PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at hospital, while in the custody of HMP Peterborough in June 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man, a prisoner at HMP Peterborough. He died of a heart attack in June 2012. He was 53 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 five months before he died. He had a known heart condition and, following his initial healthscreen, staff referred him to a cardiac specialist. He was due to undergo a procedure to alleviate the blockage in his heart, but collapsed unexpectedly in June and died.

I do not consider that the risk assessment which resulted in restraints being used when the man was being taken to hospital was sufficiently thorough, but overall I am satisfied that he received good care at Peterborough. His death could not have been foreseen by the prison and the emergency response was well-managed. After his death the prison responded effectively and sympathetically to the needs of his family.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man appeared at Crown Court on 26 January 2012 and was sentenced to 17 months imprisonment. During his reception healthscreen, he disclosed that he had angina and schizophrenia for which he was prescribed medication. He had a long history of drug and alcohol misuse. Basic observations were taken and were just outside of the normal range, so he was referred to the prison doctor the next day.

2. Following an assessment by the prison doctor, the man was referred to a cardiologist (heart specialist). The cardiologist recommended a procedure to unblock his arteries, but he died before this could take place.

3. One morning in June, the man was due to attend a home detention curfew board (HDC – early release to a suitable address and subject to an electronic tag). While he was waiting to attend the meeting, a manager noticed that he looked unwell. Healthcare staff were called and an ambulance was requested. He was moved to the healthcare centre, where he was treated by healthcare staff and paramedics until he was stable enough to be transferred to hospital. Although he was assessed as a low security risk and despite his condition, he was handcuffed by an escort chain to an officer.

4. The man was on his way to a specialist hospital in heart care. However, a short time into the journey he suffered a cardiac arrest. Paramedics stopped the ambulance to administer cardiopulmonary resuscitation (CPR, an emergency procedure to assist someone who has suffered cardiac arrest) and then re-directed to another hospital. Despite attempts to revive him, he was pronounced dead at 12.36pm.

5. The prison appointed a family liaison officer (FLO) to break the news to the man's mother, his next of kin. It was initially decided to use the police to contact his mother, although she lived only about 45 miles away from the prison. It was then established that she was on holiday and family members requested that they break the news to his mother in person. When his mother and family returned home the next day two FLOs visited to offer support to them.

6. The clinical reviewer concludes that the medical care the man received throughout his time at Peterborough was equivalent to what he would have received in the community and the response when he became unwell was expedient. One of our recommendations is intended to strengthen escort risk assessments and the other to improve staff support after a death in custody.

THE INVESTIGATION PROCESS

7. The investigator visited HMP Peterborough on 19 June, and met one of the liaison officers for the investigation, as well as other members of the senior management team, and was given all of the man's records. She met the Head of Healthcare, the nurses who responded to the medical emergency and the family liaison officers. She visited the wing where he lived and the healthcare centre. She also met his cousin on the induction wing. In advance of this visit, notices were issued announcing the investigation to staff and prisoners.

8. A clinical reviewer was appointed by the local Primary Care Trust (PCT) to review the man's clinical care at the prison. He received copies of all relevant documentation to assist this review. He and the investigator returned to Peterborough on 10 July, and jointly interviewed four members of staff. The investigator interviewed two additional staff and one prisoner, the man's cousin. She also spoke to a workshop instructor on the telephone. She met the Director of the prison immediately after the interviews to give preliminary feedback, which was confirmed in writing on 13 July 2012.

9. The investigator contacted the Ambulance Service, who provided details of the contact they had with Peterborough in June.

10. Her Majesty's Coroner for Peterborough was informed of the investigation. A copy of the report will be sent to the Coroner. A post-mortem report was received on 16 August, and indicated that the man died of a heart attack.

11. One of the Ombudsman's family liaison officers contacted the man's mother on 11 July, to explain the investigation and allow her to raise any concerns about his care. During a meeting on 3 August, the family asked the following:

- Why was there no follow up on 28 May, when he told a nurse he had pins and needles in his feet?
- Was he stable enough to be moved from HMP Peterborough?
- Why was he sent to a particular hospital and not sent directly to the local hospital?
- What drugs/medication/procedure could be administered at that particular hospital that was not available at the local hospital?
- Is there a coronary care unit at the local hospital?
- Is there a named nurse system at HMP Peterborough?

The family received a copy of the draft report as part of the consultation period. His mother and sister raised concerns about the prison's use of restraints, the decision to take the man to another hospital and found the whole experience very stressful. Although the comments have led to no changes in the investigation report, the investigator has addressed the issues raised in separate correspondence to the family.

HMP PETERBOROUGH

12. HMP Peterborough opened in March 2005 and is run by a private contract services provider. It houses both male and female prisoners in separate sides of the prison. For male prisoners, the establishment serves as a local prison (a prison that sends and receives prisoners directly to and from the courts) and holds up to 624 men. There were 578 male prisoners at Peterborough on 15 June.

13. The prison has 24 hour healthcare cover, and prison clinical staff are employed directly by the services provider, although there is collaboration with two NHS Trusts. General Practice (GP) services are commissioned through an agency.

HM Inspectorate of Prisons

14. The Inspectorate 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.
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> " … 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

15. There have been two previous deaths from natural cause deaths at Peterborough in the past year. While there are some similarities in the causes of the deaths, there were no common issues of concern.

KEY EVENTS

16. The man was born in July 1958 and lived in the Stevenage area of Hertfordshire. He was sentenced to 17 months imprisonment at Crown Court on 26 January 2012 for possession of drugs with intent to supply and was taken to Peterborough prison. He had previously served a number of custodial sentences.

17. His person escort record (PER) noted that he was taking medication for schizophrenia and angina (a PER accompanies prisoners on all journeys from and between prisons, police stations and courts and is a communication tool about a prisoner's risks.) During his initial health screen at Peterborough, he told a nurse that he was a smoker, daily cannabis user, had consumed other illegal drugs in the past and continued to drink alcohol to excess. He provided details of his community GP and said that he was known to the community mental health team. He said that he was prescribed flupentixol (an antipsychotic drug used to manage the symptoms of schizophrenia) and a GTN spray (glyceryl trinitrate to manage angina – muscle pain in the heart). He tested positive for benzodiazepines (an opiate based medication used for treating anxiety, but often misused), but said he had not used the drug.

18. He was seen by a doctor the following day for his secondary health screen. His blood pressure was recorded as just outside the normal range at 126/91 (the normal range for blood pressure is 100/70 to 140/90). The doctor requested his community GP records and telephoned the surgery, who confirmed that he was prescribed flupentixol and GTN spray. The surgery also told the doctor that he had been assessed by the rapid chest clinic in September 2011, following chest pains, but that he did not attend a follow-up appointment for an angiogram (a procedure that involves injecting a special dye to show any abnormalities inside blood vessels).

19. On 27 January, the man was assessed by a nurse from the integrated drug treatment system team (IDTS is the clinical management of drug and alcohol dependence in prison). He asked to be referred to the CARATs team (Counselling, Assessment, Referral, Advice & Throughcare Service which provides support and counselling to prisoners with substance use problems).

20. On 30 January, a doctor examined the man and completed an electrocardiogram (ECG – which measures the electrical activity of the heart to help with diagnosis). This assessment showed that there was tissue damage caused by lack of blood supply through damaged arteries and diagnosed ischaemic heart disease. Blood tests showed some abnormalities and were to be repeated in four weeks. (These were completed on 29 February and were normal.) He was referred to hospital on 1 February, for an angiogram and prescribed aspirin (to reduce the 'stickiness' of platelets in the blood which helps to prevent blood clots forming). An appointment at another hospital (a specialist heart centre) was arranged for 27 March.

21. The next day, 31 January, the man was seen by a nurse from IDTS for his five day review. He said he had no problems with drug use and that his only ongoing issue was linked to his angina, but his GTN spray helped.

22. He sought medical attention for minor ailments over the following weeks, but nothing significant. On 8 March, an IDTS nurse completed his six week review and there were no issues reported.

23. The man had a computerised tomography coronary angiogram on 27 March (a CT scan used to determine if any of the coronary arteries supplying blood to the heart are narrowed or becoming blocked). On 23 April a consultant cardiologist wrote that the CT scan showed he had moderate stenosis of the left main stem (narrowing of the artery), concentric soft plaque (thickening in arteries) and scheduled a further diagnostic procedure to determine where the blockage was for 4 July.

24. The last contact he had with healthcare was on 28 May, when he had a discussion with a nurse. During this contact he complained of experiencing "pain in both feet for 1 week, some pins and needles and shooting pains". He told her he had experienced this before and he was prescribed vitamins by his GP. The nurse recorded her conversation with him in his medical record, but she did not record a diagnosis or plan for follow up action.

25. The man's HDC application was reviewed on 12 June by a Probation Officer at Peterborough. An enhanced mandatory assessment HDC board (for prisoners serving over 12 months) was scheduled for 15 June, at which a recommendation for HDC would have been made.

26. He attended work on the morning of 15 June at approximately 8.30am, but went back to the wing just before 10.30am for his HDC board. He was sitting in the hub area waiting to meet the operations manager to discuss his HDC application. The manager noticed that he did not look well and described him as "very, very pale". He said he instinctively knew that he was poorly, asked healthcare staff on the wing for assistance, and a radio call for the duty nurse, was made.

27. A senior nurse examined him and she was quickly joined by the duty nurse, in response to the emergency call. He had a fast pulse, was clammy and pale and was not fully responsive. The nurses alerted staff in the healthcare centre to prepare the treatment room and he was moved to the healthcare centre. The investigator viewed closed circuit television (CCTV) footage that showed he was moved, using an evacuation chair, from the wing at 10.30am and arrived at the healthcare centre at 10.31am.

28. An ECG was performed which showed that his heart was not functioning properly, although he was conscious and able to communicate. The duty nurse requested an ambulance while he was being examined. The Ambulance Service has confirmed that the request for an ambulance was made at 10.41am.

29. Paramedics arrived at Peterborough at 10.46am and assessed the man. They completed another ECG that showed he had likely suffered a heart attack. He was stabilised and the paramedics decided to transfer him to a specialist hospital, in line with the Cambridgeshire county protocol for those having a heart attack.

30. As part of the duty to protect the public prisons make judgements about the level of security needed when prisoners are taken out of the prison for any reason. An individual risk assessment should be completed on each occasion. An escort chain (a 1.8 metre long escort chain with a handcuff at either end to which the prisoner and an officer is attached) was used to restrain him. He was escorted by two prison custody officers. Authority was given before he left the prison for the immediate removal of restraints, should his condition deteriorate or if requested to do so for medical intervention.

31. The ambulance left Peterborough at 11.41am on its way to hospital. Approximately 10 minutes into the journey, the man suffered a cardiac arrest (when the heart stops beating). Restraints were immediately removed. Paramedics stopped the ambulance, administered emergency first aid (with the assistance of the following paramedic) and went to the local hospital. The ambulance arrived at the hospital at 12.11pm and he was taken directly to the resuscitation unit. Despite the continued efforts of hospital staff, he was pronounced dead at 12.36pm.

Liaison with the man's family

32. Peterborough asked Stevenage Police to break the news of the man's death to his next of kin, his mother. The police found no one at home at the listed address and were unable to locate a family member. The Head of Security listened to a recent telephone call that he made to his mother. (Telephone calls in prison are recorded.) His mother had told him that she was going on holiday to the Isle of Wight. The wing telephones were temporarily switched off to prevent his family being informed before the prison had the opportunity to break the news.

33. The Head of Security reviewed the man's prison records and saw that he was in touch with his cousin, who had recently become a prisoner at Peterborough. She and the duty director broke the news to him at 5.15pm. The cousin was allowed to make some telephone calls to establish where his aunt was. He spoke to his nephew and his family, at their request, travelled to the Isle of Wight to break the news in person to the man's mother. The cousin was allowed an additional visit and telephone calls.

34. The duty orderly officer (a senior member of staff on duty) received a telephone call from the man's mother at 6.00pm on 16 June. He told her the information he knew, and explained that the prison family liaison officer (FLO) would contact her the following day.

35. The prison chaplain and a prison manager and a member of the care team (trained staff who have the skills to support others at difficult times), were nominated as the prison FLOs. The chaplain contacted the man's mother on 17 June and arranged to visit her the next day. During this visit the FLOs explained their role and offered ongoing support.

36. The prison FLOs maintained contact with the family over the subsequent days and an additional family visit was arranged in the chapel for the man's cousin. The prison offered financial assistance with the funeral costs and ensured that all of his property requested by his family was returned.

37. The funeral was held on 5 July. The man's cousin applied for release on temporary licence to attend the funeral, but it was decided he did not meet the eligibility criteria. However, he was allowed to attend escorted by two prison custody officers. He told the investigator that he was grateful for the opportunity to say goodbye to his cousin and had written to the Director to express his thanks for the professional and sensitive manner in which he and his family had been treated. The prison FLOs also attended at the family's request. His cousin received ongoing support at the prison and the prison FLOs maintained contact with the man's mother. A visit to Peterborough by the man's mother and his sisters was arranged on 30 August when they were also able to have a visit with the man's cousin.

Support for prisoners

38. The man was well liked by staff and prisoners and the prison was aware that his death would have a significant impact on those who knew him. Listeners (prisoners trained by Samaritans to offer confidential support to other prisoners) were briefed at 1.10pm to ensure that they were present on the wings and able to provide immediate support. In addition, 10 prisoners who were subject to suicide prevention procedures were reviewed and monitored. A notice to prisoners was issued by the Director the same day which announced the death and expressed condolences. The notice reminded them of the support available from wing staff, the prison chaplaincy and Listeners.

39. The following day local Samaritans attended the prison and the chaplaincy team visited the wings to provide information and support to prisoners.

40. A memorial service was held in the chapel on 24 June, for all those who wished to attend.

Support for staff

41. A member of the care team (specially trained staff to support other staff at difficult times) and a manager went to the hospital to support the officers who had accompanied the man. They were offered ongoing support from the care team and chaplaincy. The duty director held a hot debrief with the escort officers on 15 June (a meeting immediately after an incident,

designed to reassure staff, and provide them with support), and then let them go home.

Post-mortem report

42. A post-mortem examination was undertaken on 22 June. He concluded the cause of death was due to myocardial infarction (a heart attack), coronary artery atheroma (narrowing of the arteries to the heart resulting in reduced blood flow and causing a heart attack) and left ventricular fibrosis (muscle scarring often associated with drug misuse).

ISSUES

Clinical care and emergency response

43. The clinical reviewer's clinical review looks at the treatment the man received at Peterborough and considers whether it was appropriate and equivalent to the care available in the community.

44. 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 obtained his GP records and quickly verified his medical history and medication.

45. His prescription for flupentixol and GTN spray were continued when he arrived at Peterborough and he was referred to a cardiologist shortly afterwards. The clinical reviewer considers that his care in the prison "was identical in both the quality and expected times for appointment and investigations compared with the care in the wider community".

46. The man's family were concerned that a nurse did not follow up his complaint of pains in his feet and pins and needles on 28 May. During interview, the nurse explained that she had no recollection of the contact with him. She said she probably advised him to make an appointment with the prison doctor, although she did not record that advice. The family was concerned that the symptoms were early signs of an impending heart attack. The clinical reviewer concludes:

> "I am unable to see why pains in the feet as described would be evidence of any specific cardiac pathology or impending event though it may be a sign of early peripheral vascular disease [when arteries to the arms and legs gradually narrow]. Such a condition would not be unusual in a man of this age and in his state of health and would not require extensive investigation and treatment."

47. The man had a history of angina attacks which healthcare staff had managed before so they did not consider it necessary to request an ambulance immediately. They quickly moved him to a well equipped treatment room in the healthcare centre, where his condition could be properly assessed. The clinical reviewer considers that the prison managed the medical emergency very well.

> "The prison management of the acute heart attack seems to be of good quality, and much better than that available to a patient who had a heart attack in the street."

We agree with the clinical reviewer that the emergency response to him was timely and appropriate.

Escort risk assessment

48. The escort risk assessment, completed by a PCO and authorised by the duty director and operations manager, concluded that the man posed a low risk of escape and low risk to staff and the public. Despite this, the initial assessment determined that he would be subject to double cuffing, although this was changed before he left Peterborough to a single cuff escort chain. (Double cuffing is when the prisoner's hands are cuffed together and an additional set of handcuffs is attached to an officer.) There was no explicit written advanced authority for removal of restraints, but, before leaving the prison, the escort officer was verbally authorised to remove restraints if necessary.

49. There is no evidence that a clinical opinion was sought about how the man's medical condition affected his level of risk. The investigator was told when healthcare contribute to an escort risk assessment, the assessment is based purely on any practical issues with cuffing arrangements (for example, known injury to wrists), as opposed to how the person's medical condition affects the risk and capacity to offend or escape.

50. As the man was judged as a low risk of escape and low risk to the public, it is difficult to see how the use of restraints was justified on a man in his condition. At all times he was escorted by two prison custody officers. The prison accepted that no medical opinion about his risk of escape, taking into account his clinical condition, was considered when reaching the conclusion that an escort chain should be used.

The Director should ensure that use of restraints for prisoners being taken to hospital are fully justified by a risk assessment and take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.

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Notifying the man's family

51. Prison Service Instruction (PSI) 64/2011 states that "wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death".

52. At 12.30pm, the prison asked Stevenage Police to notify the man's next of kin that he had been taken to hospital. At 12.36pm, the prison was told that he had died. While looking for the details of his next of kin, the prison heard in a telephone call that his mother was possibly on holiday, but his cousin lived nearby. The prison asked the police to find his cousin on their behalf, if his mother was not at home. Stevenage Police did not confirm that his mother's house was empty until 2.44pm.

53. Following the man's death, Peterborough should have taken responsibility for travelling the relatively short distance of 45 miles to his mother's

address. We do not accept the decision to use the police to inform her was appropriate.

The Director should ensure that wherever possible the next of kin are visited in person by representative from the prison to break the news of a death in custody.

Staff support

54. After the man's death, the officers who had escorted him to hospital were immediately supported by a manager and a member of the care team and attended a hot debrief. However, healthcare staff who attended him when he collapsed were not involved.

55. In PSI 64/2011, a hot debrief is a mandatory requirement: "*a 'Hot Debrief' must be held immediately after the (sic) all deaths in custody. A senior member of staff must act as the debriefer and a member of the care team must attend. All staff directly involved in the incident, including Healthcare staff, should be invited".*

56. Giving staff the opportunity to collectively discuss an incident and reflect on all aspects of how it was managed is fundamental to providing the prison with feedback on any issues that need to be addressed or to identify what went well. It provides those directly involved with an opportunity to process events and to provide mutual support. The prison should have ensured that healthcare staff were invited to the hot debrief.

The Director should ensure that all staff involved in an incident are invited to a hot debrief following a death in custody.

CONCLUSION

57. We agree with the clinical reviewer that the man was treated appropriately during the time he was at Peterborough and received a comparable level of care to that expected in the wider community. The emergency response was swift and healthcare staff demonstrated that their response to an emergency situation was well established and appropriate.

58. Good arrangements were made to support the man's family, although the prison needs to ensure that where possible families are informed of a death in custody in person by someone from the prison. We do not consider that the decision to use restraints when he was taken to hospital was justified by the risk assessment. There is also a need to ensure an inclusive approach to supporting staff involved in emergency incidents.

RECOMMENDATIONS

1. The Director should ensure that use of restraints for prisoners being taken to hospital are fully justified by a risk assessment and take into account and record how the prisoner's health and physical condition impact on his risk while outside the prison.

   NOT ACCEPTED: *The Orderly Officer was the manager who signed off the changes to the risk assessment. The report does not take account of his views. He is clear that he discussed the matter with the Paramedic to see if the agreed 'double cuffing' was appropriate in medical terms. This discussion was had with the prisoner sat up talking and there was no apparent rush to discharge the ambulance.*

   Having taken account of healthcare advice, he checked that a single escort chain would not affect treatment if assured that staff could take these restraints off without consultation if needed. This was agreed to be satisfactory on health grounds. He then checked with the authorising manager to ensure he was content, and the restraints were reduced to an escort chain.

   The Director believes this judgement to be reasonable and appropriate.

2. The Director should ensure that wherever possible the next of kin are visited in person by representative from the prison to break the news of a death in custody.

   NOT ACCEPTED: *The Director believes that HMP Peterborough have a proved track record of notifying next of kin, in person, where possible.*

   The Director states that, in this case, circumstances would not allow a personal visit to the man's next of kin because he had reported his mother was on holiday. Because of this, and the fact that the family home was some considerable distance from the prison, reasonable justification was to contact the police as the prison were aware that, in all likelihood, they would be sending an FLO to an empty house.

   The only way direct prison contact was possible was via protracted family links the following day. The police did not inform the man's mother of the death, it was other family members

   The background to the rationale for the prison's action is clearly outlined in the interview of the chaplain.

3. The Director should ensure that all staff involved in an incident are invited to a hot debrief following a death in custody.

   ACCEPTED: *Local contingency plans now reinforce the need for a hot debrief for all staff involved. The Director acknowledges in this case that*

the targeting of staff "immediately" involved in the debrief was inadequate.
Target date: Completed.