PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in January 2015 at HMP Peterborough

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 investigation report into the death of a man, who died in January 2015, at HMP Peterborough. He was 47 years old. The man died of a subarachnoid haemorrhage (a type of stroke caused by bleeding on the surface of the brain). I offer my condolences to the man's family and friends.

The man was serving an eight-week sentence for breaching a Community Order and arrived at Peterborough on 6 January 2015, the day before he died. He had a history of alcohol and drug misuse and had a cell on the drug treatment wing, where staff observed him hourly through the night. The next morning, at 9.40am, a prison GP assessed the man and prescribed methadone, which the man had been taking in the community. As a safety precaution, the doctor prescribed a lower initial dose. The man took the medication and went back to his cell. Just over an hour later, another prisoner found the man collapsed in his cell. Attempts at resuscitation were unsuccessful and, at 12.00pm, an emergency doctor pronounced the man dead.

The investigation found that the man received a good standard of care at Peterborough. He had a thorough assessment of his substance misuse needs when he arrived and he received appropriate treatment. I am satisfied that his sudden death could not have been foreseen or prevented. Prison staff reacted promptly to the man's collapse but, while this would not have altered the outcome for the man, the investigation identified a need for staff to take the correct equipment immediately to an emergency incident to avoid any delay in treatment.

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 **July 2015**

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SUMMARY

1. On 6 January 2015, the man was sent to HMP Peterborough for breach of a Community Order. At a reception health screen, a nurse noted he had a history of drug and alcohol misuse. A prison GP reviewed the man and prescribed medication for alcohol withdrawal. He went to the prison’s drug treatment wing and staff monitored him hourly throughout the night.

2. The next morning, at 9.40am, another GP assessed the man and prescribed methadone (a heroin substitute) which the man had been receiving in the community. The man went back to his cell after receiving his methadone dose.

3. About an hour later, two prisoners, who had looked through the observation hatch of the man’s cell, were concerned about his appearance. One of the prisoners alerted a prison officer.

4. The officer went into the cell and found the man unresponsive. He placed the man in the recovery position and radioed an emergency code blue, used to indicate circumstances such as when a prisoner is not breathing. While he was doing so, the two prisoners, began cardiopulmonary resuscitation and continued until other officers arrived and took over the resuscitation attempt.

5. The control room called an ambulance immediately they received the code blue. Two nurses went to the man’s cell, but initially took only a small response bag, without any resuscitation equipment. Although this caused no significant delay, during the resuscitation attempt, they had to go to the central hub twice to get an emergency bag, and later a defibrillator. Two sets of paramedics arrived, including an intensive therapy unit doctor in an air ambulance.

6. Prison staff and the paramedics tried to resuscitate the man for nearly an hour but were unsuccessful. At 12.00pm, the emergency doctor pronounced the man dead.

7. We are satisfied that the man received an appropriate standard of healthcare at Peterborough and nothing could have been done to prevent his death. While it would not have affected the outcome for the man, we noted that staff did not routinely take all the relevant equipment immediately to the scene of an emergency. We make one recommendation about this.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Peterborough, informing them of the investigation and inviting anyone who had relevant information to contact her. One prisoner, asked to speak to her.

9. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

10. The investigator obtained copies of the man's prison medical records and relevant aspects of his prison records. The investigator, one of the Ombudsman's investigation managers, and clinical reviewer interviewed six members of staff and two prisoners at Peterborough in February and viewed CCTV footage of the incident. The clinical reviewer and another investigator, interviewed a further member of staff in March.

11. We informed HM Coroner for Peterborough of the investigation, who sent us the post-mortem report. We have sent the coroner a copy of this report.

12. The draft report was issued for consultation with the prison service. They pointed out some factual inaccuracies. This report has been amended accordingly. The action plan has been added to the end of this report.

13. One of the Ombudsman's family liaison officers, contacted the man's family to explain the investigation process. The man's family had a number of questions about the man's medical treatment at Peterborough. They wanted to know whether prison staff had monitored him appropriately during his detoxification and asked for clarification of the exact time of his death.

14. The man's family received a copy of the draft report. They did not make any comments.

HMP Peterborough

15. HMP Peterborough is a local prison, privately operated by Sodexo Justice Services. It holds both men and women in separate sides of the prison. The prison has 24-hour healthcare provision.

HM Inspectorate of Prisons

16. The report of the most recent inspection of HMP Peterborough men's side in February 2015 has yet to be published, but we understand that inspectors found good clinical services for prisoners with substance misuse problems. At the time of the previous inspection, in April 2011, the Inspectorate found that emergency resuscitation equipment and automated defibrillators were available in the healthcare centre and on each of the house blocks. All nurses had up to date mandatory training in basic life support, including the use of defibrillators (a device that gives the heart an electric shock in some cases of cardiac arrest.) Other staff were not trained to use defibrillators and not all staff were up to date with their resuscitation or first aid training.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2014, the IMB commented that there was an excellent framework to improve the quality of the health services and safeguard high standards of care. There had been a shortage of nurses, which had caused problems, but recruitment had improved.

Previous deaths at HMP Peterborough

18. The man's death was the fifth at Peterborough since August 2014. Two previous reports identified the need for staff to take appropriate equipment to an emergency.

KEY EVENTS

19. The man was convicted of possession of an offensive weapon on 3 July 2014. The court imposed a Community Order, requiring him to receive treatment for alcohol problems and to meet his offender manager (probation officer) regularly. He breached the Order as he failed to attend a number of required appointments. As a result, he received an eight-week prison sentence on 6 January 2015. He arrived at HMP Peterborough that evening. He had served previous sentences at Peterborough.

20. At a reception health screen, a nurse carried out a full alcohol withdrawal assessment. She recorded that the man was taking a daily 50ml dose of methadone (heroin substitute), 5mg of diazepam (for anxiety) and an antidepressant. She noted that he said he had an alcohol intake of 330 units per week and used heroin in addition to methadone. The man tested positive for cannabis, opiates and diazepam. The man told the nurse that he had episodes of shaking if he was not able to have an alcoholic drink in the mornings. The nurse referred him to a doctor to assess his substance misuse.

21. The man's medical history from previous times in prison was available on SystmOne (the prison computerised medical record). His records showed that in October 2012, he suffered from alcohol-induced epilepsy, though was not receiving any medication for this condition. He also had abnormal liver function test results, consistent with high alcohol intake.

22. Shortly after his health screen, a doctor saw the man to discuss his alcohol consumption in more depth. The man told the doctor that he drank three litres of cider each day and was suffering mild alcohol withdrawal symptoms. He said that he was prescribed 50ml of methadone daily. The doctor prescribed diazepam, thiamine and vitamin B and the man went to the prison's drug treatment wing for alcohol detoxification and treatment.

23. The man was the only occupant of a double cell on X1 wing, the alcohol and drug treatment wing. As it was his first night in the prison, staff observed him every hour. The man did not report any problems between 9.00pm on 6 January and 6.00am on 7 January.

24. A prisoner and wing cleaner, said that he met the man at around 7.15am on 7 January, when they were unlocked for breakfast. The man told the prisoner that he was feeling unwell.

25. At about 9.40am, the man went to the healthcare centre, where another prison GP, saw the man and found him alert and oriented. The man engaged well with the doctor and did not show any obvious signs of opiate withdrawal. The GP telephoned the man's community pharmacy and confirmed that the man was prescribed 50ml of methadone each day. Contrary to what the man had told reception staff, his community prescription had been unsupervised, which meant that the community pharmacist did not watch the man taking his methadone. In such cases, clinical staff are cautious, as some people with

unsupervised prescriptions sell part of their prescribed dose and are used to a lower dose.

26. Because of the information from the pharmacist, the GP decided it would be safer to prescribe an initial dose of 30mg and then increase it to 40mg and then 50mg daily after two days. A nurse gave the man his initial dose of methadone and the man went back to his wing and was locked in his cell.

27. Shortly afterwards, the prisoner was cleaning the wing and looked through the observation flap on the man's cell door, but could not see him. He carried on cleaning. At approximately 10.45am, the prisoner looked through the man's door flap again and saw that he was on the toilet.

28. A few minutes later, the prisoner looked again and saw that the man was still sitting on the toilet in the same position and did not seem to have moved. He told another prisoner that the man did not look well and the other prisoner looked into the cell and agreed that the man looked unwell. The prisoner then called an officer who was nearby.

29. The officer said he looked through the flap and could just see the man at the right hand side of the cell. He went in and found the man sitting on the toilet, slumped forward. The man did not reply when he spoke to him so he tapped him on the shoulder. The man did not respond but felt warm.

30. The officer laid the man on the floor in the recovery position. He then noted that he was a blue-grey colour and not breathing. Immediately, at 10.58am, the officer radioed a code blue medical emergency code to indicate a serious medical emergency such as where a prisoner is not breathing or unresponsive. He said that that the man was not breathing and asked for the healthcare emergency responder and the first response senior officer. The control room called an ambulance.

31. While the officer was making the emergency call, the two prisoners who had come into the cell, began cardiopulmonary resuscitation, giving rescue breaths and chest compressions. The officer said he let them continue as they were in a better position in the cramped cell and were doing it correctly.

32. The Senior Officer (SO) and officer arrived at the cell. The officer moved the other prisoner and the prisoner away and after checking for signs of life and for obstructions, the SO started mouth-to-mouth resuscitation. The operational manager, then arrived and assisted the SO by performing chest compressions.

33. Two nurses who had heard the emergency code over the radio, went to the man's cell. The on-call emergency response nurse, took a response bag, which contained items such as bandages and gel for burns. The nurse did not take any equipment. The nurse said this was because she was not the designated emergency response nurse. The nurse opened the response bag while another nurse went to the hub (central office on the wing) to get the larger emergency grab bag, which contained oxygen and other emergency

equipment. They then used an ambu-bag (a manual resuscitator) to give the man oxygen from the emergency bag.

34. The nurse did not take the defibrillator to the cell. An officer went to get it, but could not find it, so the nurse went to the hub and brought it to the cell.

35. A doctor arrived followed about 30 seconds later, at 11.05am, by the first paramedic. A second paramedic arrived at 11.07am. The doctor instructed the nurses to inject the man with naloxone (a drug to reverse the effects of heroin and other opioids) in case the man was suffering from an opiate overdose.

36. Staff placed privacy screens on the landing outside the man's cell and moved him to the middle of the landing to allow more space for emergency treatment. The operational manager, a nurse and the paramedics continued cardiopulmonary resuscitation in rotation. At 11.19am, an air ambulance arrived at the prison, with two paramedics and an Intensive Therapy Unit (ITU) doctor.

37. The doctor left the wing and telephoned the man's community GP to find out if there was any relevant medical information that they should take into account. His community GP had no additional information.

38. The emergency team gave the man three doses of adrenaline, a further dose of naloxone and two litres of saline. The defibrillator shocked him twice and the ITU doctor inserted a breathing tube down the man's throat to ventilate his lungs. The paramedics carried out full advanced life support for 53 minutes, but there were no signs of improvement.

39. The ITU doctor assessed the man and, together with the doctor and the paramedics, decided that a transfer to hospital would be of no benefit. The ITU doctor confirmed the man's death at 12.00pm.

Liaison with the man's family

40. A manager at the prison, acted as the prison's family liaison officer. At 12.45pm that day, the manager visited the man's father to inform him of his death and offer condolences.

41. In line with national guidance, the prison contributed to the cost of the man's funeral.

Support for prisoners and staff

42. The prison issued information notices to prisoners and staff about the man's death. Staff arranged for Listeners (prisoners trained by the Samaritans to give emotional support to other prisoners) and the Samaritans, to provide support. Staff reviewed prisoners considered at risk of suicide or self-harm. Staff arranged for the two prisoners to get specific individual support.

43. The Director of Peterborough held a meeting to debrief the staff involved in the emergency response at 12.30pm. The paramedics also attended. The care team spoke to all the staff directly involved and offered support if required.

Post-mortem

44. A post-mortem examination concluded that the man died of a subarachnoid haemorrhage. This is an uncommon type of stroke caused by bleeding on the surface of the brain.

ISSUES

Clinical care

45. The clinical reviewer commended the Staff Nurse and doctor's initial assessment of the man. He received a full and prompt alcohol withdrawal assessment, medication for alcohol withdrawal and a methadone prescription. Staff monitored him overnight. We are satisfied that the man received appropriate treatment and support for his substance misuse problems and his clinical care was good. The man's death was sudden and unexpected and there was nothing staff at Peterborough could have done to foresee and prevent it.

Emergency response

46. When the nurse responded to the emergency code blue, she took only a small response bag, with limited equipment, which was not suited for a prisoner with breathing difficulties. The nurse told the investigator that this was usual, and when they arrived at the man's cell, they assessed that they needed more equipment. The nurse therefore went to the hub to get the larger grab bag with additional emergency equipment. Later, the other nurse had to go back to the hub again to bring a defibrillator.

47. Prison Service Instruction (PSI) 3/2013 requires prisons to have a protocol which, amongst other things, "provides guidance to staff on efficiently communicating the nature of a medical emergency [and] ensures staff called to the scene bring the relevant equipment, (i.e. medical staff and escort staff are alerted and bring relevant 'grab bags'." Peterborough's policy on medical emergencies states that the duty nurse should attend with necessary equipment. The officer who found the man unresponsive used the correct medical emergency code, which clearly indicated an emergency where a prisoner might have breathing difficulties, yet no one brought relevant equipment to the man's cell immediately.

48. We accept that the emergency equipment was nearby and there was no substantial delay. However, we are surprised that, as the equipment was held on the central hub, wing staff did not take it to the man's cell to be ready for nurses when they arrived. The clinical reviewer was satisfied that staff had the relevant emergency training and were able to use their skills appropriately, in collaboration with the paramedics. We also commend the efforts of the prisoners who began cardiopulmonary resuscitation. It is evident that the man could not have been saved, but in future emergencies we consider it is important that appropriate emergency equipment is taken to an incident as soon as an emergency medical code is called, a matter we have brought to the prison's attention before. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff take appropriate life-saving equipment to the scene of an emergency when responding to an emergency medical code.

RECOMMENDATION

The Director and Head of Healthcare should ensure that staff take appropriate life-saving equipment to the scene of an emergency when responding to an emergency medical code.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Director and Head of Healthcare should ensure that staff take appropriate life-saving equipment to the scene of an emergency and when responding to an emergency medical code.	Accepted	A full review of the local medical response protocol will take place. This will identify all locations where emergency medical equipment will be stored and which member of staff is responsible for ensuring it is taken to the scene. Staff will be fully briefed on the process and a written protocol will be produced and circulated.	31 July 2015 Safer Prisons Manager