

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Robert Peach, a prisoner at HMP Altcourse, on 25 September 2019

**A report by the Prisons and Probation Ombudsman**

## 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.

Mr Robert Peach was found dead in his cell at HMP Altcourse on 25 September 2019. The cause of his death is unknown. He was 40 years old. I offer my condolences to Mr Peach's family and friends.

Mr Peach arrived at Altcourse on the evening of 24 September. A urine test showed that he had used drugs and a nurse assessed that he had moderate drug withdrawal symptoms. He was located on the substance misuse wing and observed twice an hour during the night. He was found dead in his cell on the morning of 25 September.

Mr Peach should have been seen by a GP before he was taken to the substance misuse wing. However, this did not happen, which meant that Mr Peach was not prescribed any medication he might have needed.

The clinical reviewer concluded that this aspect of Mr Peach's care at Altcourse was not equivalent to that which he could have expected to receive in the community.

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

**Sue McAllister CB**  
**Prisons and Probation Ombudsman**

**September 2020**

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# Summary

## Events

1. On 24 September 2019, Mr Robert Peach was recalled to prison because he breached his licence. He was sent to HMP Altcourse.
2. Mr Peach arrived at Altcourse shortly before 7.00pm. At his reception health screen, the nurse noted that Mr Peach had moderate drug withdrawal symptoms, and would need to be located on the substance misuse wing.
3. Mr Peach was taken to his cell at approximately 9.00pm. At 11.49pm, the night nurse went to Mr Peach's cell to check on him. She noted that he was asleep but that he then woke up and acknowledged her presence. The night officer went to Mr Peach's cell twice an hour throughout the rest of the night. He noted that Mr Peach was under the covers and appeared to be asleep.
4. The following morning, at 7.37am, an officer unlocked Mr Peach's cell and called to him that he had a gym induction. When Mr Peach did not respond, the officer went into the cell, pulled back the bed covers and tried to wake him. Mr Peach still did not respond so the officer called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties).
5. Healthcare staff attended and assessed that Mr Peach was dead so they did not try to resuscitate him. At 8.55am, a prison GP confirmed that Mr Peach was dead.
6. The post-mortem examination was unable to establish the cause of Mr Peach's death and recorded it as unascertained.

## Findings

7. The clinical reviewer found that the care that Mr Peach received was of a mixed standard, and therefore, not wholly equivalent to that which he could have expected to receive in the community.
8. Mr Peach's reception health screen was completed to a good standard, and it was quickly identified that Mr Peach had alcohol and drug issues. However, the nurse did not record the results of Mr Peach's urine drug screen, which tested positive for drugs, as he should have done.
9. We are also concerned that Mr Peach was not reviewed by a doctor, or prescribed any medication that he might have needed before being taken to his cell.
10. When the night nurse checked on Mr Peach, she did not record if Mr Peach gave a verbal response and if he did, what he said.

## Recommendations

- The Head of Healthcare should ensure that staff record the results of a urine drug screen in the prisoner's medical record.
- The Director and Head of Healthcare should ensure that prisoners are reviewed by a GP before being taken to the substance misuse wing.
- The Head of Healthcare should ensure that when staff carry out a check on a prisoner, they make a full record of the check, including details of any response obtained from the prisoner.

## The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Altcourse informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Peach's prison and medical records.
13. The investigator interviewed six members of staff at Altcourse on 12 November 2019.
14. NHS England commissioned an independent clinical reviewer to review Mr Peach's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
15. We informed HM Coroner for Liverpool of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Peach's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She asked if Mr Peach had been checked during his first night in custody. This has been covered in this report.
17. Mr Peach's next of kin received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

# Background Information

## HMP Altcourse

19. HMP Altcourse is a local prison in Liverpool, which takes prisoners from courts in Merseyside, Cheshire and North Wales. It holds up to 1,324 remanded and sentenced adults and young men. G4S manages the prison and provides primary healthcare services. There is an inpatient unit with 12 beds and 24-hour healthcare cover.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Altcourse was in November 2017. Inspectors reported that reception processes were swift and the area was bright and spacious, but prisoners in holding rooms did not have anything to keep them occupied. Initial risk assessment structures were good and assessments were conducted in private. Some first night cells were grubby and poorly prepared. A comprehensive induction was delivered the day after arrival. Peer support during prisoners' early days was very good.
21. Mainstream prisoners spent their first night in the Reynoldstown Brown unit and prisoners who were vulnerable because of their offence went to the Beechers Green unit. Prisoners identified as needing stabilisation from the effects of drugs or alcohol were usually located in the Furlong Red detoxification or stabilisation unit, although there were occasional delays before they were admitted. Inspectors noted that the staff they spoke to in the first night unit were aware of all new arrivals, provided support and carried out additional first night observations.

## Independent Monitoring Board

22. 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 June 2019, the IMB reported that prisoners were treated fairly and humanely. The prison continued to work towards ensuring that a culture of safety, decency and dignity were embedded within the life of the prison.

## Previous deaths at HMP Altcourse

23. Mr Peach was the 10th prisoner to die at HMP Altcourse since September 2017. Of the previous deaths, three were self-inflicted and six were from natural causes. There are no similarities between Mr Peach's death and previous deaths at Altcourse.

## Key Events

24. On 24 September 2019, Mr Robert Peach was recalled to prison because he breached the terms of his licence. He was sent to HMP Altcourse.
25. A nurse completed the reception health screen. Mr Peach's clinical observations were normal, apart from slightly elevated blood pressure. The nurse noted that Mr Peach had ongoing problems with alcohol and drugs, including cocaine and opiates (heroin). A urine drug screen showed that Mr Peach had recently used drugs. The nurse assessed that Mr Peach had mild withdrawal from opiates and moderate withdrawal from benzodiazepines. (Benzodiazepines are tranquillisers, which are prescribed for anxiety and insomnia, but they can be abused. Using tranquillisers can be risky and especially dangerous if they are mixed with other depressants such as heroin and alcohol.) Mr Peach also had mild alcohol withdrawal (at a level that would not usually require medication).
26. When the nurse was interviewed, he said that Mr Peach appeared physically well but because of Mr Peach's drug and alcohol issues, he decided he should be located on the substance misuse wing. The nurse said he added Mr Peach to the GP ledger for review, but Mr Peach was not seen by the GP.
27. At approximately 9.00pm, an officer took Mr Peach from reception to the substance misuse wing, and he was located in a cell on his own.
28. At 11.49pm, a nurse checked on Mr Peach by looking through the observation panel in his cell door. The nurse recorded that Mr Peach was asleep but that he then woke up and acknowledged her presence. An officer checked Mr Peach twice an hour throughout the rest of the night. He recorded that Mr Peach was asleep under the covers.
29. On 25 September, at 7.37am, an officer unlocked Mr Peach's cell and shouted to him that he needed to go to a gym induction. Mr Peach did not respond so the officer went into the cell and pulled back the cover from Mr Peach. He said that when he touched his shoulder, it felt solid and he knew that something was wrong. He called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties).
30. A nurse responded to the code blue and went to Mr Peach's cell. She turned Mr Peach over and tried to find a pulse. She could not find a pulse and saw that Mr Peach was not breathing. She noted that Mr Peach had rigor mortis (stiffening of the limbs that occurs two to six hours after death) so she did not try to resuscitate him. At 8.55am, a prison GP arrived and confirmed that Mr Peach was dead.

### **Contact with Mr Peach's family**

31. On 25 September, after Mr Peach's death, the prison appointed a prison manager, as the family liaison officer (FLO). The FLO went to Mr Peach's father's house with another prison manager and broke the news of Mr Peach's death. They offered Mr Peach's family support and discussed the funeral arrangements.
32. The prison contributed towards Mr Peach's funeral in line with national guidelines. The funeral took place on 24 October.

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

33. After Mr Peach's death, a prison manager debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
34. The prison posted notices informing other prisoners of Mr Peach's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Peach's death.

### **Post-mortem report**

35. The post-mortem report concludes that the cause of Mr Peach's death is unascertained. The pathologist said that the circumstances suggested a sudden death in bed, but there was insufficient evidence to reliably establish a cause of death.

# Findings

## Clinical Care

36. Mr Peach arrived at Altcourse with a long history of substance misuse. The clinical reviewer considered that overall, the care that Mr Peach received was of a mixed standard, and therefore not wholly equivalent to that which he could have expected to receive in the community.
37. The reception health screen identified that Mr Peach had moderate drug withdrawal symptoms and Mr Peach was appropriately located on the substance misuse wing. However, the clinical reviewer was concerned that the results of Mr Peach's urine drug screen, which tested positive for drugs, were not recorded in Mr Peach's medical record as they should have been. We make the following recommendation:

**The Head of Healthcare should ensure that staff record the results of a urine drug screen in the prisoner's medical record.**

38. We are concerned that Mr Peach was not reviewed by a GP before being taken to the substance misuse wing, which meant that he was not prescribed any medication that he might have needed. When interviewed, a nurse said that he had added Mr Peach to the GP ledger. He also said that officers, who were responsible for taking prisoners to the GP, were aware that anyone going to the substance misuse wing needed to see the GP first. He could not say what went wrong in Mr Peach's case.
39. The Head of Healthcare said that she had looked into the issue. She said that the slots on the GP ledger started from 5.00pm but the GP did not start his shift until 6.00pm. All the slots from 6.00pm onwards had been taken by the time the nurse saw Mr Peach, so he added him into a slot between 5.00pm and 6.00pm. She thought the GP had not looked at the slots before 6.00pm as that was before his shift started, so Mr Peach had been missed.
40. The clinical reviewer noted that this went against Department of Health guidelines (2006) on the management of drug dependence in an adult prison setting, which state that appropriate prescribed clinical management should be undertaken by a doctor at reception. We make the following recommendation:
- The Director and Head of Healthcare should ensure that prisoners are reviewed by a GP before being taken to the substance misuse wing.**
41. The clinical reviewer was also concerned that when a nurse completed her night check she did not record if Mr Peach gave a verbal response, and if he did, what he said. We tried to contact the nurse on several occasions but she was unavailable for interview. We make the following recommendation:
- The Head of Healthcare should ensure that when staff carry out a check on a prisoner, they make a full record of the check, including details of any response obtained from the prisoner.**

## Overnight checks

42. An officer checked on Mr Peach twice an hour during the night. At interview, he said that he was responsible for checking on the prisoners' welfare. He was not required to get a verbal response from them but if they were in a strange position, or on the floor, he would ask them if they were okay. He said he was not required to wake them up if they appeared to be asleep, unless there were issues of concern.
43. Mr Peach appeared to be asleep in bed when he was checked overnight. We are satisfied that the officer carried out his checks appropriately and there was no indication that anything was wrong with Mr Peach during the night.

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