been in contact with”. Peterborough prison did not have his GP records as he did not provide the information and he gave no reason for the prison to believe it was important that they were tracked down.

46. The clinical reviewer obtained the community medical records which identified that the man had previously been examined by a cardiologist (heart specialist) at hospital on 21 June 2011. Despite being assessed as a high risk of heart disease, he failed to attend any of the subsequent appointments for follow-up tests and did not collect medications prescribed, which included medication to reduce cholesterol, as well as anti-clotting and anti-angina treatments and heart rhythm stabilisers.

47. The man’s cardiology appointment took place more than seven months before he arrived at Peterborough. He did not disclose this previous contact with a cardiologist or provide details of his community GP during his first reception health screen, or the secondary health screen despite having the opportunity and being asked for them. He presented as fit and well and his blood pressure and pulse were recorded as normal.

### Emergency response

48. The clinical reviewer states:

> “The emergency care of the man was of a very high standard both on the wing and in MHC [male healthcare]. The prison is commended on its preparations for such an event. Because of the almost immediate availability of assessment and CPR, the chances of success of resuscitation are much higher than for a patient having a cardiac arrest at home or in the street. I note that there was no delay in getting the ambulance into the prison as close as possible to the MHC.”

49. In respect to the level of clinical care provided at the point the man became critically ill, the clinical reviewer concludes in his report:

> "Despite the excellent quality of resuscitation, he sadly could not be revived. However, I can find no clinical issue with the management of this emergency situation which certainly provided the best possibility of survival. The appropriate storage of medical supplies on the wing, despite security problems they could pose is to be commended. This is also true of the high quality staff reaction to a rare event, which could have caused panic and confusion, but in this case showed the benefit of training."

In light of the clinical reviewer's conclusions, the investigation found that the emergency response to his collapse was timely and appropriate.

**Notifying the man's family**

50. As outlined in PSO 2710, Follow-up to Deaths in Custody, it is desirable that a senior representative from the prison, or an appointed family liaison officer, breaks the news of a death to the next of kin in person. A chaplain was appointed as the prison FLO, assisted by an operational manager and they left Peterborough at the earliest opportunity to go and break the news to the man's family. Unfortunately, the family had already been alerted to the fact that something was wrong.

51. During his interview, the man's son said that he had told his mother and sister of his father's death when he was taken to the chaplaincy, but was unable to recall what time he telephoned them. However, his telephone call was made after the prison FLO reached the family home. The investigator was unable to establish who had informed the family and at what time.

52. In interview the chaplain said:

> "What we [Peterborough] think piecing it all together has happened is because the man got taken off the wing by the medics in a sense and then from the wing [prisoners] would be aware that an ambulance would have turned up at healthcare because you can see it and then they would see the ambulance leave again. We think perhaps what's happened is that there's been a telephone call from the wing [by a prisoner] to the family and with the assumption that he has gone off to hospital."

53. It is regrettable that the family were contacted before the prison representatives could reach them that morning. However, we are satisfied that the prison followed the correct procedures and without unnecessary delay.

## Attendance at the man’s funeral

54. In certain circumstances, a prisoner may be allowed to leave prison on a temporary licence (ROTL – release on temporary licence), or escorted by prison staff if ROTL is not appropriate, for a precisely defined and specific activity. In order to ensure public safety and maintain public confidence in the system, prisoners are only released on temporary licence or subject to an escort after a risk assessment, which has been approved by an authorised senior manager. In respect to attendance at a funeral, chapter 2.7 2 of PSO 6300 Release on Temporary Licence outlines the criteria that needs to be met for attendance at a funeral:

> “Temporary release should normally be granted for prisoners to attend funerals of close relatives. A close relative is defined as the prisoner’s spouse, parent, child, brother, sister (including half – or step – brothers and sisters), fiancé or fiancée, or a person who has been in loco parentis to a prisoner, or to whom the prisoner has been in loco parentis. However, Governors will want to take account of other close caring relationships that may occur in extended families. It is for the prisoner to establish the closeness of the relationship.”

55. The man’s son could attend his funeral because he was a close relative. However, the man’s ‘nephew’, who was not strictly related to him, did not necessarily meet the criteria set out in PSO 6300 to be granted permission to attend the funeral. Initially, he did not submit an application, as he did not believe that Peterborough would consider a request. However, following a visit by the prison FLO to the family on 29 January, when they requested his attendance at the funeral, he was encouraged to submit an application to the Director, which he did. The Director was aware of the close family dynamics, and the wider cultural impact of the man’s death on the travelling community within which he was a respected elder, and agreed that the ‘nephew’ could attend.

56. The man’s son and ‘nephew’ both attended the funeral, subject to restraints and escorted by Peterborough staff. During interview the man’s son indicated that he was pleased to have the opportunity to say goodbye to his father and see his family. The ‘nephew’ said “I did go and the officers were great, everyone was good they was, yes. You couldn’t ask no better really under the circumstances.”

57. We are pleased to see that the Director was sensitive to the family’s cultural heritage and approved an escorted attendance, allowing the man’s ‘nephew’ to be with his friends and family at the funeral.

**Post death in custody reviews**

58. In addition to the initial hot debrief held on the morning of the man's death, two follow-up meetings were held on 30 January and 16 February, chaired by the Director. The first meeting focussed on ensuring that his family had been properly supported and provided with the necessary information, that staff had been supported and offered ongoing support and that Peterborough had gathered all the documentation relating to him for the subsequent investigation. In the second review, the Director ensured that all actions had been completed and that a formal critical incident debrief had been scheduled for 24 February. The critical incident debrief meeting was attended by all relevant senior managers and focussed on ensuring all contingency plans were adequate and actions from the earlier meetings had been completed.

59. In a previous investigation into a death that occurred at Peterborough in March 2010, we made a recommendation that the Director should review local procedures for the inclusion of clinical staff in debrief meetings and for a robust process to ensure that action plans resulting from these briefings are implemented. The Director, having accepted this recommendation and implemented the review. The response following the man's death was exemplary.

## CONCLUSION

60. We agree with the clinical reviewer that the man was treated appropriately during the time he was at Peterborough. It is regrettable that he chose not to disclose that he had been assessed as at high risk of heart disease and because of this the prison could not have foreseen his death or done anything to prevent it. The emergency response was swift. Good arrangements were made to support his family and we have recognised the thorough post incident review process as an area of good practice.

## GOOD PRACTICE

**HMP Peterborough has introduced a robust post incident review process. This is an area of good practice which other establishments could emulate.**