Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mrs Doreen Joseph a prisoner at HMP Peterborough on 4 January 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

Mrs Doreen Joseph died on 4 January 2017 of heart disease at HMP Peterborough. She was 83 years old. I offer my condolences to Mrs Joseph's family and friends.

I agree with the clinical reviewer that Mrs Joseph's healthcare at HMP Peterborough was good and staff could not have prevented her sudden death. However, the investigation identified a need for improved prisoner welfare checks.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **August 2017**

Contents

Summary

Events

1. Mrs Doreen Joseph was sentenced to eight years and three months in prison on 17 December 2015 and sent to HMP Peterborough.

2. Mrs Joseph suffered from a number of chronic health problems including type 2 diabetes, heart disease, high blood pressure, arthritis, diabetic foot ulcers and sciatica. She was obese and used a wheelchair. Healthcare staff monitored Mrs Joseph and prescribed relevant medication. They also conducted regular reviews of her diabetes and leg ulcers.

3. On 4 January 2017, an officer unlocked Mrs Joseph's cell at 7.15am. He said he looked in and saw Mrs Joseph asleep in her chair. Just after 7.15am, another prisoner found Mrs Joseph unresponsive in her cell and alerted staff.

4. Two officers went into the cell. An officer radioed for help and he and other officers began chest compressions. The officer called the wrong emergency code but nurses arrived quickly with emergency equipment. Nurses and officers continued with resuscitation attempts. Paramedics arrived and continued to try to resuscitate Mrs Joseph, but they pronounced her dead at 8.09am.

Findings

5. The clinical reviewer said that Mrs Joseph entered prison with a number of medical issues, which were risk factors for heart disease. He concluded that she received an appropriate standard of care at the prison, equivalent to that she could have expected to receive in the community. We agree and found that staff at Peterborough could not have prevented Mrs Joseph's sudden death.

6. When Mrs Joseph attended a hospital appointment, the consultant did not have any details about her medical conditions. The prison inappropriately used restraints for this visit but have now amended their procedures.

7. When unlocking a prisoner's cell, staff have a responsibility to ensure that the prisoner is not only present, but also alive and well. They should also account, personally, for this important check.

Recommendations

- The Head of Healthcare should ensure that medical summary printouts are available for hospital appointments.
- The Director should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Director should ensure that all staff fully understand that inappropriate completion of documents can amount to a serious disciplinary matter.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded and said that she and two other prisoners had relevant information. However, one prisoner did not respond to the invitation to participate in the investigation.

9. The investigator obtained copies of relevant extracts from Mrs Joseph's prison and medical records.

10. The investigator interviewed four members of staff and two prisoners at Peterborough on 7 February 2017.

11. NHS England commissioned a clinical reviewer to review Mrs Joseph's clinical care at the prison. He conducted joint interviews with the investigator.

12. We informed HM Coroner for Cambridgeshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. The investigator contacted Mrs Joseph's husband to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Peterborough

15. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. The women's side of the prison holds over 300 women. There is 24-hour healthcare provision.

HM Inspectorate of Prisons

16. The most recent inspection of the women's side of HMP Peterborough was in June 2014. Inspectors found that the standard of healthcare services was variable. Although women could see a GP shortly after arrival, reception and secondary health screenings did not adequately assure inspectors that all health risks were identified. Well Woman services were very good and women prisoners had reasonable access to the nurse triage clinic and GPs, including a female GP. Care for women with long-term conditions was developing. Inspectors considered that the purpose of the inpatient unit was unclear.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 2016, the IMB reported that the prison offered a good standard of care to residents which was in line with care in the community.

Previous deaths at HMP Peterborough

18. Mrs Joseph was the third woman prisoner to die from natural causes at HMP Peterborough since 2015. There were no significant similarities with the circumstances of the other deaths.

Key Events

19. Mrs Doreen Joseph was sentenced to eight years and three months in prison on 17 December 2015 and sent to HMP Peterborough. She had several complex medical conditions including angina, high blood pressure, diabetes, kidney disease and arthritis. She was obese and used a wheelchair.

20. At an initial health screen, a healthcare assistant noted that Mrs Joseph said she was in constant pain. She arranged for her to be admitted to the healthcare unit due to her poor mobility.

21. A locum GP reviewed Mrs Joseph and completed a prescription for her medications. A nurse saw Mrs Joseph in the diabetic clinic on 22 December. She noted that she was morbidly obese, had angina and poor circulation as her legs and feet were extremely swollen and purple in colour. She offered healthy dietary advice.

22. She frequently saw nurses and doctors to monitor her conditions. She had regular podiatry and optical assessments in relation to her diabetes.

23. Friends of Mrs Joseph told the investigator that she had many medical problems and had hearing loss. They said she had limited mobility and they helped her to collect her meals and medication. They said that on occasions she had slipped and increasingly used a wheelchair.

2016

24. On 23 January 2016, staff moved Mrs Joseph to a disabled cell on C wing (an adapted larger cell that has a hospital bed). As part of an external care package for social care, a carer visited her daily to help her dress. When Mrs Joseph complained that in an emergency she would have difficulty reaching the in cell intercom button, staff issued her with a pendant panic alarm. She wore this around her neck in the day and in the evening kept it on her pillow.

25. On 10 June, Mrs Joseph developed swelling and infection in her lower leg. A locum GP diagnosed cellulitis, prescribed antibiotics, and told Mrs Joseph to keep her legs elevated. Initially, the problems appeared to clear up but they returned on 21 June. A prison GP noted that the cellulitis had returned, so she prescribed another course of antibiotics for two weeks. Nurses frequently changed Mrs Joseph's leg dressings.

26. The cellulitis again flared up on 1 August. A prison GP noted that this occurred shortly after the completion of the course of antibiotics. He prescribed another two week course of antibiotics.

27. On 11 October, Mrs Joseph told a nurse that for two months she had shortness of breath. She referred her to see a GP. A locum GP examined Mrs Joseph and diagnosed a chest infection. He prescribed antibiotics and decongestant steroids.

28. On 14 November, Mrs Joseph attended a hospital appointment at hospital to review the diabetic nerve damage to her legs. The hospital consultant said that the prison had failed to provided a medical summary for her appointment. He

noted that she had circulation problems and nerve damage in her legs. He recommended physiotherapy.

29. A locum GP described "massive cellulitis" on both legs and prescribed antibiotics when he saw Mrs Joseph on 16 December. Nurses recorded fluctuating changes to the cellulitis.

30. A prisoner said that she last saw Mrs Joseph in her cell at approximately 6.20pm on 3 January. She made sure that Mrs Joseph was comfortable, said good night, and went to her cell.

Events on 4 January 2017

31. At approximately 7.15am, Officer A unlocked the door to Mrs Joseph's cell. He said he saw her asleep in her chair and did not notice anything untoward. The wing log was signed to this effect.

32. Just after 7.15am, a prisoner said she went to Mrs Joseph's cell. She knocked on the door and entered. She saw Mrs Joseph in the chair and her eyes and mouth were open. Her lips were blue and her tongue was swollen. She checked her pulse but there was nothing so she closed her eyes and left the cell. Outside the cell, she saw Officer B, called over to him, and shook her head. He asked her what she meant and she said that Mrs Joseph had gone.

33. Officer B said that when the prisoner called him over, he opened the cell door and thought something was wrong. He called Officer C to enter the cell with him. Officer B said that Mrs Joseph looked grey/green in colour and her tongue was swollen. He radioed for immediate medical assistance (he radioed a "code red" medical emergency, indicating a life threatening incident involving blood loss) and added that an ambulance was needed. At interview, Officer B said he realised he radioed the wrong code, as it should have been a "code blue" medical emergency (indicating a life threatening incident involving breathing difficulties).

34. A nurse responded when she heard the emergency radio code at approximately 7.20am. She said that Mrs Joseph was non responsive in her chair, her lips were slightly blue. With assistance from prison staff and nurses, they placed her on the floor and started cardiopulmonary resuscitation (CPR). She found there was no pulse, attached a valve mask with high flow oxygen, and used a defibrillator machine. She noted that there were no signs of life. They continued with the resuscitation attempts until the paramedics arrived. Paramedics arrived at the prison at 7.40am and attended to Mrs Joseph. At 8.09am, a paramedic confirmed that Mrs Joseph had died.

Contact with Mrs Joseph's family

35. The prison appointed an officer as the family liaison officer. Mrs Joseph's nominated next of kin was her husband, who was also in prison. After she died, the officer contacted HMP Isle of Wight for staff to break the news of her death to her husband. Chaplaincy staff at HMP Isle of Wight broke the news and offered condolences and support.

36. Later that day, Mrs Joseph's daughter-in-law rang the officer. She said that Mrs Joseph's husband had told her that Mrs Joseph had died. Mrs Joseph's daughter also rang the officer. He offered condolences and support.

37. Mrs Joseph's funeral was held on 8 February 2017. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

38. After Mrs Joseph's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

39. The prison posted notices informing other prisoners of Mrs Joseph's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mrs Joseph's death.

Post-mortem report

40. The Coroner confirmed that the cause of Mrs Joseph's death was ischaemic heart disease, caused by coronary artery atheroma (hardened arteries), aortic stenosis (narrowing of the aortic valve) and left ventricular hypertrophy (enlarged and thickening of the heart).

Findings

Clinical care

41. The clinical reviewer said that Mrs Joseph's age, long term medical conditions, diabetes and obesity were all risk factors for heart disease. We agree with the clinical reviewer that the standard of Mrs Joseph's care at the prison was equivalent to that she could have expected to receive in the community.

42. The clinical reviewer said that medical summary printouts should accompany prisoners for hospital appointments. We agree and make the following recommendation:

    The Head of Healthcare should ensure that medical summary printouts are available for hospital appointments

Welfare checks

43. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that:

    "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

44. Prison Service Instruction (PSI) 75/2011 also states that:

    "There need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

45. Officer A, who did the roll check at about 7.15am, saw that Mrs Joseph was in her chair, but did not realise that anything was wrong. While roll checks are principally for security reasons, to check that prisoners are present, staff should also satisfy themselves by a visual and verbal check, that the prisoner is alive and breathing. This was not done in Mrs Joseph's case.

46. Almost immediately after, a prisoner entered the cell and saw that something was wrong. We consider that when unlocking the cell staff should have checked on her welfare. While this may not have affected the outcome for Mrs Joseph, it could make a difference in the future.

47. Each wing has a log book which staff are required to sign to confirm that they have completed the welfare checks. It became apparent during the investigation that the process in place meant that staff who completed the check did not sign the wing log book but would relay this to a colleague in the wing office who would sign the log. The person in the wing office relied on a message from the person

unlocking the cell. On this occasion, Officer B signed the formal wing book to confirm he had completed the welfare checks. We are concerned that this indicates a falsification of the document. We make the following recommendations:

The Director should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Director should ensure that all staff fully understand that inappropriate completion of documents can amount to a serious disciplinary matter.

Restraints, security and escorts

48. 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 a 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 judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

49. On 3 January, Mrs Joseph was taken to hospital for an eye appointment. At the time, she had leg dressings and had poor mobility. The escort risk assessment noted that she was a wheelchair user and had a heart condition. She was assessed as low risk to the public, of hostage taking, escape potential and having assistance. The assessment noted that taking into account her age, wheelchair use and the unlikelihood of escape, handcuffs may not need to be applied. An operational manager authorised the use of an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). He also said that there should be two officer escorts, one of which should be female.

50. Later that day, when Mrs Joseph returned to the prison, the operational manager went to the reception area to assist her out of the taxi. He said that he then realised that the handcuffs he had authorised were unnecessary. He said he had spoken to the Director and Security manager and there had been a change in their process. He said the new process was that the security manager completed risk assessments, to ensure consistency. In addition, reception staff were told to contact a duty manager if they had any concerns so the risk assessment could be reviewed to ensure the handcuffing arrangements were appropriate.

51. Public protection is fundamental but the level of security for the hospital visit was disproportionate. The clinical reviewer noted that restraints were unnecessary as Mrs Joseph was in poor physical health and a wheelchair user. We remind the prison of the importance of risk assessments clearly showing that consideration has been given about how or whether a prisoner's health condition at the time

affected the risk of escape As the prison has already implemented changes to the risk assessment process to reflect this, we make no recommendation.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141