

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of a man, a prisoner at HMP Peterborough, in February 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died in February 2015, after stabbing himself in the heart with a chisel at HMP Peterborough. He was 51 years old. I offer my condolences to his family and friends.

When the man arrived at the prison on 6 December 2014, staff identified some of his risks for suicide and self-harm, including that he had been charged with a violent offence and that it was his first time in custody. The staff did not begin Prison Service suicide and self-harm prevention procedures. This was a matter of judgement, but I consider that it would have been prudent to monitor him for a time, to consider his risks holistically, allow staff time to get to know him and ensure that he was settled at the prison. However, I also recognise that given his presentation it is unlikely the monitoring would have continued indefinitely or been in place at the time of his death.

There was very little recorded about the man after his arrival, but by the time of his death two months later, he does not appear to have given any signs that he was at heightened or imminent risk of suicide. He appears to have made a determined decision to kill himself and I consider it would have been very difficult for prison staff to have predicted or prevented his death.

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**

**October 2015**

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# Summary

## Events

1. On 6 December 2014, the man was remanded to HMP Peterborough, charged with a serious offence. When he arrived, a nurse recorded that he had no health concerns, was not receiving medication, and had no thoughts of suicide or self-harm. He said that he might have mild depression. Reception officers identified as risk factors for suicide and self-harm that he had been charged with a serious offence and this was his first time in prison. They did not begin monitoring procedures, as he said he did not intend to harm himself.
2. The man lived in the safeguarding unit, at Peterborough. Little was recorded about him in the two months he was at the prison. He worked in the carpentry workshop and appeared to engage well with other prisoners.
3. On Friday 30 January, the man learnt his wife had started divorce proceedings. He told his cellmate that he had been expecting it, as he had lied to her and let her down. Over the weekend, no one noted any concerns about him. On Monday, he went to work as usual and told his cellmate that he would see him at lunchtime.
4. At 10.56am, a prisoner found the man slumped and unresponsive in the workshop toilet. He alerted an officer, who noticed a bloodstained chisel on the floor, and radioed a medical emergency.
5. Other staff arrived quickly and noticed blood on the man's shirt. They found a small wound on the left side of his chest. He had stopped breathing and nurses began cardiopulmonary resuscitation, which they continued until paramedics arrived at 11.09am. The paramedics took him to hospital. A doctor found a puncture wound in his heart and, at 11.48am, declared him dead. He had left a note in his pocket and letters in his cell, which indicated he had planned to kill himself.

## Findings

6. We consider it would have been difficult for staff at Peterborough to have anticipated or prevented the man's actions in February. Although it is unlikely to have affected the outcome for him, we consider that reception staff placed too much weight on his presentation when he arrived, rather than the risk factors they had identified. There was little evidence of any supportive staff interaction with him had after he arrived at the prison. Nurses did not immediately bring the correct emergency equipment and the ambulance was not called immediately, in response to the emergency medical code, as should have happened. We make three recommendations.

## Recommendations

- The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, and record and explain decisions not to open an ACCT when they identify risks.
- The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.
- The Director and Head of Healthcare should make active efforts to ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:

Bring relevant emergency first aid equipment immediately to a code blue or code red; and

Call an ambulance as soon as an emergency medical code is received.

## The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and inviting anyone with information to contact him. No one responded.
8. NHS England appointed a clinical reviewer to review the clinical care the man received at Peterborough.
9. The investigator obtained all relevant documents about the man's time at the prison. He and the clinical reviewer interviewed eight members of staff and two prisoners at Peterborough.
10. We informed HM Coroner for Peterborough of the investigation and have sent him a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's brother to inform him of the investigation and to invite him to identify any relevant issues for the investigation to consider. He said that he would consult other members of his family and let the family liaison officer know. The family did not identify any specific issues or concerns they wanted the investigation to take into account.
12. The family received a copy of the draft report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## Background Information

### HMP Peterborough

13. HMP Peterborough is privately operated by Sodexo Justice Services. It holds men and women in separate sides of the prison and has 24-hour health care provision. Cambridge and Peterborough NHS Foundation Trust provides mental health services.

### HM Inspectorate of Prisons

14. HM Inspectorate of Prisons last inspected Peterborough in February 2015 and noted that there had been four self-inflicted deaths since the previous inspection in 2011. They considered that the prison had made good progress in implementing recommendations from PPO investigations but did not have an integrated action plan.
15. Inspectors described reception as busy. All prisoners were interviewed in private. Suicide and self-harm prevention measures were very good. In their survey, 70% of prisoners said that they had not met their personal officer, although inspectors found that the generally positive approach from the majority of staff meant that prisoners had options if they needed help. Emergency arrangements and response times were appropriate and the prison had a suitable protocol. Resuscitation equipment and defibrillators, which were checked every day.

### Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. The IMB annual report for 2013/14 noted that staff took prisoner safety and security seriously. Communication between all areas of the prison was well organized and focused. The IMB considered that the safer prisons team was highly effective.

### Previous deaths at HMP Peterborough

17. The man's death was the fifth death at the men's side of Peterborough since 2012. In a recent investigation report into a death at the prison, we made a recommendation about staff bringing appropriate medical equipment to an emergency and calling an ambulance immediately. We make a similar recommendation in this report.

### Assessment, Care in Custody and Teamwork

18. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews

involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

19. On Saturday 6 December 2014, the man was remanded to HMP Peterborough, charged with a serious offence. He was 51 years old and this was the first time he had been in prison.
20. An officer, who was working in the prison reception when the man arrived, said he checked for information about a prisoner's risk of suicide or self-harm from police or court records or from the Person Escort Record (which goes with prisoners when they move between police stations, courts, and prisons and lists their risks). He told the investigator that reception staff use a checklist when assessing newly arrived prisoners, which lists potential triggers and risk factors for suicide and self-harm, such as previous self-harm, first time in custody and type of offence (especially violent offences).
21. The officer said that he was aware that this was the man's first time in prison and that his alleged offence was one of violence, both factors which increase the risk of suicide and self-harm. He said that he did not recall anything else of concern about him and would also have considered how he appeared. He did not open an ACCT or use a heightened awareness sheet, which is used when reception staff at Peterborough consider that a prisoner might need additional monitoring on their first night. He did not record the reasons he decided not to open an ACCT, despite the identified risk factors.
22. A nurse saw the man for an initial health screen. She did not identify any immediate risks, but noted that it was his first time in prison and that staff should monitor him. She recorded that he had no physical health problems and was not taking any medication. He said that his GP had considered he might have mild depression, but had not prescribed him medication. She recorded that he had no thoughts or history of suicide or self-harm. There is no record that she was aware of the nature of his alleged offence or how it might affect his risk.
23. The nurse told the clinical reviewer that, during the week, a nurse completes a secondary health screen a few days after the prisoner arrives. However, if a prisoner arrives from court on a Saturday, as the man had done, the duty GP sees them the next day, and this is regarded as the secondary screen. She said that he had no ongoing physical problems, was not on medication, and had no history of mental health problems. She did not refer him to the mental health team. When interviewed, she could not recall him, other than what she had recorded on his medical record.
24. After his healthcare assessment, the man went to the safeguarding unit at his request.
25. The next day, Sunday 7 December, a locum GP assessed the man and made brief notes in his medical record. He recorded that the man smoked 15 cigarettes a day, drank alcohol socially, and was allergic to aspirin. The GP, who was not available for interview, did not refer to the man's previous comment about depression. After this, the man saw healthcare staff only twice more, on 10 December and 21 January, for Hepatitis B vaccinations. He completed his prison induction on 11 December, and started a job in the carpentry workshop.

26. There are only three observational entries in the man's case notes: about his reception, public protection restrictions because of offence and noting that he had completed his induction. After 11 December, there were no entries from officers on his unit, evidencing any interaction with him. Some officers told the investigator that he mixed well with other prisoners, attended work regularly, and gave them no cause for concern.
27. On Friday 30 January, the man received a court letter telling him that his wife had started divorce proceedings. His cellmate told the investigator that they had shared a cell for around two weeks, and got on well. When the letter arrived, the man told him that he had been expecting divorce papers. He said the man seemed to take the news quite well, although he did not want to talk about it. He said that he had lied to his wife and let her down. After this, he did not mention the letter again.
28. Over the weekend, the cellmate said that the man appeared his usual self. He played pool, and they drank tea and ate biscuits. On the morning of the incident the man went to work and, as he left the cell, told his cellmate that he would see him at lunchtime.
29. A prisoner, who worked in the carpentry workshop with the man, said that he first met him on the day he arrived at the prison. He said that he had never had any concerns about him, who was pleasant and amicable. He said that on the day of the incident he saw him briefly on their unit before they left for the workshop and he appeared no different from usual. He had spoken to him in the workshop and did not think that anything was wrong.
30. The prisoner told the investigator that from where he was working he could see the workshop toilet, which is a single toilet with a saloon-type door with no lock. He did not notice the man go to the toilet. Shortly before 11.00am, two other prisoners pointed towards the toilet, which was open and he went to see what was happening. He found the man was sitting on the toilet, but collapsed to the right corner with his head and shoulders against the wall. He shouted for help but none of the other prisoners came to assist. He said that he went into the cubicle and lifted him, who looked grey. He thought that he had collapsed or died.
31. In a police statement, an officer said that he had been in the workshop office that day when, at about 11.00am, he saw a prisoner gesturing towards the toilet, which was next to the office. He went straight out and saw a prisoner trying to lift the man, who was slumped on the toilet. The officer said that he tried to lift the man from the cubicle so they could put him into the recovery position. As he did so, he saw a chisel, approximately 8" long and with blood on it, on the floor beside the toilet. He said that he checked him for any obvious signs of injury and radioed a medical emergency 'code red', which indicates a life-threatening situation involving blood loss.
32. The control room recorded the emergency code at 10.56am, but did not call an ambulance until 11.00am. The staff said that they had been waiting for an update from the workshop before they called an ambulance.

33. Two Senior Prison Custody Officers (SPCO), who were duty managers that day, were close to the workshop when they heard the code red and went straight the workshop. The officer told SPCO A that he thought the man had cut himself.
34. SPCO A said that they lifted the man from the toilet cubicle and laid him on the floor. He said that the man was barely conscious and, when he was breathing, he appeared to be 'blowing bubbles'. They noticed that his shirt had blood on it underneath his workshop overalls and that he had a hole in his shirt. They lifted the shirt and found a puncture wound in his chest area, just above his left nipple. He said that there was not much blood coming from the wound. He put some disposable gloves on and placed his hand over the wound as he thought that air might be going in, and that was why he was blowing bubbles.
35. SPCO B radioed to ask that nurses to bring oxygen and other medical equipment, although he thought that the emergency medical code would mean that nurses would bring emergency equipment anyway. SPCO A said that nurses arrived within a few minutes.
36. Two nurses brought an emergency response bag, but one then left to get a resuscitation bag as the man had gone into cardiac arrest. A third senior prison custody officer, who had responded to the emergency call, began cardiopulmonary resuscitation with the remaining nurse.
37. When the nurse returned with the resuscitation bag, another nurse put a small airway into the man's mouth. She then used an ambu-bag (a hand-held device used to help ventilate people who are not breathing adequately) to administer air and then oxygen. Staff continued with cardiopulmonary resuscitation. They did not notice much blood and she covered the puncture wound with a gauze dressing.
38. The nurse inserted a cannula (a small, flexible plastic tube inserted through the skin to allow access to a vein). However, there were no intravenous fluids in the resuscitation bag as nurses had used them during an emergency on 7 January and not replaced them. She used ampoules of saline instead and injected them into the cannula. They attached a defibrillator to the man, which found no shockable heart rhythm.
39. Paramedics arrived at 11.09am and decided to take the man to hospital for further treatment. They left the prison at 11.25am. No restraints were used.
40. Three prison staff went in the ambulance with the man and continued to attempt resuscitation. When they reached the hospital, staff opened his chest to perform open cardiac massage and found a puncture wound in his heart. At 11.48am, a doctor declared him dead.

### **Contact with the family.**

41. The man had named his brother as his next of kin. Two prison family liaison officers went to the man's brother's home at 1.00pm to let him know what had happened. They telephoned him and asked to speak to him in person. At 2.50pm, he arrived back at his home and they told him that his brother had died. The family liaison officers informed the man's sister and his wife in person later

that day. In the following days, they visited his parents, as agreed with his family. The prison offered funeral expenses in line with national policy.

### **Support for prisoners and staff**

42. The Director of HMP Peterborough debriefed the staff involved in the emergency response. Those involved said that they found it helpful and that the prison's care and welfare team offered them good support.
43. Staff reviewed all prisoners being managed under ACCT procedures in case they had been affected by the man's death and to offer support. Listeners (prisoners who are trained by the Samaritans) and Samaritans were available for prisoners on the safeguarding unit.
44. Because of the circumstances in which the man was found, the prison initially treated the events as a potential crime. Police officers interviewed all prisoners who had been present in the workshop that morning. The police concluded that there had been no third party involvement and that his injuries were self-inflicted.

### **Post-mortem report**

45. A post-mortem examination found that the man had died from a stab wound to his heart. The wound was consistent with a self-inflicted stab wound with the chisel.
46. During the post-mortem, the pathologist found a note in the pocket of the man's clothes. It read, 'This is best, no funeral please,' Police officers found letters to his family in his cell, in which he apologised for his actions.

# Findings

## Management of risk of suicide and self-harm

47. The man saw a reception officer and nurse when he arrived at Peterborough. An officer said that staff at Peterborough use a 'heightened awareness sheet' if they consider that a newly arrived prisoner requires additional monitoring on the first night at the prison, but is not at risk of suicide and self-harm and does not need to be monitored under ACCT procedures. Neither the officer nor the nurse considered him to be at risk of suicide and self-harm or to need this additional monitoring.
48. Prison Service Instruction 64/2011, which governs safer custody procedures, indicates that relationship instability, early days in custody and certain violent offences, are factors that might increase a prisoner's risk of suicide and self-harm. The officer said that he was aware of the man's alleged offence and that it was his first time in prison, but said that he had no concerns about the way he presented. The nurse also recorded that this was his first time in prison, and that he had been told by his GP that he might have mild depression. She did not record his offence.
49. Prison Service suicide and self-harm prevention procedures rely on staff using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. While a prisoner's presentation is obviously important and reveals something of their level of risk, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors should be collated and considered to ensure that a prisoner's level of risk is holistically judged, and any decisions should be recorded. We welcome the fact that staff identified some of his risk factors when he arrived, but they did not record why they had discounted them. We consider that this is important, particularly at a time of high suicide rates in prisons.
50. The man had allegedly committed a violent offence. This was his first time in prison and he told the nurse that he might have mild depression (which might have been adversely affected by his circumstances). In a PPO thematic report on the risk factors, which increase the risk of suicide and self-harm, published in April 2014, we identified these and other risk factors that staff need to take into account when assessing the risk of suicide and self-harm. They are also set out in Prison Service instructions to staff.
51. Although other prisoners said that the man adjusted well to prison, we consider that staff should have supported him using ACCT when he first arrived at Peterborough rather than being reassured by his presentation. This would have given him additional support and might have highlighted other potential triggers for suicide and self-harm, such as his later divorce proceedings. We make the following recommendation:

**The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly arrived**

**prisoner when determining their risk of suicide or self-harm, and record and explain decisions not to open an ACCT when they identify risks.**

### **The man's contact with staff**

52. There were no entries in the man's prison record after he arrived at Peterborough to show any meaningful contact with officers. Peterborough has a personal officer scheme, but at the recent inspection in February 2015, inspectors found that 70% of prisoners they surveyed had not met their allocated officer.
53. We are concerned at the apparent lack of staff interaction with the man. Personal officers are expected to get to know prisoners, support them and help them with any problems. There is no record of anyone introducing themselves to him as his personal officer at Peterborough and no other record of positive staff interaction. The lack of staff interaction meant wing staff had no insight into his concerns or changes in his circumstances, such as his impending divorce and would have been unable to identify whether he needed extra support. We make the following recommendation:

**The Director should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.**

### **Clinical care**

54. The man had little contact with healthcare staff while he was at Peterborough. The clinical reviewer concludes that the care he received was equivalent to what he could have expected in the community. However, the clinical reviewer noted that he did not have a secondary health screen and that the doctor who saw him the day after he arrived did not ask him about depression. The clinical reviewer has made recommendations about this issue in the clinical review, which the Head of Healthcare will need to address.

### **Emergency response**

55. The clinical reviewer commented that, although staff initially responded well when the man was found, there were some problems with the nursing response. During a previous investigation into a death at the prison in January 2015, we found that nurses took only a small response bag to the emergency and had to go and bring other equipment. This happened again this time. Nurses said that this was because they sometimes attend code blue or code red calls that turn out not to be emergencies. The resuscitation bag they took to the emergency did not have intravenous fluids, as they had not been replaced when used during a previous emergency. (This appears to have been the previous death we investigated at the prison.) The clinical reviewer said this was very poor practice.
56. PSI 03/2013, Medical Response Codes, requires governors to have a medical emergency response code protocol and states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical

emergencies. The instruction states that, when a medical emergency is called, the control room should call an ambulance immediately and there should be no requirement to wait for a member of healthcare staff or a manager at the scene to confirm that an ambulance is needed. The control room staff at Peterborough said that they waited for an update from healthcare staff at the scene, which had led to a delay of several minutes before they called an ambulance. We make the following recommendation:

**The Director and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:**

**Bring relevant emergency first aid equipment immediately to a code blue or code red; and**

**Call an ambulance as soon as an emergency medical code is received.**

# Action plan

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Director and Head of Healthcare should ensure that reception staff identify, consider and record all the relevant risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm, and record and explain decisions not to open an ACCT when they identify risks.	Accepted	<p>The Early Days In Custody (EDIC) Manager will ensure that all operational staff are aware of their responsibilities in identifying, recording and sharing risk information and this responsibility begins when a prisoner is received into prison. Quality Assurance checks will be undertaken by the EDIC manager.</p> <p>In May 2015, Peterborough developed and embedded an assessment tool designed to provide additional local guidance for staff during the initial reception screening process. The pro forma takes into account the standards outlined in PSI 64/2011 and draws on learning from the Scottish Prison Service.</p> <p>The Reception Risk Assessment guide has been communicated to staff using Information For Colleagues notice and is also on display at work stations where operational and healthcare reception risk assessments are carried out in reception. A detailed guide to its use will also be available in the same locations and on the EDIC areas.</p>	<p>Early Days In Custody (EDIC) Manager September 2015</p> <p>Completed</p>	
2	The Director should ensure that officers have meaningful contact with every	Accepted	The prison will reinforce the importance of P-NOMIS entries from all departments where any contact is made	Head of Male and Female Services	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs, backed up by regular case history notes.		<p>either directly or indirectly.</p> <p>The Local Operating Procedure for Custodial Support Officers (CSO) will be re-issued via an Information for Colleagues notice with a link to the document.</p> <p>The Directors weekly brief will include the link to the CSO Local Operating Procedure throughout the rest of August.</p> <p>Quality assurance checks will be completed by functional heads of departments.</p>	September 2015	
3	<p>The Director and Head of Healthcare should make active efforts to ensure that all prison and healthcare staff are made aware of and understand their responsibilities during medical emergencies, including that staff:</p> <ul style="list-style-type: none"> <li>▪ Bring relevant emergency first aid equipment immediately to a code blue or code red; and</li> <li>▪ Call an ambulance as soon as an emergency medical code is received</li> </ul>	Accepted	<p>A full review of the medical response protocol has taken place and was presented at the full staff meeting on 26/5/15 and a Local Operating Procedure was published on 31/05/15.</p> <p>The review has introduced a medical response officer that is responsible for ensuring the relevant emergency equipment for each code is brought to the scene. The Safer Prison team held individual briefings with the staff that will be assigned this role. This was conducted daily throughout June and sporadically throughout July.</p> <p>A weekly brief is published for all staff to read. This brief has highlighted how staff should act appropriately in a medical emergency, with clear guidance on what constitutes a Code Red or Code Blue. The weekly brief is</p>	Head of Healthcare September 2015	

**Action Plan**

<b>No</b>	<b>Recommendation</b>	<b>Accepted/Not Accepted</b>	<b>Response</b>	<b>Target date for completion and function responsible</b>	<b>Progress (to be updated after 6 months)</b>
			<p>available in the gate, and other areas of the prison, and is sent electronically to all staff.</p> <p>The safer custody team will continue to brief both operational and non-operational staff throughout the month of August.</p>		