

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Peters, a prisoner at HMP Whatton, on 2 January 2022

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



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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Michael Peters died on 2 January 2022 of lung disease at HMP Whatton. He was 76 years old. We offer our condolences to Mr Peters' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Peters received at Whatton was equivalent to that he could have expected to receive in the community. She made no recommendations.

We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

1. NHS England commissioned an independent clinical reviewer to review Mr Peters' clinical care at HMP Whatton.
2. The PPO investigator has investigated non-clinical issues, including Mr Peters' location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
3. The PPO family liaison officer wrote to Mr Peters' next of kin, his sister, to explain the investigation. She did not respond to our letter.
4. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Whatton

5. Mr Peters was the 16th prisoner to die at HMP Whatton since January 2020. Of the previous deaths, 14 were from natural causes and one was self-inflicted.

Key Events

6. In May 2017, Mr Michael Peters was sentenced to eight years imprisonment for sexual offences.
7. Mr Peters had chronic obstructive pulmonary disease (COPD – a group of lung conditions which affect breathing) and obstructive sleep apnoea (OSA - a condition where you stop breathing while sleeping). He was also morbidly obese.
8. On 18 April 2018, Mr Peters was moved to HMP Whatton. His health conditions continued to deteriorate. There were several occasions where staff had to call a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) due to Mr Peters struggling to breathe or being found unconscious.
9. On 7 September 2020, Mr Peters said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect. He also said he did not want to be admitted to hospital and wanted to remain in prison.
10. On 16 December 2021, an officer called a code blue because Mr Peters had chest pain. Staff called an ambulance but this was stood down by the prison nurse, who thought his chest pain was caused by trapped wind. The nurse asked officers to check on Mr Peters regularly in case his chest pain returned.
11. From 19 December onwards, Mr Peters' respiratory condition noticeably deteriorated. He had several further code blue incidents, where he had low blood oxygen levels or was found unconscious. Paramedics attended each time and recommended Mr Peters should be taken to hospital but he refused to go.
12. At approximately 5.00am on 2 January 2022, an officer completed a welfare check on Mr Peters. He noted slow breathing and spoke with the Night Orderly Officer, who was in charge of the prison at that time. The Night Orderly Officer told him to continue monitoring Mr Peters and if his breathing stopped, to call a code blue.
13. At approximately 5.55am, an officer called a code blue as Mr Peters was not breathing. When further officers arrived, they entered the cell and found no signs of life. An on-call doctor attended at 1.00pm and confirmed Mr Peters' death.

Post-mortem report

14. The Coroner accepted the cause of death provided by the doctor and no post-mortem examination was carried out. The doctor gave Mr Peters' cause of death as respiratory arrest, caused by COPD, OSA and type 2 respiratory failure. He listed morbid obesity as a contributory factor.

Louise Richards
Assistant Ombudsman

July 2022

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