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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man in December  
2014 while a prisoner 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 of lung disease in December 2014, while a prisoner at HMP Peterborough. He was 57 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Peterborough was undertaken. The prison cooperated fully with the investigation.

The man had been in prison since July 2014. He had chronic obstructive pulmonary disease (COPD), a severe lung condition. Healthcare staff monitored his condition and he used a nebuliser twice a day in the prison's healthcare centre to help relieve his symptoms. He was occasionally admitted to the prison's healthcare inpatient unit and to hospital, for monitoring and treatment. In the early hours of 19 December, he was taken to hospital after developing breathing difficulties. Officers used handcuffs and an escort chain to restrain him. The next day, doctors moved him to the hospital's intensive care unit and officers removed the restraints. He did not recover and died several days later.

Progression of COPD can only be halted by lifestyle change and, although healthcare staff helped the man to cut down on smoking, he did not give up completely. The clinical reviewer considered that healthcare staff treated him with care and compassion, but did not manage his condition fully in line with current guidance. While nothing about his care at the prison caused his condition to worsen, a more active approach might have improved his last months. I am concerned that he was restrained in hospital without a fully considered risk assessment to justify this. I have raised this matter with the prison before and the Director needs to take active steps to ensure that all staff undertaking risk assessments understand the legal position.

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**

**August 2015**

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## SUMMARY

1. On 31 July 2014, the man was sentenced to three years imprisonment and was sent to HMP Peterborough. He was a smoker and suffered from chronic obstructive pulmonary disease (COPD). He had managed his condition at home with oxygen monitoring and nebuliser therapy. (A nebuliser gives medication in the form of a mist inhaled into the lungs.) When he arrived at Peterborough, he was extremely short of breath and looked unwell. Staff admitted him to the prison's inpatient healthcare unit for observation and a doctor later diagnosed a chest infection.
2. On 6 August, the man moved to a standard prison wing. He had an outreach care plan requiring staff to ensure that a nurse should see him as soon as possible if he became out of breath. He went to the healthcare centre twice each day to use a nebuliser. A doctor referred him for help to stop smoking, but he did not attend an appointment until 9 October.
3. On 23 October, the man told a nurse that he had cut down his smoking and was feeling quite well. A low carbon monoxide reading a few weeks after he had started the stop smoking programme evidenced this. However, it seems he quickly relapsed. On 8 November, he bought three packs of rolling tobacco from the prison shop. On 16 November, he was admitted to hospital as his oxygen levels had dropped to 85%. On 21 November, the hospital discharged him, after treating him for a chest infection. He continued to smoke, but applied to see a smoking cessation advisor again.
4. At 11.53pm on 18 December, the man pressed his cell bell as he was short of breath. A nurse checked his oxygen levels, which were low at 86%. The nurse administered oxygen but could not maintain his levels and asked for an ambulance, which took him to hospital. In the ambulance, he was restrained by an escort chain (a long chain with a handcuff at both ends) to allow paramedics room to treat him. When he arrived at hospital, a prison manager decided he should be handcuffed until a further risk assessment in the morning, when the escort staff used an escort chain again. There is no record of any healthcare input into the risk assessments.
5. At 11.10am on 20 December, the man stopped breathing. An officer removed the escort chain to allow emergency treatment. The hospital moved him to the intensive care unit, sedated him and put him on a ventilator. The prison informed his family, who went to the hospital to be with him. Several days later hospital staff removed the ventilator and he died the next day.
6. The clinical reviewer found that, although the man received some good compassionate care, healthcare staff did not manage his COPD in line with current best practice guidance. We do not consider that the use of restraints in hospital was based on fully considered risk assessments. We make three recommendations.

## THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Peterborough, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
9. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She interviewed one member of staff at Peterborough on 7 January 2015. The clinical reviewer and another investigator interviewed three members of staff on 19 January.
10. 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 investigation report.
11. One of the Ombudsman's family liaison officers contacted the man's sister-in-law, who acted as his family's point of contact, to explain the investigation process. She asked whether a consultant had advised her brother-in-law to have part of his lung removed before he was sentenced and how his lung condition had been managed in prison. She wanted to know details of his medical appointments and whether he had received a flu vaccination.
12. The draft report was issued for consultation with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of this report.
13. The man's sister-in-law received a copy of the draft report. She provided written representations and asked a number of questions on behalf of the family that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

## **HMP Peterborough**

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

## **HM Inspectorate of Prisons**

15. 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 that health services were reasonably good and that prisoners had good access to a nurse triage clinic and the GP service. There was an appropriate range of clinics but management and care planning arrangements for prisoners with long-term conditions were underdeveloped.

## **Independent Monitoring Board**

16. 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 Peterborough**

17. The man's death was the sixth from natural causes at Peterborough since January 2012. We have made previous recommendations about escort risk assessments and the use of restraints.

## KEY EVENTS

18. On 31 July 2014, the man was sentenced to three years imprisonment for the production and possession of indecent photographs of children. He was sent to HMP Peterborough.
19. At a reception health screen a healthcare assistant noted that the man had chronic obstructive pulmonary disease. (COPD - the name used for a collection of lung diseases including chronic bronchitis and emphysema. People with COPD have difficulty breathing, primarily due to the narrowing of their airways.) He was extremely short of breath and looked unwell. His medication was noted as cetirizine (for hay fever), salbutamol and seretide asthma inhalers, spiriva powder capsules (for use with a nebuliser) and laxatives, lactulose and senna. He was a smoker and had cared for himself at home, using a nebuliser. (A nebuliser is a machine used to give medication in the form of a mist inhaled into the lungs through a mask or mouthpiece.) A prison GP reviewed him and admitted him to the prison's inpatient healthcare unit for observation.
20. On 1 August, a locum GP examined the man and found he had a moderate wheeze and crackles in both lungs. The GP diagnosed a chest infection and prescribed antibiotics and steroids.
21. On 6 August, the man left the inpatient unit and went to Y Wing, a standard prison wing. An outreach care plan instructed that a nurse should see him quickly if he became short of breath and he should use the nebuliser in the healthcare unit. Staff on Y Wing, monitored him for any deterioration in his condition and he went to the healthcare centre twice a day to use the nebuliser. He had a single ground floor cell and healthcare staff referred him for treatment to stop smoking (smoking cessation). (He did not attend smoking cessation appointments on 14 August or 25 September.)
22. On 2 September, the man moved back to the inpatient healthcare unit as he was finding it difficult to breathe. He had a wheezy chest and his blood oxygen level was 92%. Healthcare staff gave him medication using the nebuliser. A prison GP prescribed steroids and said that he should continue to use the nebuliser twice daily.
23. On 3 September, a prison GP reviewed the man and noted that he was still smoking. The next day, healthcare staff discharged him back to his wing on the understanding that he would go to the healthcare centre twice a day for observation and to use the nebuliser. Staff created another outreach care plan for wing staff.
24. On 9 October, the man attended his first smoking cessation appointment. He told a healthcare assistant that he had smoked 40 cigarettes a day for about 30 years. Healthcare staff gave him nicotine replacement patches and lozenges. On 16 October, at his next session, he stopped using the patches as they had given him a rash, but continued with the lozenges.

25. On 23 October, the man told a healthcare assistant that he had cut down on his smoking and now only smoked an occasional 'rollup' during the day. He said he felt better and she advised him to continue taking the nicotine replacement lozenges. On 28 October, he had a flu vaccination.
26. The man continued to attend stop smoking sessions. A low carbon monoxide reading on 6 November indicated he was doing well, with little or no tobacco use. However, after a five-week break, he bought three packs of rolling tobacco from the prison shop on 8 November. On 13 November, he complained that he had been short of breath for three days. A prison GP examined him and noted that he had a cough and a noticeable wheeze in his chest. He prescribed antibiotics and steroids.
27. On the morning of 16 November, a nurse reviewed the man as staff on his wing were concerned about him. She noted he had chest pain and was short of breath. His oxygen saturations were very low at 85% so she took him to the healthcare centre to use a nebuliser. His oxygen levels increased to 92%, but would not stabilise and quickly reduced back to 85%. The nurse requested an ambulance, which took him to hospital at 8.00am.
28. A prison escort risk assessment recorded that the man was a medium risk to the public and a low risk of escape. The healthcare section of the form was blank. Two prison officers escorted him to hospital and used an escort chain to restrain him. (An escort chain is a long chain with a light handcuff at each end, one attached to an officer and the other to the prisoner.)
29. Hospital staff treated the man with oxygen and strong antibiotics for a chest infection. The hospital discharged him on 21 November, and healthcare staff admitted him to the prison's inpatient healthcare unit. He continued to smoke and did not refer him for more smoking cessation sessions. He went back to Y Wing on 1 December, with an outreach care plan for wing staff.
30. On 16 December, the man asked for an appointment for smoking cessation. Two days later, on 18 December, during the afternoon medication round, he asked a pharmacist if he could see a triage nurse or a prison doctor, to review his medication. He was not unwell at the time and did not say the appointment was urgent, so the duty doctor advised that he should put in an application for a routine doctor's appointment.
31. At 11.53pm that evening, the man pressed his cell bell and complained he was short of breath. A nurse examined him and found his blood oxygen levels were low at 86%. She gave him oxygen, which increased the level for a while, but he was unable to maintain this. She asked the Senior Officer in charge of the prison that night to call an ambulance. Paramedics arrived at 0.14am and decided to take him to hospital.
32. The Senior Officer assessed the man as high risk to the public and low risk of escape for the escort to hospital. There is no record of any healthcare staff input into the assessment. He decided that two officers should escort him to hospital and the ambulance left the prison at 0.50am. The escort officers

used an escort chain on the journey to the hospital to allow more space for the paramedics to treat him. At 1.50am, the Senior Officer telephoned the escort officers and instructed them to replace the escort chain with handcuffs, until managers completed a new risk assessment.

33. A prison manager re-assessed the man's risk at 1.45pm, that afternoon. He reduced his assessed risk to the public from high to medium and decided that officers should use an escort chain to restrain him.
34. At 11.10am on 20 December, while hospital doctors were examining him, the man stopped breathing. One of the escort officers removed the escort chain to allow hospital staff to give emergency treatment. Doctors moved him to the intensive care unit, sedated him and put him on a ventilator. The officer telephoned the prison manager to update him about the man's condition. The manager agreed that they did not need to restrain him while he was sedated and receiving treatment.
35. At their request, the prison manager gave the hospital the details of the man's next of kin and phoned his brother and sister-in-law to tell them he was in hospital. Doctors were treating him with strong antibiotics and he remained sedated and attached to the ventilator. The next day, after a risk assessment, the prison reduced his hospital escort to one officer.
36. Several days later, the doctor in charge of the man's care spoke to his brother and sister-in-law and explained that he was critically ill. He was no longer sedated but was still ventilated. His family agreed that he should be taken off the ventilator and that hospital staff should not attempt to resuscitate him if he stopped breathing or his heart stopped. He continued to receive oxygen through a mask. His brother stayed with him at the hospital throughout the night.
37. The man's brother spoke to the doctor in charge of his care. They decided to remove the oxygen mask and allow him to die. He died the next day.

### **Liaison with the man's family**

38. A prison family liaison officer visited the hospital. The man's brother was asleep in the relative's room at the time so she decided to return to see him later that morning. She arrived back at the hospital just after the man had died. She spoke to his brother in the relatives' room and offered condolences and support. The funeral took place on 21 January 2015. The prison contributed towards the costs, in line with national policy.

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

39. The Director issued a notice to inform staff and prisoners of the man's death. A senior manager debriefed the escort staff and offered them the support of the prison's care team.
40. Staff offered support to the prisoners on the man's wing and access to Listeners (prisoners trained by the Samaritans to support other prisoners). Staff checked prisoners considered at risk of suicide or self-harm in case they had been affected by the news of his death.

### **Post-mortem**

41. A post-mortem examination found that the man had died from plural bronchitis and bronchial pneumonia with COPD.

## ISSUES

### Management of COPD

42. The man had been suffering from severe lung disease for a number of years before he arrived at Peterborough. His sister-in-law wanted to know whether a consultant had previously advised him to have part of his lung removed. There was nothing in his records to indicate he had any outstanding hospital appointments or referrals when he arrived at the prison.
43. The man had cared for himself at home and managed his condition with medication, a nebuliser and support from his community GP. The clinical reviewer noted that this previous self-management had not always been optimal, as he had had several urgent admissions to hospital caused by exacerbations of his lung condition. He chose to smoke heavily which made his condition worse.
44. It was not possible for the man to have a nebuliser in his cell, as the prison's healthcare department had only one machine for the whole of the men's prison. He therefore had to attend the healthcare centre twice each day to use this. A prison GP asked a number of times whether his nebuliser could be obtained from his home, as he knew how to operate his own nebuliser and this would have allowed him to have it in his own cell and continue to self-care. However, this was not pursued. The clinical reviewer considered that, due to the prevalence of respiratory disease, there is a need to ensure there is an adequate provision of nebulisers to allow the best care.
45. The man was a heavy smoker and healthcare staff at Peterborough tried their best to manage his COPD within the prison environment. When he had a chest infection or had trouble breathing, staff admitted him to the prison's inpatient healthcare unit for treatment and monitoring. Healthcare staff appropriately ensured that he was admitted to hospital when he had exacerbations of his COPD.
46. The man had care plans to help manage his COPD in the prison. While acknowledging the efforts of healthcare staff, the clinical reviewer did not consider that they managed his COPD in line with the National Institute for Health and Care Excellence (NICE) best practice guidance 2010. Although nothing about his care at the prison caused his condition to worsen, the clinical reviewer considered that there was too little patient information and more could have been done, such as the provision of a nebuliser in his cell to help him self-manage his condition, as he had done in the community. He had no access to pulmonary rehabilitation (which includes inpatient education, exercise training, psychosocial support and advice on nutrition).
47. There was no specialist respiratory nurse to oversee patient management and staff professional development. The Clinical Team Manager (Head of Healthcare) said that the practice development nurse was trained in spirometry (to diagnose lung conditions) and was the prison's designated respiratory lead, but was not trained to the minimum expected diploma level.

While it was possible to obtain external ad hoc advice about respiratory disease, no formal relationship had been established with secondary services.

48. The clinical reviewer commented that it was apparent that the healthcare staff cared for the man, as well as they could, in a very caring and compassionate manner, but there was a need to develop their respiratory disease knowledge, skills and management to provide the best possible care. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with COPD are managed and reviewed in line with NICE guidelines, including adequate provision of nebulisers to allow optimum care.**

### **Help to stop smoking**

49. A prison GP referred the man for smoking cessation support on 6 August, six days after he arrived at Peterborough. Before then, there was nothing in his medical record to indicate that he smoked. Opportunities to smoke are limited to two outside smoking breaks a day, in the healthcare inpatient unit. In the rest of the prison, prisoners are free to smoke in their cells. He did not attend a smoking cessation appointment until 9 October.
50. A nurse told the investigator that, when motivated, the man made good efforts to stop smoking and managed to cut down significantly. However, as his tobacco consumption increased, so did his symptoms. On 23 October, he commented how well he felt once he had reduced his smoking. On 13 November, five days after he had bought a large amount of rolling tobacco, he was short of breath and, on 16 November, was admitted to hospital with a chest infection. When he returned to the prison on 21 November, he continued to buy tobacco. There is no record that anyone actively encouraged him to seek help to stop smoking again and, on 16 December, he had to make an application to ask to see a smoking cessation advisor again.
51. While it was the man's own decision to smoke, the Clinical Team Manager agreed that healthcare staff should have been more proactive in helping him to stop. We make the following recommendation:

**The Head of Healthcare should ensure that all prisoners, especially those with respiratory problems, are fully and actively supported to stop smoking.**

## Restraints

52. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.
53. The man was admitted to hospital with breathing difficulties on 16 November and 19 December. There is no evidence that anyone sought healthcare advice about how his medical condition affected his risk of escape on either occasion. On 19 December, a SO assessed the man as high risk to the public (although his offences would not suggest this was the case) and a low risk of escape. At the time his blood oxygen levels were very low as he was finding it difficult to breathe. As he had judged him to be a low risk of escape, it is not clear why he decided that restraints were necessary.
54. While we are pleased to note that restraints were not reapplied after an escort officer removed them on 20 December, we are concerned that the escort risk assessments did not evidence that managers had taken into account healthcare advice, as the court judgement requires. We make the following recommendation:

**The Director should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that prisoners with COPD are managed and reviewed in line with NICE guidelines, including adequate provision of nebulisers to allow optimum care.
2. The Head of Healthcare should ensure that all prisoners, especially those with respiratory problems, are fully and actively supported to stop smoking.
3. The Director should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

## ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1.	The Head of Healthcare should ensure that prisoners with COPD are managed and reviewed in line with NICE guidelines, including adequate provision of nebulisers to allow optimum care.	Accepted	<p>Nurses have attended specialised training days on respiratory disease. Information will be cascaded to all staff.</p> <p>NICE Pathway for managing exacerbation of COPD (March 2015) is now undertaken in both healthcare departments.</p> <p>More nebuliser units are in place, and more can be obtained if required to maintain care.</p>	<p>August 2015 Head of Healthcare</p> <p>Completed Head of Healthcare</p> <p>Completed Head of Healthcare</p>
2.	The Head of Healthcare should ensure that all prisoners, especially those with respiratory problems, are fully and actively supported to stop smoking.	Accepted	<p>Residents with respiratory problems are highlighted as urgent to the Smoking Cessation Co-ordinator.</p> <p>Non-attendance at appointments is followed up with any reasons documented. The number of smoking cessation clinics are being increased to allow easier access.</p>	August 2015 Head of Healthcare
3.	The Director should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	<p>All Security, Operations and Reception staff will be briefed to ensure a risk assessment is conducted to determine the level of restraints required based on the information received from Healthcare and the actual risk the prisoner presents at the time. The risk assessment for hospital appointment/escort/emergency escort will be amended to ensure Healthcare staff comment on the following: physical ability to escape, need for medication, disability, deterioration in condition, risk to life, and imminent end of life.</p>	30 July 2015 Head Of Security

