

**Investigation into the circumstances surrounding the  
death of a man at HMP Peterborough  
in December 2009**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**November 2010**

This is the report of an investigation into the circumstances of the death of the man in December 2009. During the morning, he complained of feeling unwell when he was unlocked to attend court. About an hour later, at 7.40am, staff discovered him unconscious. Cardio pulmonary resuscitation was carried out by staff but, sadly, he was pronounced dead by paramedics at 8.16am.

The post-mortem report indicated that the man died from bronchopneumonia (an infection of the lungs). He was found to have enlargement and scarring of the heart thought to be due to previous cocaine use which made him more susceptible to an abnormal heart rhythm, especially once his health was compromised by the pneumonia. He was 30 years old.

I would like to offer this public expression of condolences to the man's family on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. His mother raised a number of matters with one of my family liaison officers. I hope my investigation begins to offer answers to their questions. I am sorry that it has been delayed.

The investigation was carried out by my colleague. I am grateful to the clinical reviewer of the local Primary Care Trust (PCT) who carried out the clinical review. I would also like to thank staff at HMP Peterborough and, in particular, the liaison officer for their co-operation with this investigation.

The man was in Peterborough for six weeks from 15 October until 24 November and, upon reception on that occasion, presented with an alcohol problem. However, he was not viewed to be in need of a detoxification. This was his first time in prison. Having been released on 24 November, he returned again to Peterborough on 3 December. During his time out of prison, he said he had started to use heroin. He was given an opiate substitute while he was in police custody. Upon reception at Peterborough on 3 December, he began a methadone programme as a result of what appeared to be withdrawal symptoms, and a positive drug test. Staff were unaware of any underlying illness. He reported feeling unwell on the morning of 8 December but this was not treated with any sense of urgency. He was found unconscious an hour later.

My report contains six recommendations, many of which echo those in the clinical review. They concern placing detoxing prisoners on ordinary location and the subsequent limited monitoring they receive as well as the requirement for discipline staff to contact medical staff if a prisoner is unwell.

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 investigations.

**Jane Webb**  
**Acting Prisons and Probation Ombudsman**

**November 2010**

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## SUMMARY

The man was in HMP Peterborough from 15 October until 24 November 2009. This was his first time in prison and, during the reception health screen, he was identified as having an alcohol problem. It was noted that he was concerned about chest pains and palpitations related to previous cocaine use but that he had not used the drug for 18 months. He was released on 24 November having had only routine entries on his clinical record during his time in custody.

On 1 December, he was arrested for being drunk and disorderly and spent the night in the police station before being released on bail in the morning. Later that day, he was arrested again for the breach of a restraining order at his mother's house. He saw a health care professional during the evening and admitted taking heroin and drinking a considerable amount. The following morning, 3 December at 8.35am, he saw another health care professional, and was given Dihydrocodeine (60mg), diazepam (10mg), and Citalopram (60mg). He later appeared at court and was remanded to Peterborough prison until 8 December.

On 3 December, during his reception health screen, the man told the nurse he was struggling with drug withdrawal symptoms. He was drug tested and gave a positive test for opiates and benzodiazepine. He was then seen by Prison Doctor A (who had previously seen him on 16 October and identified alcohol abuse), and told him he had started to use heroin during the past few days. A methadone stabilisation programme was put in place and he was given 15mls of methadone. He was not taken to the stabilisation wing but instead was taken to an ordinary wing where he shared a cell with a cellmate.

Over the next few days, the man's methadone was increased daily by 5mls reaching 30mls on 7 December, which is a standard prescription. There are no additional entries on the clinical record and he does not seem to have come to the attention of medical staff in any other way. One member of the discipline staff recalled him appearing unwell and told him to go to the medication hatch to see a nurse. This is not recorded anywhere and it is not known whether he followed the advice. The cellmate described him as being unwell throughout the entire time, which he thought was due to drug withdrawal.

At 6:35am on 8 December, the day the man was due in court, he was heard crying out for help. He was seen by an officer (new to Peterborough and first day on the wing) and said he felt very unwell and had never felt like it before. The officer spoke to more experienced and senior staff, one of whom went to see him 15 minutes later. He groaned at him and the officer went away and took no further action. He was seen again when staff went to collect prisoners for work about 7.45am. He was found unconscious and cardio pulmonary resuscitation was performed by discipline and healthcare staff. Paramedics arrived at 7.55am but he was pronounced dead at 8.16am.

Six recommendations have been made including monitoring prisoners on ordinary location when they are stabilising/detoxifying and the requirement for wing staff to contact medical staff if a prisoner presents as unwell.

## THE INVESTIGATION PROCESS

1. Initially, the documentation in relation to the man was sent to my investigator. She visited HMP Peterborough on 21 January and was shown the cell where he had died. She interviewed four staff and the prisoner who had shared the man's cell. On another occasion, she interviewed one member of staff at his home as he was off sick at the time.
2. During the initial visit, telephone contact was made with the Independent Monitoring Board (IMB) and my colleague gave them the opportunity to meet her to discuss any issues of relevance they may have had. The chairman said he would discuss with his colleagues but no further contact was made with my investigator.
3. The investigator spoke with the man's solicitor who represented him in the past as well as the solicitor who was presented in court on 3 December. She also contacted the man's probation officer who provided a copy of his Pre-Sentence Report. All three provided useful background information.
4. My investigator made contact with the police officer investigating the death. He provided her with copies of the police custody records for both 1 and 2 December.
5. The clinical review was carried out by a clinical reviewer on behalf of the local Primary Care Trust and joint interviews of a number of medical staff were carried out on 23 February. At that stage of the investigation, the cause of the man's death was not known and it was not clear which aspects of his care would be most relevant to his death. Consequently, two staff from the Integrated Drug Treatment Service (the clinical lead and lead nurse) were interviewed as he had been prescribed methadone in Peterborough as part of the policy. Neither had had any personal contact with him but were able to provide an overview of the service. My investigator and the clinical reviewer met with the (former) Director to provide feedback.
6. The investigator spoke with the coroner and the pathologist who conducted the post mortem with regard to further questions from herself and the clinical reviewer. As part of his review, and with the support of the coroner, the reviewer interviewed, by telephone, two health care providers (HCP) who treated the man in police custody. They were able to provide extra information that they had not recorded on the medical forms (Detained Persons Medical Form). He also spoke with the pathologist.
7. One of my (former) family liaison officers contacted the man's mother offering the opportunity to meet herself and the investigator. His mother declined the invitation but telephone contact was maintained. Specifically, she said that her son was not a heroin user and wanted to know why he had been prescribed methadone.
8. A draft version of this report was sent to the Prison Service and their response to the recommendations has been repeated verbatim in section. The man's

mother provided some additional information after she received the draft and this is included on page 7.

## HMP PETERBOROUGH

9. HMP/YOI Peterborough opened in spring 2005 and is the only prison that holds both men and women, though they are held wholly separately. It is privately run by Kalyx, who also run HMP Bronzefield and Forest Bank in England, on a 25 year contract. The male side of the prison can hold 624 prisoners.
10. The male residency unit has two house blocks made up of four wings of two landings, each wing being self-contained. Each block has a central hub from which officers can respond directly to the ringing of cell bells via a speaker.
11. The first inspection of the male side of the prison at Peterborough by the former Majesty's Chief Inspector of Prisons took place in October 2006 and was followed up in July 2008. The second inspection found that staff-prisoner relationships remained the prison's weakest link.
12. At the time of the initial inspection, the Chief Inspector found that the provision of healthcare was amongst the worst the inspection team had seen for some considerable time. However, by the time of the follow up inspection, they found that healthcare had improved "but there remained much to be done."
13. Since 2008, the responsibility for the provision of primary health services transferred to Kalyx. Greater Peterborough PCT Partnership (now NHS Peterborough) had commissioning responsibility for some health care services. It was also the provider of primary nursing and associated administration until February 2008 when Kalyx took over these services. Commissioning mental health in-reach and secondary care remain the responsibility of NHS Peterborough.
14. In late 2009, the Integrated Drug Treatment Service (IDTS) was set up in Peterborough. The IDTS is a national programme designed to increase volume and quality of drug treatment available to prisoners.
15. Prisoners with a heroin problem who need to be stabilised are generally placed on wing, X1, where they usually remain for at least five days, known as stage 1. As outlined in the guidance Clinical Management of Drug Dependence in the Adult Prison Setting (Department of Health 2006) prisoners:

"should initially be accommodated on a unit that offers access to unrestricted 24-hour observation, utilising open healthcare hatches where they have been installed. When new-builds or refurbishments are undertaken, these facilities should be created."
16. Following the five day stabilisation, prisoners are able to move cell location where they continue to be monitored but not as closely. The stabilisation unit monitors withdrawal and the prisoner's response to treatment, for example that they are not over medicated indicated by being over sedated.

Additionally, “ongoing clinical monitoring is valuable as the early symptoms of drug withdrawal may mask a separate underlying physiological condition”.

17. By February 2010 when staff were interviewed for this investigation, the clinical lead stated that the IDTS at Peterborough was only 75 percent towards being fully set up. Therefore, in December 2009 when the man was there, the service was even less developed.
18. There were four other deaths at Peterborough in 2009. Only one of which has been to inquest. The reports into the circumstances of the remaining three deaths are awaiting the inclusion of clinical reviews which have yet to be completed by the PCT.

## KEY FINDINGS

19. The man had previously been remanded to HMP Peterborough on 15 October 2009. On that occasion, he was identified by Prison Doctor A as having an alcohol problem although this was not identified as severe enough to need treatment for withdrawal. He was, however, prescribed a short night time course of Zopiclone to help him sleep. It was confirmed with his community General Practitioner (GP) that he had been prescribed Citalopram (60mg), an anti-depressant, and this was continued whilst in custody. It was noted that he was concerned about chest pains and palpitations related to cocaine use, but that he had been drug free for 18 months.

20. He was released on 24 November 2009 having had only routine entries on his clinical record during his time in custody. In his wing history sheet, he was described as having:

“exceptional behaviour on the landing, respectful and polite to the wing staff, interacting very well with the staff and adherence very well to the regime, no issues at all”.

21. In the early hours of 2 December, the man was arrested for being drunk and disorderly at a hospital. He was later taken back to hospital by the police but discharged into their care within a couple of hours so he could “sober up” under regular and frequent observations. He was bailed to appear at court at a later date and released that morning at 9.00am from the police station.

22. Later that day, at 7.25pm, the man was arrested at his mother’s house for breaching an injunction and was described by arresting officers as being intoxicated. He told officers he had drunk a large amount of alcohol and was a user of heroin and cocaine and that he had a heart condition. At 9.10pm, he was seen by a health care professional (HCP) who recorded that “DP [detained person] is clearly under the influence of something, admits to using heroin today and drinking heavily today”. No medication was prescribed and the HCP recommended a review the following morning. He was not drug tested as his alleged offence was not one which automatically prompts a test.

23. In Cambridgeshire Police Constabulary the healthcare staff attending their police stations are from the G4S Forensic and Medical Services Ltd (known previously as EMFS). They are referred to as health care professionals (HCPs) and are used as a substitute service for forensic medical examiners (FMEs - previously known as police surgeons and general practitioners). Their website says:

“There are over 100 paramedics working with us providing cover on shifts in their off duty from the ambulance service. They work under the direct supervision of experienced FMEs until they have a prescribed level of experience at which point they manage specified cases independently under strict protocols. Until then they call every job through the FME for a decision on management, fitness to detain and so on. Paramedics are local to their patch and usually know their local custody staff well and this

has greatly improved relations between forensic medical teams and the police.

24. The clinical reviewer spoke to the HCP who saw the man that evening. The HCP said that in addition to the notes he made on the Detained Persons Medical Form (DPMF) he also made other notes which he referred to when speaking with the reviewer. The HCP told him that the man said that for the previous nine days, since being released from prison, he had started to use intravenous (injected) heroin bought from the streets as well as large quantities of alcohol. He admitted using crack cocaine and heroin on 2 December, but previously had just used heroin and alcohol. His heroin use was recorded to be one to two bags (£10-20) on most days. He had occasionally smoked it but usually injected it.
25. During the medical review, the man was alert and compliant but complained of shivering and being cold but had no other symptoms of opiate withdrawal such as anxiety, itching, abdominal cramps or diarrhoea. The HCP examined him and noted that he had needle marks on his arms suggesting intravenous drug use. He also examined his chest in detail and found nothing of concern. His condition was considered safe to allow detention, with instructions that he should be reviewed again by a HCP after six hours.
26. The following morning, 3 December, the custody record shows that at 6.32am, the man said that he was starting to suffer from withdrawal symptoms but was happy to wait until he got to prison before seeing the doctor. At 7.13am, it is again recorded that he declined to see the doctor for his withdrawal symptoms. However, at 7.18am, it is recorded that:

“EMFS call centre contacted due to the effects the DP is suffering from. G4S [the company that escorts prisoners to court] have been notified to delay transportation to court”.

There is no explanation of why he was to be seen by medical staff when he said he was well enough to wait until he reached Peterborough.

27. At 8.24am, the man was seen by the HCP who concluded he was suffering from withdrawal and prescribed three medications. They were:
- 60mg Dihydrocodeine (an opiate drug used for routine pain relief in moderate pain but with heroin like effects on the heroin receptors of the brain)
  - 10mg Diazepam (an anti-anxiety treatment for alcohol and opiate withdrawal states)
  - 60mg Citalopram (anti-depressant).

Again, the clinical reviewer spoke with this HCP who had also seen the man 36 hours earlier. He said that by this time he had begun vomiting which he suspected was the result of drug withdrawal. The man again said that he had used heroin over the last few days. On examination by the HCP, he was alert, but yawning, had goose bumps on his skin, a runny nose and eyes, a

raised pulse rate. His chest was examined and found to be clear. Medical advice was sought from the FME by telephone who concurred with the diagnosis of opiate withdrawal.

28. The man later appeared at court and was remanded until 8 December. The solicitor representing the man said he saw him at about 2.30pm at court. He said that he appeared 'chipper' and did not complain about feeling ill. He said that drug use was not mentioned either to him by the man or during his court appearance. The solicitor thought that only alcohol had been mentioned as a factor in his arrest by the prosecution. He said that the man did not want to apply for bail and understood that his mother could not accommodate him any more.
29. The man arrived at Peterborough at 5.10pm. The Prisoner Escort Record (known as the PER, which is used to communicate any areas of risk between the different criminal justice agencies) identified him as having drugs/alcohol issues. It did not mention that he was given medication at the police station and it did not indicate whether the DPMF was attached to the PER as it should have been. In reception, he went through the routine paperwork, describing himself as a butcher and providing his mother's details as his next of kin.
30. A Cell Sharing Risk Assessment (CSRA - used to assess whether a prisoner is suitable to share a cell) was completed and the man was assessed as a medium risk to others. It is recorded that he had concerns about sharing a cell. The officer recorded that the man said he "got angry/frustrated quickly", suffered from depression and was "rattling" (a term used to describe the effects of withdrawing). The CSRA was also ticked to confirm that he said he had previously been on ACCT monitoring (Assessment, Care in Custody and Teamwork – used to identify and support those at risk of self-harm and suicide). (However, there is no evidence from his previous time at Peterborough to suggest he had been on an ACCT. He had told the probation officer that he had been banging his head against the police cell wall after being arrested in October which is confirmed in the police custody records.)
31. Nurse B was on duty in reception and she completed some routine paperwork about the man. As part of her duties she completed section 3 of the CSRA, assessing him as a low risk to others and with no concerns about self-harm. Not all of the form was completed and section 4, which should be completed by the officer who allocates the prisoner into a cell was not filled in.
32. In interview, the nurse, although unable to recall him in any detail, explained that for a person returning to prison after a brief period in the community, she would not undertake a full reception health screen. Instead, she would ask whether there had been any changes from the time when they were in before. She recorded in his clinical record that:

“returned after 1 week struggling with drug withdrawal, drug screen re done, physical general health good but scarred heart from drug use. Mental health depression but normally copes well until drug use”.

His urine drug test was positive for opiate and benzodiazepine and she referred him to the doctor.

33. Nurse B completed a Mental Health Reception Assessment and the man said he felt he had mental health problems. He said he was depressed but not suicidal although he had attempted suicide five years before. She did not refer him for a mental health assessment because he had been referred for an assessment on 15 October. However, the previous medical records do not show that this assessment was carried out.
34. Later that evening, Prison Doctor A saw the man (who he had previously seen on 16 October and identified alcohol abuse). (The clinical record records that the doctor saw him on 4 December. However, in interview he explained that he had not had access to a computer at the time and so had written his notes up the next morning which the system recorded as taking place at that time.) The note in the clinical record reads:
- “patient was released from this prison on 24/11/09 which was 9/7 [nine weeks] ago. Patient started to use heroin £10-20 worth daily, injecting, also started to drink again about 0.7 litres of vodka and 2-4 litres of cider. Patient presented severe withdrawal symptoms yesterday: very shaky, abdominal cramps etc. Methadone titration was started yesterday and his received methadone 15mls last night. In addition Zopiclone for 5/7 [five days] and supportive meds [medication] for 7/7 [seven weeks].”
35. The man was prescribed Zopiclone, supportive medication and Citalopram. He was given 15mls of methadone in line with their IDTS policy.
36. In interview, Prison Doctor A remembered the man very well and recalled having a conversation with him regarding his declared use of heroin. The man said he used heroin for the first time whilst he had been out of prison for nine days. He said that he had been depressed, had started to drink again and had used heroin for the first time. The doctor said that he stood out in his memory because his presentation was unusual in that he had not previously used heroin, but had started within the last nine days and was already experiencing withdrawal symptoms.
37. Again at the time of my investigator’s interview with Prison Doctor A, the post-mortem results and the cause of death were unknown. The doctor said that the man was shaky and not looking well but he did not present with any pain or any physical problems. He said that the man told him he was injecting heroin but could not recall whether he had checked his arms for evidence of needle sites. Neither the doctor or nurse recalled seeing the DPMF from the police and so they did not know that he had been given medication which might have caused the prison drug test to be positive.

38. The man was not located to the detoxification/stabilisation wing, known as X1. In interview, neither the doctor nor nurse were aware of any system which meant that they could direct where in the prison to house a drug user. Instead he went to W1-15. His wing history sheet was stamped to say that he was detoxifying.
39. The man's mother told my family liaison officer that he telephoned her on Thursday 3 December. She said he sounded very drowsy and told her he did not feel well.
40. On 4 December, it is recorded in the man's history sheet that he did not require an induction as he had been in prison before and he had no issues. He was moved into cell Y1-14 and his cellmate was already there. This was the last cell on the first floor and the one furthest away from the wing office and the hub. The cellmate recalled having seen the man around the wing previously but did not know him. In interview, he said that the man was suffering with hot and cold sweats during his time there and he thought he felt at his worst in the mornings. He also said that the man told him that he used heroin for the first time when he had been released.
41. Later that day, 4 December, the man was given 20mls of methadone. Medication is given out in the morning and prisoners have to go to a medication hatch to collect it. Over the next few days, he was given an increasing dose of 5mls of methadone per day reaching the standard maintenance dose of 30mls daily on 6 December.
42. The following day, 5 December, PCO (Prison Custody Officer) A introduced himself to the man as his personal officer. He recorded that he knew him from his last stay on the wing. He was described as polite and respectful, and no issues were raised.
43. At some point over the weekend, PCO A recalled seeing the man and stated "he was a little bit shaky, he was trying to hold his water and he was making some funny noises". The PCO said he told him to go straight to the front of the medication hatch. He said the man came back but did not say anything so the PCO assumed that he had been dealt with by medical staff.
44. Cell bell records show that on 7 December the cell bell was rung at 7.10am and 8.48am. The cellmate remembered the man ringing the cell bell the first time and complaining that his medication was not working and he needed something to help him. He said that the man was told he would have to wait for the medication round. He went to work before the man rang the bell the second time. In Peterborough, the cell bell can be answered from a central hub from where staff can speak to prisoners without going to the cell to see and speak with the prisoner.
45. The man saw a member of the CARAT team later on 7 December with reference to trying to arrange a methadone prescription should he be released from court the following day. She recorded that she explained what he needed to do the following day and he was happy with the arrangements.

The same day he wrote to his mother asking for money to buy cigarettes, saying that taking methadone increased his smoking habits.

46. Later that evening, PCO B said he recalled seeing the man in the cell sitting in his bed talking to his cell mate when he did the roll count at approximately 7.25pm.
47. The man was due to appear at court the next day, 8 December. PCO C, who had recently started at Peterborough and was on his first morning on duty on the wing, was responsible for conducting a roll count on the wing before unlocking prisoners for court that day. He described that at about 6.35am, he heard someone crying out for help as he walked down the wing so he went to unlock the cell. He went into the cell and turned on the light and the man told him he felt very unwell. He gave him a glass of water and asked him to sit up which he did, although he had to lie back down again as he said he was dizzy. The cellmate, who was sleeping on the bottom bunk, told him that the man was detoxifying. Given that the man was due in court that day, the PCO asked him if he would be going to which he replied that he did not feel right and had never felt like that before.
48. The cellmate told the investigator that the man said he could see in black and white and needed help. He got him a couple of bottles of water as he could not get out of bed. He said that he repeatedly asked for help and had been in a similar state on other mornings. However, on those occasions he could get out of bed and did not describe seeing everything in black and white. He asked him if he was going to get his medication and he said no.
49. PCO C did not know whether it was appropriate for him to telephone Hotel 3 (the medical emergency nurse in the prison) so he spoke to two more experienced and senior staff, SPCO (Senior Prison Custody Officer) A and PCO D, on the wing. He explained that the man said that he did not feel right although without making a specific complaint, and said that he was not going to court. PCO D said that he would go and see him, which he did at approximately 6.50am. He was familiar with the man as the officer in charge of the wing. In interview, PCO D said that he asked him why he was refusing to go to court. In response, he groaned at him and he left the cell and continued with the morning duties.
50. In interview, PCO D said that prisoners regularly refused to attend court. Rather than interrupt the rest of the morning regime, he said that staff deal with them later in the morning and often prisoners decide to go on their own accord at unlocking time. The court is contacted by reception staff to see if the prisoner has to attend and "in the worse case scenario" they could be taken under restraint. He said that because he had not been told anything specific about how the man was feeling, such as having chest pains, and he did not tell him anything, he did not consider radioing for medical staff to assess him. The PCO explained that medical staff come to the wing every morning at approximately 8.00am to give medication and they might assess a prisoner at the request of staff.

51. At 7.15am, when all the cells were unlocked, the cellmate left the cell. PCO A was the officer responsible for unlocking the man's cell that morning but said in interview that this does not require the staff to look in the cell.
52. PCO B was responsible for collecting prisoners to go to work that morning. He spent some of the early morning in the office dealing with queries and paperwork. The cellmate had approached him saying that he wanted another cellmate as the man was keeping him awake in the night because he was detoxifying. In interview, the PCO said that he believed that the man was on the work list which was why he went to his cell (my investigator has been unable to confirm whether this was the case or not). He arrived at the cell at about 7.45am. PCO B shouted his name a couple of times, hit his clipboard against the door and kicked the door. The man, who was in the top bunk, did not respond. He went into the cell and touched the man's lower leg, which was sticking out. It was cold to touch, and the PCO stepped forward to look at his face as he was lying on his front. He was pale and did not look well and the PCO realised that something was wrong.
53. PCO B said he shouted down the landing to PCO A to "get SPCO A". PCO A ran to the hub and knocked on the window for the SPCO and they both ran to the cell. Meanwhile, PCO B pressed his personal alarm and called for medical assistance over his radio. He turned the man on to his back and, within seconds, he said that the SPCO was there beside him. He started mouth to mouth breaths and the SPCO did compressions as they stood on the bottom bunk.
54. Very quickly the orderly officer (the most senior member of the discipline staff) entered the cell and saw the officers carrying out CPR on the man. He immediately called for an ambulance over the radio at 7.50am, and asked staff to move the man on to the floor, which they did.
55. At this point, the emergency nurse and health care assistant (HCA) arrived. Nurse C took over from the officer giving breaths and tried to get an airway into his mouth. Unfortunately, the man's jaw was tightly shut and she was unable to do so. Instead, she gave oxygen using a normal mask using a jaw thrust to keep the airway as open as possible. The emergency bag, which was kept in the hub, about 50 yards away, was collected by the HCA. The HCA arrived and started to use an Ambu bag. She also used the defibrillator which advised not to administer an electric shock and continue with CPR.
56. The paramedics arrived at 7.55am and continued to treat the man. Sadly, he was pronounced dead at 8.16am.
57. The Director of the prison and a prison family liaison officer went to break the news of the man's death to his mother that morning. She lives with her elderly mother. Over the next few days, she said that she would prefer all contact with the prison to be carried out by her son as she found it upsetting. The prison paid for the funeral and three members of staff attended including the Director.

## ISSUES

### The man's time in police custody

58. The man was released from Peterborough on 24 November. He was at liberty until the night of 1 December which he spent in police custody and was released in the morning of 2 December. Later that same evening, he was arrested again and spent the night in police custody. On this second occasion, he declared using heroin over the past nine days and saw a health care professional at 7.25pm that evening. He was reported to be alert and compliant and no medication was prescribed. At 7.13am, he declined the offer of seeing a doctor until he got to prison but custody staff did call the Forensic Medical Service. The HCP prescribed Dihydrocodeine when he saw the man an hour later. Given that he expressed the wish to wait to see the prison doctor, the decision to prescribe medication to relieve withdrawal symptoms at that time, appears surprising. However, the actions of the staff at the police station are beyond the remit of this investigation. A copy of this report will be shared with Cambridgeshire Police Constabulary.
59. The HCP completed a Detained Persons Medical Form which should have been attached to the PER which accompanied the man to Peterborough. Usually the report comes within an envelope marked "medical in confidence" and its purpose is to outline any medical concerns and actions taken by medical staff at the police station. In interview, the prison nurse, Nurse B, could not recall seeing the form (albeit she could not recall him in any detail) and it was not given to my investigator as part of the documents received from the prison following his death. Either the form did not travel to Peterborough or, upon arrival, it was misplaced.

**Medical records should always accompany prisoners from police detention to prison admission and be given to the medical staff upon arrival.**

### Were appropriate decisions taken as to where the man should be located?

60. Nurse B completed a shortened version of the first reception health screen on 3 December as the man had only been released a few days earlier. She referred him to Prison Doctor A who interviewed him. Having given a positive drug test for opiates, appearing to be withdrawing and saying that he had used heroin over the past few days, he was assessed as appropriate for methadone stabilisation.
61. Peterborough has a wing, X1, dedicated for prisoners undergoing treatment for substance misuse problems as part of the IDTS. Clearly, there will be times when that wing is full and prisoners will have to be located on an ordinary wing. However, this has not been suggested as a reason why the man did not go to X1 but was placed on Y1. Neither the nurse or doctor were aware that they played a crucial role in informing discipline staff where it was most appropriate to place the man because of his medical needs. The prison's IDTS clinical lead told the investigator that the reception nurse should

be proactive in this process. Nurse B was not a regular reception nurse and in interview believed that this responsibility rested with the doctor.

62. At the time of interviewing staff, in February 2010, the clinical lead described being 75 percent of the way towards a fully set up ITDS at Peterborough. Clearly, in December 2009, when the man was there the service was less fully organised. He said that movement from reception to the stabilisation wing was working more effectively (although this was not completely clear from Prison Doctor A and the nurse's interviews in February 2010).

**The head of healthcare, and clinical lead in IDTS, should clarify the responsibilities of health care staff to recommend the appropriate wing to which prisoners should be admitted, especially those who require additional monitoring.**

63. The 2006 Department of Health guidance states that when methadone is administered (by a registered nurse), the nurse should ensure that the prisoner is fully alert and responds appropriately, and that there are no signs of drowsiness or collapse, slurred speech, droopy eyelids or lowering of blood pressure.

64. There are numerous opportunities for health care staff to observe detoxifying prisoners on wing X1 in Peterborough. However, those on ordinary location will only be seen when they collect their medication at the hatch which, by its nature, is a busy place and does not lend itself to significant monitoring of prisoners medical needs. There is no allocated space on the methadone medical record to note the prisoner's appearance as the record only requires signatures by the prisoner, the nurse administering the drug and a witness. It is unclear under these circumstances what degree or quality of observation would take place. PCO A said that he told the man to go to the medication hatch because he was unwell. If the man did do this, there is no record anywhere from medical staff. The clinical reviewer noted that no medical staff recorded that the man was over sedated. However, it is unclear whether staff made any observations at all as nothing is recorded and, except for the main medical record, there is no place to record anything. I do not suggest that the nurses' observations were inadequate but simply that there is nowhere to record any issues. It would seem that guidance or protocols do not exist for staff in respect of detoxifying prisoners who are not located on a dedicated detoxification/stabilisation wing.

**The head of healthcare, and clinical lead in IDTS, should provide guidance concerning the monitoring and recording of prisoners being prescribed methadone on an ordinary wing.**

#### **Doubts regarding the man's heroin habit**

65. The clinical reviewer conducted a clinical review of the care the man received in Peterborough. He describes the evidence about his heroin use as conflicting. He reported use of one to two bags per day whilst out of prison for a very short period of time, together with his apparent ability to effectively

deliver the drug to a vein in his forearm, was unusual. The clinical reviewer comments that the dose is high for a new user and significant skill would be needed to inject. However, the man showed withdrawal symptoms at the police station which led to substitute medicine being given to him. Medical staff at Peterborough were not aware that he had been given any medication and took the positive drug test on face value. They accepted his account of a newly acquired dependence on heroin. He was prescribed methadone in the standard way for any detoxifying prisoner. The increased dose of methadone given to him during the last days of his life is considered a significant dosage for a new heroin user and it would be expected to cause significant sedation.

66. However, the clinical reviewer says that staff did not notice that the man was sedated. He also noted that the cellmate described him feeling worse in the morning and asking for medication. He continued:

“Methadone works for over 24 hours and an early wearing off of effect could suggest that the initial, cautious and entirely appropriate doses of methadone and his convincing symptoms of withdrawal in police custody, all suggest that the man had used heroin for some time.”

67. However, this does not take account of the man's repeated account that he used heroin for a very short period of time and his consistent self-declared report of heavy use of other drugs in the past but not heroin. In addition, the absence of ongoing clinical monitoring, as outlined in the guidance for those being stabilised on methadone, did not take place. Without this monitoring, an assessment did not take place which may well have been “valuable as the early symptoms of drug withdrawal may mask a separate underlying physiological condition”. (Clinical Management of Drug Dependence in the Adult Prison Setting, Department of Health 2006.)

Did staff act appropriately when the man reported feeling unwell?

68. PCO C was working his first day on duty as a wing officer and understandably was a little unsure about procedures. He responded to the man's calls for help and went to see him. He realised that he was unwell and considered calling for the emergency nurse. Correctly, he spoke to two senior staff members and was told that the situation would be dealt with by one of them.

69. Fifteen minutes later, PCO D went to see the man. In interview, he could not recall PCO C telling him any specific details about his health. Having seen the man, PCO D did not judge him to be sufficiently unwell to call for healthcare staff, despite him groaning at him. In interview, he said that if he had known the whole picture he would have acted differently. However, PCO C told the investigator that he did tell his more experienced colleagues what the man had said to him.

70. It is impossible to know whether earlier medical intervention would have made a difference to the man, but nonetheless I believe that staff should have contacted healthcare and asked them to attend as soon as possible. They

may not have been able to respond as quickly as they would have done in an emergency. However, they should have been called.

**The Director of HMP Peterborough should remind staff of their obligation to contact healthcare when a prisoner presents as unwell.**

### **Mouth to mouth resuscitation**

71. Without regard to his own health, PCO B gave the man mouth to mouth resuscitation although he did not have a mask to form a barrier between his mouth and the man's. The PCO had been trained outside of the Prison Service but was confident about his capabilities. The clinical reviewer wrote in his clinical review that:

“it would be preferable for the safety of staff for standard resuscitation to be used. In modern CPR, chest compression is the most significant intervention with mouth to mouth or other ventilation of the chest taking a secondary role.”

72. Prison staff who have been trained in CPR should be issued with a ventilation mask as a matter of course as they are the staff most likely to be involved. However, even for those who are not trained, it would be sensible to make masks available for staff to carry and use in any situation which might arise.

**Protective face pieces for mouth to mouth resuscitation should be available to all staff.**

### **Cause of death**

73. The post mortem report includes the following amongst its concluding comments:

“The pneumonia present would have taken many hours to develop to the degree seen. This may raise questions about the deceased's status in the last 24 hours or so, including whether he sought any medical treatment. Further this is not the first case of fatal pneumonia that I have dealt with from HMP Peterborough and I raise as a possible concern whether there is some common factor. I trust for instance that adequate measures are in place to mitigate against the development of Legionella bacteria in the air conditioning systems at the prison.”

74. In response, the clinical reviewer wrote in his clinical review:

“At the end of the report the pathologist notes that this is not the first fatal pneumonia that he has seen at HMP Peterborough. He raises the concern about possible sources of Legionella. This bacterium causes pneumonia and can be caught from spread via air conditioning systems as these provide good conditions for the bacterium to grow. It does not respond to the normal antibiotics used for chest infections. It is often diagnosed with difficulty as it is an unusual organism that is not easy to

culture under normal laboratory circumstances and is not routinely looked for but bacteriologists. It tends to be diagnosed by more specialist tests after initial treatment with ordinary antibiotics has failed. HMP Peterborough was included in a public health investigation of a suspected Legionella outbreak in north-west Peterborough but no evidence of contamination was found in the prison environment systems in August 2009. Unfortunately no specimens of sputum before death or of lung tissue from the post mortem are available or suitable for culturing the causative organism.”

75. The clinical reviewer made the following recommendation which I endorse.

**The prison should review their policies and management of potential Legionella infection. Prison medical staff should have heightened awareness of the potential for Legionella to be a cause of chest infection in staff and prisoners.**

#### **Other issues**

76. I would like to draw the Director’s attention to the PER form which had been completed for the man’s court appearance on 8 December. It is entirely appropriate for considerable sections of this document to be completed in advance of the journey thereby leaving only relevant sections to be completed once the prisoner is in reception. In this case, my investigator was surprised to see that the form had already been signed by a senior officer to indicate that prior to leaving the prison for court, the man had been searched, correctly identified and a verbal handover given to escort staff. Clearly, this was not the case. Under no circumstances should this section have been completed without the prisoner present and having been searched. I trust that the Director of Peterborough will speak with the officer involved.

## **CONCLUSION**

77. Having been released from prison on 24 November, just nine days later, the man said that he had started to use heroin. Upon arrest, his presentation and self-declared heroin use led police medical staff to prescribe an opiate substitute which may have resulted in the positive drug test result in Peterborough. Having been identified as a heroin user, he was given methadone but was not located on the stabilisation wing and so he did not receive an enhanced level of monitoring. According to his cellmate, the man felt unwell for the duration of his time in Peterborough. On the morning of his court appearance, he told staff that he felt very poorly but this was not acted upon with any degree of urgency. It is not possible to know whether earlier medical intervention either through enhanced monitoring or any action taken that morning, could have prevented his death.

## RECOMMENDATIONS

All recommendations, with the exception of number 1, were accepted. Number 1 was partially accepted. The proposed action is written in italics following each recommendation.

1. Medical records should always accompany prisoners from police detention to prison admission and be given to the medical staff upon arrival.

*We accept the principle of this recommendation and will discuss this with our colleagues from the local Constabulary.*

2. The head of healthcare, and clinical lead in IDTS, should clarify the responsibilities of health care staff to recommend the appropriate wing to which prisoners should be admitted, especially those who require additional monitoring.

*We will address this issue at the next IDTS meeting to ensure that correct protocols and Standard Operating Procedures are in place and followed by all staff in relation to the location of prisoners onto the most appropriate wing.*

3. The head of healthcare, and clinical lead in IDTS, should provide guidance concerning the monitoring and recording of prisoners being prescribed methadone on an ordinary wing.

*Initially a Notice to Staff will be issued to provide staff with the necessary guidance. This will then be captured in the induction training for new staff.*

4. The Director of HMP Peterborough should remind staff of their obligation to contact healthcare when a prisoner presents as unwell.

*Notice to staff issued reminding staff of their obligations. Notice to be re-issued on a monthly basis.*

5. Protective face pieces for mouth to mouth resuscitation should be available to all staff.

*Face pieces will be made available to staff for this purpose as part of the resuscitation packs on the houseblocks. Nurses will also be provided with individual face pieces.*

6. The prison should review their policies and management of potential Legionella infection. Prison medical staff should have heightened awareness of the potential for Legionella to be a cause of chest infection in staff and prisoners.

*HMP Peterborough have confirmed that they have reviewed their arrangements in relation to Legionella and are confident that procedures are sufficiently robust to identify and such potential infections before they become problematic.*