Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Allen, a prisoner at HMP Nottingham, on 8 April 2022

A report by the Prisons and Probation Ombudsman

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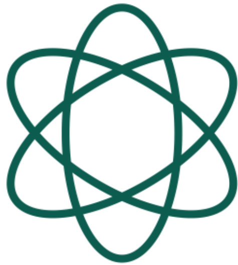
Our vision

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 Peter Allen died on 8 April 2022 of hospital acquired pneumonia (a bacterial infection that occurs 48 hours or more after hospital admission) in Queens Medical centre, whilst waiting to be transferred to HMP Nottingham. He was 79 years old. We offer our condolences to those who knew him.

4. Mr Allen was recalled to custody in February 2022; however, he did not return to prison before he died. He had been unwell with chronic obstructive pulmonary disease (COPD - a lung condition that causes breathing difficulties) for some time and was assessed as not fit enough to be in prison. He remained in hospital until he died.

5. The clinical reviewer was unable to comment on equivalence of care provided by HMP Nottingham as Mr Allen never entered prison and his care was delivered by the healthcare team at Queens Medical Centre. She made two recommendations not directly related to Mr Allen’s death, but that the Head of Healthcare will need to address.

6. We found no non-clinical issues of concern within the scope of our investigation. However, we note that Mr Allen remained in hospital for a month after he was first assessed as fit for discharge. Mr Allen was not arrested for recall until 29 March and subsequently could not be allocated to a suitable prison. During this time, Mr Allen developed a hospital acquired infection, which he later died from. Whilst these events fall outside of our investigation, it is difficult not to acknowledge that a timely transfer and availability of appropriate resources may have changed the outcome for Mr Allen.

The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Allen's clinical care at HMP Nottingham.

8. The PPO investigator investigated the non-clinical issues relating to Mr Allen's care, including his location, the security arrangements for his hospital escorts and whether compassionate release was considered.

9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Nottingham

10. There were five deaths at Nottingham in the two years prior to Mr Allen's death. Of the previous deaths, four were from natural causes and one was self-inflicted. There have been two further deaths since Mr Allen died, both of which are suspected to be from natural causes. At the time of writing, there are no similarities in our findings across these investigations.

Key Events

11. On 11 April 2018, Mr Peter Allen was sentenced to 65 months custody for a violent offence and sent to HMP Nottingham. He had been diagnosed with chronic obstructive pulmonary disease (COPD - a lung condition that causes breathing difficulties) and anxiety and depression.

12. On 11 June 2020, Mr Allen was released from custody on licence. He was unwell with his COPD and needed significant health and social care input. He was released to Beechdale Manor community care home, where his needs could be met. In November 2020, Mr Allen told his probation officer that he was unhappy at Beechdale Manor. On 26 March 2021, he was transferred to Highfield Care Home.

13. Between March 2021 and February 2022, Mr Allen's behaviour and health had deteriorated. On 23 February, he threw items at care staff and residents at Highfield and had threatened them with a knife. Mr Allen was recalled to custody on the basis that his risk could no longer be managed in the community, without specialist accommodation. At the time of his recall, he was very unwell from the symptoms of his COPD, which continued to worsen. Mr Allen was transferred to hospital instead of prison as he was considered too unwell to be in custody. Mr Allen was taken by Nottinghamshire police to Queens Medical Centre, where he was admitted for treatment. Probation recorded that Mr Allen would be transferred to prison when he was well enough.

14. On 9 March, a police sergeant from Nottinghamshire Police informed Probation that Mr Allen would be discharged from hospital to HMP Birmingham the following day. HMP Birmingham and HMP Nottingham engaged in discussions about Mr Allen's care needs, but neither prison could accept him as he had not yet been formally arrested.

15. On 29 March 22, Mr Allen was arrested for the recall that had been activated in February. He was assessed as medically fit to be discharged and was allocated a place at HMP Nottingham. However, he was not able to leave hospital until a social care needs assessment was completed. HMP Nottingham allocated two officers to facilitate a bedwatch (staff responsible for ensuring that prisoners are kept in secure and lawful custody). The escort risk assessments appropriately took into account Mr Allen's health needs and no restraints were used.

16. On 31 March, the duty discharge coordinator at Queens Medical Centre told a nurse at Nottingham that Mr Allen had developed a chest infection and was no longer fit to be discharged.

17. On 1 April, Mr Allen declined support with his personal care and his medication, and he was being aggressive to staff. A nurse in the Nottingham healthcare team was told by the hospital discharge team that Mr Allen was still not fit to be discharged and that HMP Nottingham did not have the facilities or care package to meet Mr Allen's health needs, as he required 24 hour care. The Head of Healthcare continued discussions with senior management about the most suitable location for Mr Allen, but no clear solution was reached due to his care needs frequently changing.

18. Mr Allen’s health continued to deteriorate, and he died in hospital on 8 April 2022 at 11:50pm.

Post-mortem report

19. The post-mortem report concluded that Mr Allen died of hospital acquired pneumonia (a bacterial infection that occurs 48 hours or more after hospital admission) caused by Infective exacerbation of chronic obstructive pulmonary disease (when an infection increases the symptoms of COPD). Severe frailty (complete dependence with personal care and unlikely to recover from even minor illness) did not cause but contributed to his death.

Tallulah Frankland
Assistant Ombudsman **November 2022**

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