Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Brett Moore, a prisoner at HMP Peterborough, on 18 March 2020

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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 Brett Moore died of intestinal bleeding and respiratory failure caused by COVID-19 at HMP Peterborough on 18 March 2020. He had excessive levels of methadone in his blood. He was 48 years old. I offer my condolences to his family and friends.

Mr Moore received a good standard of healthcare at Peterborough, equivalent to that which he could have expected in the community. I am satisfied that staff could not have reasonably predicted Mr Moore's death. However, requests for blood tests should be promptly actioned.

I am concerned that staff failed to monitor his deteriorating condition sufficiently and that continued monitoring by a qualified nurse might have led to resuscitation efforts starting sooner. While this is unlikely to have affected the outcome for Mr Moore, it could make a crucial difference in other medical emergencies.

Not all staff involved in the emergency response had up-to-date training in first aid. I am satisfied, however, that this did not affect the outcome for Mr Moore.

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**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 5

Findings 8

Summary

Events

1. On 18 October 2019, Mr Brett Moore was remanded to HMP Lincoln, charged with conspiracy to supply controlled drugs. He moved to HMP Peterborough on 7 November.

2. On 9 March 2020, Mr Moore reported abdominal pain to a nurse and she booked a GP review. On 13 March, a prison GP examined Mr Moore and suspected a peptic ulcer. He requested blood tests but there is no record these took place.

3. At 1.33am on 18 March, two prisoners told staff that someone on the wing was shouting, "Help me". Two Operational Support Officers (OSOs) found that the shouting was coming from Mr Moore's cell and looked through the cell door observation panel. Mr Moore looked like as though he might be under the influence of a substance and an OSO radioed for assistance at 1.33am. At 1.37am, a Senior Prison Custody Officer (SPCO) arrived and entered the cell with two officers and a nurse. The nurse took Mr Moore's clinical observations and requested an ambulance.

4. At 1.44am, the SPCO radioed a medical emergency code blue. At 1.45am, the control room called an ambulance. An OSO told the operator what had happened and was told that an ambulance would arrive in about 40 minutes. The nurse was not satisfied with the timeframe and at 1.53am, left a healthcare assistant to monitor Mr Moore while he phoned the ambulance service.

5. At 2.01am, the nurse returned to the cell and noticed that Mr Moore's condition had declined. At 2.02am, the nurse left Mr Moore's cell once more to print his medical record. The healthcare assistant continued to monitor Mr Moore but had difficulty taking his pulse.

6. Paramedics arrived at Mr Moore's cell with the nurse at 2.15am and asked him to start cardiopulmonary resuscitation (CPR). At 3.31am, a paramedic pronounced that Mr Moore had died.

7. A post-mortem examination found that Mr Moore had died of intestinal bleeding, respiratory failure caused by COVID-19. Toxicology analysis of Mr Moore's blood found fatal levels of methadone that the post-mortem report indicated could have been caused by his liver not working properly or by him taking additional methadone. However, the post-mortem report concluded that even if Mr Moore had not taken methadone, it was unlikely that he would have survived the extensive bleeding and lung abnormalities.

Findings

8. The clinical reviewer concluded that the healthcare that Mr Moore received at HMP Peterborough was equivalent to that which he could have expected in the community. We are satisfied that Mr Moore did not display symptoms of COVID-19 and that healthcare staff could not have predicted his death. However, we are concerned that healthcare staff did not arrange blood tests when requested.

9. Although it is unlikely that earlier intervention would have changed the outcome for Mr Moore, continued monitoring of his condition by a qualified nurse between 2.02am and 2.15am on 18 March might have resulted in CPR starting sooner.

10. Not all staff involved in the emergency response had up-to-date first aid training.

11. While Mr Moore may have taken additional methadone, there is little evidence to suggest he used illicit drugs in prison. Additionally, the high level of methadone in his blood could have been caused by his liver not working properly. In light of this, we have not been able to reach a definitive conclusion about illicit drug use.

Recommendations

- The Head of Healthcare should ensure that all requests for blood tests are promptly actioned.
- The Head of Healthcare should ensure that the most suitably qualified member of healthcare staff remains with a prisoner throughout an emergency response, wherever possible.
- The Director should ensure that operational staff have up-to-date training to administer basic life support in an emergency.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him.

13. The Investigator obtained copies of relevant extracts from Mr Moore's prison and medical records.

14. NHS England commissioned an independent clinical reviewer to review Mr Moore's clinical care at the prison. They jointly interviewed three members of healthcare staff between 18 and 25 June.

15. We informed HM Coroner for Cambridgeshire and Peterborough 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 Moore's next of kin to explain the investigation and to ask if they had any matters they wanted the investigation to consider. He did not raise any specific concerns.

17. Mr Moore's next of kin received a copy of the initial report. He did not raise any further issues, or comment on the factual accuracy of the report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Peterborough

19. HMP Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

20. The most recent inspection of HMP/YOI Peterborough men's prison was in July 2018. Inspectors reported that access to healthcare was good for all prisoners. There was an appropriate range of primary care services. All prisoners were seen by a registered nurse on arrival and received a comprehensive health screen. However, there was a large backlog of prisoners who had not received their secondary health screen.

Independent Monitoring Board

21. 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 2019, the IMB reported that they were concerned about the availability of illicit drugs. The IMB noted an improvement in the governance and delivery of healthcare services and there was no waiting list to see a doctor.

Previous deaths at HMP Peterborough

22. Mr Moore was the third male prisoner to die at Peterborough since March 2018. The previous deaths were due to natural causes. There are no similarities between Mr Moore's death and the previous deaths.

COVID-19 (coronavirus)

23. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs or sneezes. The first reported case of COVID-19 in the UK was in February 2020. On 11 March, the World Health Organisation (WHO) declared COVID-19 as a worldwide pandemic.

24. COVID-19 can make anyone seriously ill, but the risk is higher for some people. There are two levels of higher risk: high-risk (clinically extremely vulnerable); and moderate risk (clinically vulnerable). People at high risk include those who have had an organ transplant; have a severe lung condition; are having certain types of treatment for cancer; or have a condition with a very high risk of getting infections. Those at moderate risk include people over 70; people with a lung condition or a chronic medical condition, such as diabetes, heart, liver, or chronic kidney disease; or those who are very obese (this list is not exhaustive).

Key Events

25. On 18 October 2019, Mr Brett Moore was remanded into custody, charged with conspiracy to supply Class A controlled drugs. He was sent to HMP Lincoln.

26. On 7 November, Mr Moore was transferred from court to HMP Peterborough. At reception, a nurse recorded that Mr Moore had a history of illicit drug use and referred him to the substance misuse team. Later that day, a prison GP prescribed methadone (to treat opioid dependence).

27. On 14 November, a nurse conducted a secondary health screen and noticed that Mr Moore had a management plan in place for methadone. He recorded that Mr Moore used a vape (an electronic cigarette) and offered to refer him to the smoking cessation clinic but he declined.

28. On 1 December, a Prison Custody Officer (PCO) introduced himself to Mr Moore as his keyworker and completed their first session. He noted that Mr Moore told him that he had been allocated a wing worker job. The PCO had a total of 14 keywork sessions with Mr Moore and there is no record that he reported any concerns about his health or presented as under the influence of illicit substances.

29. On 3 February 2020, a nurse reviewed Mr Moore and recorded that he reported abdominal pain, constipation, bloating and vomiting at night. She took his clinical observations, which were normal, and tasked a GP with prescribing a laxative. A prison GP prescribed lactulose later that day.

30. On 14 February, a nurse completed a substance misuse review and recorded that Mr Moore remained stable on methadone. Mr Moore said he had not recently used illicit substances.

31. On 9 March, a nurse requested a GP review after Mr Moore told her that he had had upper abdominal pain for a couple of weeks and was vomiting every night.

32. On 13 March, a prison GP examined Mr Moore and noted that although his abdomen was tender, there was no rigidity or obvious mass. He suspected a peptic ulcer (a break in the inner lining of the stomach, the first part of the intestine or the lower oesophagus) and prescribed omeprazole (to reduce the amount of acid the stomach makes). He also requested a series of blood tests but there is no record that these were taken.

Events from 17 to 18 March

33. At 2.00pm on 17 March, a PCO unlocked Mr Moore's cell so that he could go to work at the prison's recycling centre. At around 4.45pm, Mr Moore returned to the wing and spent time talking to other prisoners.

34. At 6.45pm, the PCO conducted a roll check. In his prison statement, he said that he asked Mr Moore if he had everything that he needed for the night and that Mr Moore did not report any health concerns.

35. At 1.30am on 18 March, an Operational Support Officer (OSO) took an intercom call from a prisoner who reported that someone was shouting “help me”. As she was leaving the hub with another OSO, another prisoner pressed their intercom button to report the same concern.

36. Both OSOs established that the shouting was coming from Mr Moore’s cell and looked through his cell door observation panel. In their prison statements, both OSOs said that they could not see Mr Moore as he was lying on the floor behind the door. Once Mr Moore got up, they noticed that he had a cut on his head and appeared to be under the influence of an illicit substance. At 1.33am, an OSO radioed for a member healthcare staff and a Senior Prison Custody Officer (SPCO) to attend.

37. In the meantime, an OSO tried to speak to Mr Moore through the observation panel. In her statement, she said that she asked Mr Moore if he had taken any illicit substances but he found it difficult to talk and just said, “Help me”. She also said that Mr Moore kept falling over and pointing to the cut on his head.

38. At 1.37am, the SPCO arrived at the cell with two PCO’s and a nurse. The SPCO opened the cell door and they found Mr Moore lying on the floor, saying, “Please help me”, with slurred speech. The nurse took his clinical observations and recorded that he had low blood pressure, a slow pulse rate and a low oxygen saturation level. He issued oxygen and asked prison staff to call an ambulance.

39. At 1.44am, the SPCO radioed a medical emergency code blue. At 1.45am, the control room called an ambulance and transferred the call to an OSO on the wing. The OSO received updates from the staff in Mr Moore’s cell by radio and relayed this information to the ambulance service operator. He confirmed that an immediate response was required and the operator said that an ambulance would arrive at the prison in around 40 minutes.

40. The nurse was not satisfied with the timeframe and at 1.53am, he left a healthcare assistant (HCA), to monitor Mr Moore while he called the ambulance service. The nurse updated the operator and confirmed that Mr Moore needed to go to hospital urgently. The HCA checked Mr Moore’s blood pressure but twice failed to get a reading. At 2.01am, the nurse returned to the cell and noticed that Mr Moore’s condition had visibly declined. He told the investigator that he was aware that the HCA was unable to get blood pressure reading but felt that Mr Moore’s position on the floor made it difficult to obtain an accurate reading.

41. At 2.02am, the nurse left Mr Moore’s cell to print a summary of his medical record for the paramedics. A summary of the body-worn camera (BWC) footage indicates that at 2.03am, the HCA shook Mr Moore’s shoulder but did not get a response. At 2.05am, it shows an officer shook Mr Moore’s feet and noticed his chest was sinking. The HCA continued to monitor Mr Moore and at 2.14am, tried unsuccessfully to take his pulse.

42. An ambulance arrived at the prison at 2.09am and the first paramedic arrived at Mr Moore’s cell at 2.15am, with the nurse. At this point, the nurse told us that Mr Moore had very shallow breathing. The paramedic assessed Mr Moore and at around 2.20am, asked the nurse to start cardiopulmonary resuscitation (CPR). At 2.26am. staff moved Mr Moore onto the wing landing so that it was easier for the

paramedics to provide emergency life support. A paramedic pronounced that Mr Moore had died at 3.31am.

Contact with Mr Moore's family

43. At 5.53am, the prison appointed a SPCO as the family liaison officer (FLO) and a prison manager as her deputy. The FLO established that Mr Moore had named his next of kin and they visited his home address. He was not at home, but the FLO was able to speak to him by phone and arranged to meet him at his workplace. At 9.00am, the FLO broke the news to Mr Moore's next of kin and offered support.

44. The FLO continued to provide ongoing support to Mr Moore's next of kin until his funeral. The Prison Service contributed towards its cost in line with national policy.

Support for prisoners and staff

45. After Mr Moore's death, a prison 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.

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

Post-mortem report

47. The post-mortem report found that Mr Moore had died of intestinal bleeding and respiratory failure caused by COVID-19. The report states that Mr Moore had severely abnormal lungs which bled extensively into the intestines, lowering his blood pressure and resulting in a cardiac arrest.

48. Toxicology analysis found fatal levels of methadone in Mr Moore's blood. The post-mortem report noted that it was possible that COVID-19 had caused his liver not to process the methadone and allowed the levels to rise. Or, alternatively, it was possible that Mr Moore had taken more methadone than he was prescribed. However, the report concluded that it was unlikely that Mr Moore would have survived the lung abnormalities and the extensive bleeding even without high blood levels of methadone.

Findings

Clinical care

49. The clinical reviewer concluded that the healthcare Mr Moore received at HMP Peterborough was equivalent to that which he could have expected to receive in the community.

50. The clinical reviewer considered that Mr Moore did not report or display a high temperature or a continuous cough in the weeks leading to his death, which are the main symptoms of COVID-19 indicated by the World Health Organisation (WHO). She noted that WHO reports had also found that some individuals could potentially have COVID-19 but not display symptoms. We are therefore satisfied that healthcare staff at HMP Peterborough could not have predicted Mr Moore's death.

51. However, we are concerned that healthcare staff failed to act upon a GP's request for blood tests. While we recognise that the blood tests would not have identified COVID-19, they may have indicated that Mr Moore was unwell and prompted investigation. We therefore make the following recommendation:

    The Head of Healthcare should ensure that all requests for blood tests are promptly actioned.

Emergency response

52. Two OSO's responded swiftly when they noticed that Mr Moore required medical assistance and continued to monitor him until additional staff arrived. A SPCO promptly opened the cell door and radioed the correct medical emergency code when a nurse requested an ambulance. The control room called an ambulance immediately, in line with national policy, and the nurse appropriately confirmed the urgency of the situation by calling the ambulance service. We are satisfied that these actions were sufficient.

53. However, we are concerned that despite having told the ambulance service that Mr Moore required urgent hospital treatment, the nurse left an HCA to monitor him for around 13 minutes while he printed his medical summary. The clinical reviewer considered that as the senior member of healthcare staff, the nurse should have remained with Mr Moore. While we consider it unlikely that earlier intervention would have prevented Mr Moore's death, the nurses continued presence after speaking to the ambulance service might have resulted in CPR starting sooner.

54. We are also concerned that the SPCO's first aid training expired in January 2008. While we consider that this did not affect the outcome for Mr Moore, the ability of prison staff to administer emergency first aid in future cases could be crucial to saving a prisoner's life.

55. We make the following recommendations:

    The Director and Head of Healthcare should ensure that the most suitably qualified member of healthcare staff remains with a prisoner throughout an emergency response, wherever possible.

The Director should ensure that operational staff have up-to-date training to administer basic life support in an emergency.

Illicit substances

56. The post-mortem report revealed fatal levels of methadone in Mr Moore's blood. Although there is a possibility that Mr Moore took additional methadone, there is no record that he presented as under the influence of a substance or reported concerns about his drug use before 18 March. When both OSOs first looked in Mr Moore's cell, they thought that he may have been under the influence but it possible that his presentation was caused by his low blood pressure. In addition, the high methadone level may have been caused by his liver not working properly. We are therefore unable to reach a conclusion about Mr Moore's illicit drug use and make no recommendation.

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