Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Siddall a prisoner at HMP Pentonville on 24 March 2016

A report by the Prisons and Probation Ombudsman
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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.

Mr Peter Siddall died on 24 March 2016 of pneumonia while a prisoner at HMP Pentonville. He was 49 years old. I offer my condolences to Mr Siddall's family and friends.

I consider that Mr Siddall received a good standard of clinical care for the four days that he was at Pentonville. Mr Siddall's death was sudden and healthcare staff at the prison could not have anticipated or prevented it. However, I am not satisfied that a decision to handcuff him when he went to hospital fully took into account his medical condition. I am also concerned that it took too long to inform Mr Siddall's family that he was seriously ill in hospital.

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 **October 2016**

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Summary

Events

1. On Friday 18 March 2016, Mr Peter Siddall was remanded to HMP Pentonville, charged with drug offences. He had been in police custody since 15 March. At an initial health screen, Mr Siddall said he took mirtazapine for depression and buprenorphine (for opiate dependency). He was suffering from moderate withdrawal symptoms, as he had not taken any buprenorphine in police custody. A nurse referred him to the substance misuse team and the mental health team.

2. A prison GP noted Mr Siddall did not appear to have severe withdrawal symptoms and prescribed sleeping tablets. The next morning, 19 March, the GP examined Mr Siddall again and prescribed a low dose of buprenorphine, as Mr Siddall said he was keen to detoxify.

3. On 21 March, the prison's substance misuse doctor assessed Mr Siddall, who said he felt unwell. His symptoms indicated he was suffering from opiate withdrawal symptoms and the doctor increased the buprenorphine dose.

4. On the morning of 22 March, a mental health worker found Mr Siddall struggling to breathe and with chest pain. A nurse and doctor assessed him. The doctor considered he might have pneumonia and arranged an emergency ambulance to take him to hospital. Mr Siddall was restrained by double handcuffs.

5. On the evening of 22 March, Mr Siddall suffered a cardiac arrest in hospital. Officers removed the restraints when a nurse asked them. Doctors placed Mr Siddall in an induced coma. On the afternoon of 23 March, when prompted by the hospital, the prison informed Mr Siddall's family that he was critically ill. Mr Siddall died at the hospital on 24 March.

Findings

6. Mr Siddall's death was sudden and unexpected and we do not consider that healthcare staff at Pentonville could have prevented it. We are satisfied that Mr Siddall received a good standard of care in the short time he was at Pentonville, equivalent to that he could have expected to receive in the community.

7. However, we are concerned that the Governor overrode medical objections to the use of restraints without giving reasons for his decision. It also took too long to inform Mr Siddall's family that he was seriously ill in hospital.

Recommendations

- The Governor should ensure that he and 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.

- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Pentonville informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator visited Pentonville on 4 April 2016. She obtained copies of relevant extracts from Mr Siddall's prison and medical records, and interviewed four members of healthcare staff.

10. NHS England commissioned a clinical reviewer to review Mr Siddall's clinical care at the prison.

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

12. One of the Ombudsman's family liaison officers contacted Mr Siddall's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why it had taken almost 24 hours for the prison to tell her that Mr Siddall had been taken to hospital.

13. Mr Siddall's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

14. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Pentonville

15. HMP Pentonville is a local prison that holds over 1,300 young adult and adult men. The prison primarily serves the courts of north and east London.

16. Healthcare services are provided by Care UK in partnership with Enfield and Haringey Mental Health Trust. There is a large purpose built healthcare centre which has 22 inpatient beds and a day care facility for patients with mental health problems who are managed on the wings.

HM Inspectorate of Prisons

17. The most recent inspection of Pentonville was in February 2015. Inspectors reported that healthcare services were reasonably good overall. There was an appropriate range of primary care services, with acceptable waiting times.

Independent Monitoring Board

18. 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 March 2015, the IMB reported that healthcare services were delivered to a reasonably efficient standard. All prisoners had a health screen in reception, there were daily GP clinics and a nurse run 'walk-in' clinic on the wings.

Previous deaths at HMP Pentonville

19. Mr Siddall was the second prisoner to die from natural causes at Pentonville since June 2014. There were no significant similarities with the circumstances of the other death.

Key Events

20. On 18 March 2016, Mr Peter Siddall was remanded to HMP Pentonville charged with drug offences. He had been in police custody since 15 March.

21. At an initial health screen, a nurse assessed Mr Siddall and noted he appeared settled in mood with slight opiate withdrawal symptoms. Mr Siddall said that he was prescribed 30mg of mirtazapine (for depression) and 12mg of buprenorphine (an opiate replacement therapy) daily. He had last received buprenorphine on 14 March, before being arrested. Mr Siddall said that he had taken heroin three weeks earlier and that he often used cocaine. A urine sample indicated the presence of opiates. The nurse referred Mr Siddall to the substance misuse team and the mental health in-reach team.

22. Later that day, a prison GP examined Mr Siddall and noted that he looked tired but his withdrawal symptoms did not appear to be severe. Mr Siddall said he was keen to detoxify and asked for sleeping tablets, which the doctor prescribed.

23. On 19 March, a prison GP reviewed Mr Siddall, who said he felt cold and sweaty. The GP wanted to prescribe his usual dose of 12mg of buprenorphine to relieve the withdrawal symptoms, but Mr Siddall asked for a lower dose. The GP prescribed 4mg.

24. On 21 March, a substance misuse GP examined Mr Siddall. Mr Siddall told her that he had missed four to five days of buprenorphine while he had been in police custody. Mr Siddall said he felt terrible; he was fidgety, wakeful, and not eating or sleeping. She increased Mr Siddall's buprenorphine to 8mg daily and booked a review for five days later. Mr Siddall was reported to be settled overnight.

25. On the morning of 22 March, a senior mental health social worker went to see Mr Siddall in his cell, to assess his mental health. During the assessment, Mr Siddall became short of breath and said he had chest pain. He asked if it was due to drugs withdrawal and Mr Siddall said he thought it might be.

26. The senior mental health social worker called an officer for help, who contacted nurses who were working two floors above. Mr Siddall left his cell and leant against the pool table on the landing outside. He was able to speak. A substance misuse nurse and a healthcare assistant arrived very quickly, at around 11.00am. Mr Siddall said that he could not get up the stairs so they used a lift to take him to the treatment room. Mr Siddall told the nurse that he had difficulty breathing and felt that he had lots of mucus stuck in his throat.

27. When they reached the treatment room, the nurse noted Mr Siddall's oxygen saturation level was low at 77% and gave him oxygen. She was unable to take a blood pressure reading, as Mr Siddall was moving around too much. The nurse gave Mr Siddall a nebuliser to widen his airways. This did not help, so she gave him more oxygen, which increased his saturation level to 84% Mr Siddall was in some distress but was able to talk and could move about the room. A prison GP assessed him and diagnosed respiratory distress, possibly pneumonia. At 11.37am, the GP requested an emergency ambulance.

28. The ambulance arrived at 11.58am and paramedics gave Mr Siddall more oxygen which increased his oxygen level to 90%. At 12.42pm, the ambulance left the prison and took Mr Siddall to hospital. The Governor decided that officers should use double handcuffs to restrain him. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving category A or category B prisoners in good health.)

29. Mr Siddall was admitted to hospital. At 5.30pm, he suffered a cardiac arrest and a nurse asked officers to remove the restraints, which they did. Doctors placed Mr Siddall in an induced coma. Mr Siddall remained critically ill. At 9.35am on 24 March a doctor recorded that Mr Siddall had died.

Contact with Mr Siddall's family

30. Just after midday on 23 March, a hospital nurse told one of the escort officers, that they should inform Mr Siddall's family that he was critically ill. The prison then contacted Mr Siddall's mother and appointed an officer as the family liaison officer. At 3.15pm, the officer arrived at the hospital, where he met Mr Siddall's mother and his sister-in-law and offered his support.

31. At 4.55am on 24 March, Mr Siddall's ex-partner and his son arrived at the hospital and spent some time with him, but had left the hospital before he died. Mr Siddall's family had arranged with the hospital that hospital staff would inform them if he died and member of his family went back to the hospital. The officer met them there and offered his condolences and support.

32. Mr Siddall's funeral was on 15 April. In line with national policy, the prison offered to contribute to the costs.

Support for prisoners and staff

33. After Mr Siddall's death, a senior manager debriefed staff involved in his care, to offer support and that of the staff care team.

34. The prison posted notices informing all staff and prisoners of Mr Siddall's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm in case they had been adversely affected by Mr Siddall's death.

Post-mortem report

35. The post mortem report concluded that Mr Siddall died of pneumococcal pneumonia (a bacterial lung infection).

Findings

Clinical care

36. When Mr Siddall arrived at Pentonville, a prison nurse and GP thoroughly assessed him and appropriately referred him to the substance misuse team and mental health team. Healthcare staff saw Mr Siddall daily but Mr Siddall did not complain about difficulty breathing and it is possible that if Mr Siddall had any symptoms, he attributed them to his drug withdrawal. The clinical reviewer noted that early symptoms of pneumonia are easily confused with drug withdrawal symptoms. He was satisfied that, until Mr Siddall's sudden deterioration on 22 March, healthcare staff could not have known about his respiratory problem or taken any action to prevent or treat it.

37. Once Mr Siddall presented with breathing difficulties, a nurse and doctor assessed him promptly and appropriately called an ambulance. We are satisfied that Mr Siddall's care at the prison was equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

38. 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

39. When Mr Siddall went to hospital on 22 March, a security risk assessment assessed Mr Siddall as a low risk of escape and medium risk to the public, as he had previous convictions for violent offences. There was no medical input as to the risk Mr Siddall posed at the time and the Governor authorised the use of double handcuffs to restrain Mr Siddall. When Mr Siddall had a cardiac arrest, a nurse asked officers to remove the restraints and they were not reapplied.

40. Mr Siddall was in respiratory distress when he left the prison and he had been unable to walk up stairs to the healthcare centre. There is insufficient information for us to be satisfied that staff fully considered whether Mr Siddall's health and mobility at the time, affected his risk. It is the Governor's responsibility to ensure that the risk assessment process is properly managed and that healthcare staff fully understand the requirements of the High Court judgment. We make the following recommendation:

    The Governor 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.

Liaison with Mr Sidall's family

41. Prison Rule 22 requires prisons to inform the prisoner's spouse or next of kin, and any other person the prisoner has reasonably asked should be informed 'at once' if a prisoner is seriously ill.

42. We consider that the prison should have informed Mr Siddall's family as soon as he was taken to hospital by emergency ambulance on 22 March, when he was in respiratory distress and had suspected pneumonia. At the latest, they should have informed his family when he suffered a cardiac arrest at the hospital later that afternoon. We are concerned that no one contacted Mr Siddall's family until prompted by a hospital nurse the next day, when his condition was critical. While Mr Siddall's family were able to get to the hospital, any delay in informing families when a prisoner is seriously ill can mean that families miss the opportunity to see them before they die. We make the following recommendation:

    The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.

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