Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Peloe, a prisoner at HMP Liverpool, on 27 January 2021

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 Anthony Peloe died on 27 January 2021 from heart disease associated with the use of a psychoactive substance at HMP Liverpool. He was 50 years old. I offer my condolences to Mr Peloe's family and friends.

HM Inspectorate of Prisons highlighted the continued availability of drugs at Liverpool when they last inspected the prison in August and September 2019. While Liverpool has strengthened its drugs strategy, Mr Peloe's death highlights the need for continued vigilance.

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 **June 2022**

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Summary

Events

1. Mr Anthony Peloe was remanded in prison custody at HMP Altcourse on 24 July 2020, charged with robbery. On 12 October, he moved to HMP Liverpool.

2. Mr Peloe had a history of heroin misuse and was in receipt of methadone. He also had a history of heart disease for which he was receiving medication.

3. On 10 November, Mr Peloe told a nurse that he was having chest pain every morning. Test results showed a deterioration in his heart function since the results of a previous test in 2018. A prison GP advised him to go to hospital, but Mr Peloe declined to go.

4. Mr Peloe's trial at court started on 25 January 2021. He attended via video link.

5. At 6.00am on 27 January, an officer knocked on Mr Peloe's door and reminded him that he would be collected at 7.00am for a video-link court appearance. Mr Peloe did not respond, and the officer moved on to the next cell.

6. At 7.00am, an officer unlocked Mr Peloe's door and found him unresponsive. The officer called for assistance and one of his colleagues radioed a medical emergency code. Prison and healthcare staff attempted to resuscitate Mr Peloe. Ambulance paramedics arrived at 7.19am and at 8.00am, they confirmed that Mr Peloe had died.

7. Staff found drug paraphernalia in Mr Peloe's cell.

8. A post-mortem examination showed that Mr Peloe died from ischemic and hypertensive heart disease and psychoactive substance (PS) use.

Findings

9. Mr Peloe was able to source and use PS, which contributed to his death.

10. There is no record that staff followed local practice and spoke to Mr Peloe about any concerns he might have had following his court appearances on 25 and 26 January.

11. Staff involved in the emergency response were not instructed to complete incident statements.

12. The clinical reviewer concluded that the care Mr Peloe received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should continue to identify and address weaknesses in measures to prevent supply of drugs into Liverpool and revise the substance misuse strategy in light of the findings.
- The Governor and the Head of Healthcare should ensure that following both physical and video-link court appearances:
    - staff speak to the prisoner and assess whether their risk has changed;
    - the prisoner is seen by a nurse if appropriate; and
    - the prisoner's NOMIS record is updated to confirm the actions taken.
- The Governor should ensure that Liverpool's local medical emergency code protocol is amended to reflect the latest instruction given in PSI 03/2013.
- The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death of a prisoner.

The Investigation Process

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

14. The investigator obtained copies of relevant extracts from Mr Peloe's prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Peloe's clinical care at the prison. Due to restrictions during the COVID-19 pandemic, the investigator and clinical reviewer jointly interviewed three members of clinical staff by video-link in March 2021. The investigator spoke to a further four members of staff by telephone. The investigation was subsequently reallocated to one of investigator's colleagues. He interviewed one further member of staff by telephone.

16. We informed HM Coroner for Liverpool of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. Our family liaison officer spoke to Mr Peloe's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Peloe's next of kin did not have any specific questions but asked for a copy of our report.

18. We shared the initial report with HM Prison and Probation Service (HMPPS). They explained that the officer who discovered Mr Peloe unresponsive on 27 January was not carrying a radio, and that national instruction does not require that all staff carry radios. We have amended the report to take account of this information.

19. We also shared the initial report with Mr Peloe's family. They did not raise any issues.

Background Information

HMP Liverpool

20. HMP Liverpool holds up to 700 adult male prisoners on remand and serving short sentences. Healthcare is provided by Spectrum. Substance misuse services are provided by Change, Grow, Live (CGL).

HM Inspectorate of Prisons

21. The most recent inspection of HMP Liverpool was in September 2019. Inspectors noted significant improvements since the last inspection that took place in 2017. They found that more than half the population said that drugs were readily available and, while there had been a reduction since 2017, positive mandatory drug testing rates remained too high. However, they noted that the prison's drug strategy focused on rehabilitation and support, and there was evidence of some early success in reducing the use of illicit substances.

22. Inspectors noted that healthcare staff were a prominent and accessible presence on the wings and that there were good arrangements in place to ensure a rapid response to medical emergencies.

Independent Monitoring Board

23. 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 December 2020, the IMB noted that it was clear that prisoners still found drugs easily accessible. The IMB noted frequent incidents of drone deliveries via broken cell windows.

Previous deaths at HMP Liverpool

24. Mr Peloe was the 11th prisoner to die at Liverpool since January 2019. Of the previous deaths, eight were from natural causes, one was self-inflicted, and one was drug related. There were no direct similarities between Mr Peloe's death and the previous deaths.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

28. In 2005, Mr Anthony Peloe was sentenced to an Indeterminate Sentence for Public Protection (IPP) for conspiracy to commit robbery and possession of a firearm with intent to endanger life. He was released from prison in February 2019.

29. On 24 July 2020, Mr Peloe was recalled to HMP Altcourse after being arrested and charged with robbery. On 12 October, he transferred to HMP Liverpool to await his trial, which was due to start in the New Year.

30. At his healthcare reception screen at Liverpool, Mr Peloe said that he had previously had a heart attack in November 2018 and was taking several medications for high blood pressure and for his heart, including glyceryl trinitrate (GTN) spray. Mr Peloe said that he had a history of anxiety and depression and was in receipt of anti-depressant medication. He said that he had no current thoughts of deliberate self-harm. He also reported a history of heroin use and said he was in receipt of methadone (he was on a detoxification programme that was due to end on 21 October). Mr Peloe was offered a referral to the prison's substance misuse team, which he declined. Mr Peloe described his health as "alright" at that time.

31. On 10 November, a nurse saw Mr Peloe after he complained of having chest pain every morning and said that he had been using his GTN spray more often than usual. Mr Peloe had an electrocardiogram (ECG) test, and the result was abnormal. It showed a deterioration in his heart function since his last ECG in November 2018. Mr Peloe was advised that he needed to go to hospital for further review, but he refused to go. Another nurse saw him again later that evening. Mr Peloe said that he no longer had chest pain and that he was fine.

32. The following morning, Mr Peloe was discussed at a multi-disciplinary meeting and he was then seen by a prison GP. The GP again suggested that Mr Peloe should go to hospital, but Mr Peloe refused to go. He sent a referral to the cardiology clinic at the local hospital noting Mr Peloe's symptoms. He also noted that Mr Peloe had refused to attend hospital, that he understood the risk and had the mental capacity to make decisions about his health.

33. Mr Peloe should have attended a health monitoring clinic on 25 November, but he did not attend.

2021

34. In January 2021, Officer A became Mr Peloe's keyworker and saw him on 12 January for a keyworker meeting. He told us that his first conversation with Mr Peloe had been when he refused to go to hospital in November 2020. He said that Mr Peloe was a quiet prisoner who just wanted to get on with his time in prison and did not generally have any interest in talking to staff. He said that Mr Peloe was believed to be a PS user, but he thought he only used PS when he knew that he would not be seen.

35. Mr Peloe's trial started on 25 January and he attended court on 25 and 26 January via video link.

36. At around 7.20pm on 26 January, Officer A carried out an evening roll check and briefly spoke to Mr Peloe before continuing with his check. Mr Peloe did not raise any concerns.

27 January 2021

37. At around 5.00am on 27 January, Officer A made a full early morning roll check. At around 6.00am, he went to the cells of the prisoners due at court that day to remind them of their attendance (Mr Peloe was due to appear in court by video link). He wrote in his statement that he turned on Mr Peloe's night light, knocked on his door and told him about court. Mr Peloe was in bed lying on his right hand side. Mr Peloe did not respond so he knocked on his door again and repeated the message, before switching off the light and moving to the next prisoner. He said that the practice of reminding prisoners about court was only a courtesy call and that it was not uncommon for prisoners to ignore the officer, especially as they were not due to be collected for court until around 7.00am.

38. Officer B started work at 6.45am and was asked to unlock the prisoners on I wing who were due for court. He unlocked Mr Peloe's cell at about 7.00am. The lights were off, and Mr Peloe was in bed lying on his right hand side. He said that he called Mr Peloe's name twice but got no response. He then shook Mr Peloe by the arm and noticed he was not breathing. He called for staff assistance and pulled Mr Peloe onto the floor to start cardio-pulmonary resuscitation (CPR). He said that Mr Peloe's eyes were open and bulging and he was completely unresponsive, but there was no stiffness in his body.

39. A Supervising Officer (SO) said that he was in the I wing tearoom when Officer C hurried past. The SO assumed Officer C was rushing to an incident, so he followed. As he went into the cell, Mr Peloe was on the floor and Officer B was clearing furniture out of the way. The SO said that he initially radioed for the prison's response nurse but, when Officer B indicated that Mr Peloe was totally unresponsive, he radioed a code blue medical emergency (indicating a prisoner is unconscious or is having breathing difficulties) at 7.08am. Officer B started chest compressions and Officer C gave rescue breaths.

40. A nurse said that she was in healthcare when she heard the call for Hotel 1 (prison's response nurse), followed immediately by a code blue call. She went directly to I wing with the emergency bag, which took around two minutes. Officers were giving CPR when she arrived, and she asked them to continue while she attached a defibrillator to Mr Peloe. The defibrillator did not detect a shockable rhythm, so staff continued giving CPR. She inserted an airway to give Mr Peloe oxygen and then she took over from the SO in giving chest compressions.

41. Two more nurses also attended. One nurse noticed drug paraphernalia on the cell floor, and he gave Mr Peloe naloxone (a medication used to counter decreased breathing in opioid overdose).

42. At 7.19am, ambulance paramedics arrived, and they took over Mr Peloe's medical care. The paramedics continued to try to resuscitate Mr Peloe until 8.00am when they confirmed that Mr Peloe had died.

43. After his death, burnt foil and a modified vape were removed from Mr Peloe's cell.

Contact with Mr Peloe's family

44. Two senior prison managers drove to Mr Peloe's father's house to break the news of Mr Peloe's death but found that he was not at home. The staff then contacted Mr Peloe's sister, and her father was with her. The staff drove on to Mr Peloe's sister's home and at 10.20am informed her and her father of Mr Peloe's death.

45. Liverpool contributed to the cost of Mr Peloe's funeral in line with national guidance.

Support for prisoners and staff

46. A custodial 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.

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

Post-mortem report

48. The pathologist gave Mr Peloe's cause of death as ischemic and hypertensive heart disease with PS use.

49. Toxicology tests showed that Mr Peloe had taken a type of PS before he died and there was also evidence of heroin use. The pathologist noted that Mr Peloe had an enlarged heart with an overall weight well above that expected for a man of Mr Peloe's size with severe narrowing of the coronary circulation.

50. The pathologist said that such heart disease would present a significant risk of a fatal cardiac arrhythmia developing at any time, and even more so in association with stress on the heart, such as with an increased heart rate. The pathologist also noted that the type of PS Mr Peloe used was considered a potent substance with multiple potential adverse effects that would be dangerous in the presence of heart disease.

Other information

51. Mr Peloe had been in a shared cell until 26 January when his cellmate moved out. The police tried to talk to Mr Peloe's cellmate to ask about Mr Peloe's drug use, but he refused to speak to them. Mr Peloe's cellmate had been released from prison custody at the time of conducting this investigation so the investigator was unable to speak to him.

Findings

Substance misuse care

52. Mr Peloe had a long history of illicit substance misuse. The clinical reviewer noted that Mr Peloe had received care from various drug support services in prison and in the community and had completed several detoxification programmes.

53. The clinical reviewer considered that court appearances can be very stressful so relapse prevention in relation to illicit drug use was an area that could have been formally explored with Mr Peloe. The clinical reviewer noted that Liverpool's Head of Healthcare had identified this as a potential missed opportunity in her 72 hour (response to serious incident) report and her proposal for a review of the relapse prevention pathway had been approved by the healthcare provider. The clinical reviewer was satisfied with the action already taken by the prison.

54. We make no recommendations.

Reducing the supply and demand for illicit substances

55. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS use has a profoundly negative impact on the physical and mental health of prisoners. Mr Peloe's death is an example of the dangers of PS and illustrates why prisons must do all they can to stop its use.

56. Both HMIP and Liverpool's IMB noted the high availability of illicit drugs in the prison and while HMIP recognised welcome signs of progress, they found that more needed to be done to address the problem. During our investigation, staff said that the restrictions caused by the COVID-19 pandemic appeared to have had some impact on drug availability, although the psychosocial team were worried that their awareness of potential drug related incidents had reduced due to fewer checks of prisoners during lockdown with prisoners not being out of their cells and visible.

57. In February 2020, Liverpool introduced a new drug and alcohol misuse strategy which aimed to reduce the supply and demand for illicit substances. The strategy aimed to reduce the supply of drugs into the prison by improving security, building intelligence and targeting criminal networks.

58. The Liverpool's substance misuse lead spoke to us about the steps Liverpool was taking to reduce the supply of illicit substances. The steps included the use of a body scanner, drug detection dogs, the replacement of cell windows to limit the effectiveness of drones, proactive intelligence led searching and the building of local community ties to encourage anonymous reporting of drugs being thrown over the prison walls. He said that the prison was soon to install an enhanced entry gate to help detect illicit items being carried by visitors and staff. In addition, prisoners' letters were being photocopied to prevent prisoners receiving PS impregnated paper.

59. Mr Peloe's records contain no instances of him being seen under the influence of any substances at Altcourse and Liverpool. However, the substance misuse lead acknowledged that with the current restrictions in prisoner movements since the

COVID-19 pandemic, misuse of substances was more hidden than was previously the case.

60. Despite the proactive steps being taken by Liverpool, it is clear that Mr Peloe was able to obtain PS. His post-mortem report also shows evidence of previous use of heroin, although we do not know if he used heroin while in Liverpool. We make the following recommendation:

The Governor should continue to identify and address weaknesses in measures to prevent the supply of drugs into Liverpool and revise the substance misuse strategy in light of the findings.

Court appearances

61. Prison Service Instruction (PSI) 07/2015, *Early days in custody*, includes guidance on assessing a prisoner's risk on arrival, including any risk identified on their Person Escort Form (PER): PER forms are used to record prisoners' risks during transfer between prisons and other custodial settings. PSI 07/2015 says that assessments must also be made of prisoners who by-pass some reception processes due to their late arrival. The PSI points out that a prisoner's status and demeanour may change after a court appearance by video link.

62. Prison Service Order (PSO) 3050, *Continuity of Healthcare for prisoners*, says that events that require a prisoner to leave the prison and pass back through prison reception can have a significant impact on the prisoner: a court appearance, either in person or by video link, is an example of such an event. The PSO says that prisons must have protocols in place for screening prisoners for any potential health or suicide/self-harm risks following such events.

63. The investigator was told that the practice at Liverpool is that a supervising officer will offer prisoners the opportunity to see a nurse following return from court or court appearance by video link. The investigator was told that an entry is only made in NOMIS (a prisoner's electronic record) if there is a specific concern about the prisoner.

64. Mr Peloe had taken PS in the lead up to his death. We do not know if this was related to any concern or worries related to his court appearances. There are no entries in Mr Peloe's NOMIS record to indicate that staff identified any concerns about him, however due to the absence of entries we are unable to establish whether he had concerns or not. We recommend:

The Governor and the Head of Healthcare should ensure that following both physical and video-link court appearances:

- **staff speak to the prisoner and assess whether their risk has changed;**
- **the prisoner is seen by a nurse if appropriate; and**
- **the prisoner's NOMIS record is updated to confirm the actions taken.**

The 6.00am check

65. At 6.00am, Officer A went to Mr Peloe's cell to remind him that he would be collected at 7.00am for a court appearance. Mr Peloe did not respond, and he moved away.

66. As it would be another hour before Mr Peloe would need to be ready for court, we can understand why Officer A was unconcerned at the lack of response from him and we do not criticise him. We make no recommendation.

The Emergency Response

67. PSI 03/2013, *Medical Emergency Response Codes*, requires prison to have a medical emergency response code protocol to ensure that healthcare staff attend immediately with the appropriate equipment and an ambulance is called immediately in a life-threatening emergency. A code blue is used to indicate a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding. In September 2021, PSI 03/2013 was amended to require local protocols to also require the member of staff using the medical emergency code to provide relevant information about the prisoner's condition to the control room to allow the ambulance service to triage the call. We make the following recommendation:

    The Governor should ensure that Liverpool's local medical emergency code protocol is amended to reflect the latest instruction given in PSI 03/2013.

68. Officer B was not carrying a radio so the SO radioed the code blue emergency as well as confirming other information requested by the communications room staff. Although this resulted in a very slight delay in making the code blue call, national instructions do not require that all staff carry a radio.

Incident report forms

69. PSI 64/2011, Management of prisoners at risk of harm to self, to others and from others (Safer Custody), says that staff directly involved in a death in custody, particularly those who were first on scene, must complete incident statements as soon as practicable. In Mr Peloe's case, Liverpool did not collect statements from staff involved in the emergency response following Mr Peloe's death, although several staff provided statements at a much later date after this was requested by the investigator. We recommend that:

    The Governor should ensure that staff directly involved in a death in custody complete incident statements as soon as practicable following the death of a prisoner.

Overall clinical care

70. The clinical reviewer concluded that Mr Peloe received a good standard of care at Liverpool that was equivalent to that which he could have expected to receive in the community. She noted that Mr Peloe had a heart condition and that his latest ECG showed abnormalities and a deterioration since his previous ECG. She noted that

staff tried to persuade Mr Peloe to access appropriate care services, but he declined to attend.

71. We make no recommendations.

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