Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Coleman, a prisoner at HMP Peterborough, on 25 January 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Mark Coleman died from heart disease on 25 January 2023 at HMP Peterborough. He was 45 years old. I offer my condolences to Mr Coleman's family and friends.

The clinical reviewer concluded that the care Mr Coleman received at Peterborough was of a good standard and 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.

Adrian Usher
Prisons and Probation Ombudsman **August 2023**

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Summary

Events

1. On 14 January 2023, Mr Mark Coleman was remanded in prison charged with burglary, and sent to HMP Peterborough.

2. At Mr Coleman's reception health screen, the nurse noted no physical health concerns. The nurse took a full set of clinical observations, which were all normal.

3. On 20 January, after expressing concerns about his safety and asking for a move, Mr Coleman was moved to share a cell with his son on a different wing.

4. At around midday on 25 January, while Mr Coleman and his son were on their bunk beds in their cell watching television, Mr Coleman said he was going to have a nap. Two and a half hours later, Mr Coleman's son checked on his father and saw that his lips were blue and he was not breathing. At 2.42pm, Mr Coleman's son used the in-cell call system to alert staff who responded immediately. They, along with prison nurses, carried out cardiopulmonary resuscitation (CPR) until ambulance paramedics arrived at around 3.00pm. Paramedics continued resuscitation attempts but at 3.17pm, they pronounced that Mr Coleman had died.

5. The post-mortem report concluded that Mr Coleman died from heart disease.

Findings

6. The clinical reviewer found no history of heart-related issues in Mr Coleman's medical record.

7. The clinical reviewer found that the care Mr Coleman received at Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community.

8. However, he noted that Mr Coleman was not offered a secondary health screen within seven days of his initial health screen in line with National Institute for Health and Care Excellence (NICE) guidelines. In response to a previous PPO recommendation on this, we were told in March 2023 that a new process had been introduced to identify outstanding secondary health screens. We do not therefore make a recommendation.

The Investigation Process

9. HMPPS notified us of Mr Coleman's death on 25 January 2023.

10. 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. No one responded.

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

12. NHS England commissioned an independent clinical reviewer to review Mr Coleman's clinical care at the prison.

13. We informed HM Coroner for Cambridgeshire & 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.

14. The Ombudsman's family liaison officer contacted Mr Coleman's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Coleman's daughter asked about Mr Coleman's medication. This has been addressed in the clinical review. She raised some other queries about Mr Coleman's concerns for his safety which we have addressed in separate correspondence.

15. We shared our initial report with HMPPS. They found no factual inaccuracies.

16. We sent a copy of our initial report to Mr Coleman's daughter. She did not notify us of any factual inaccuracies.

Background Information

HMP/YOI Peterborough

17. HMP/YOI Peterborough is operated by Sodexo Justice Services. It holds around 4,200 men and 800 women in separate sides of the prison. Sodexo provides primary healthcare 24 hours a day seven days a week.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Peterborough men's prison was a scrutiny visit in November 2020. Inspectors reported that reception health screening had continued during the COVID-19 pandemic and a focus on secondary health screening for new arrivals meant that these were now completed promptly.

Independent Monitoring Board

19. 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 31 March 2022, the IMB reported that the steps required to contain and manage the spread of the COVID-19 virus had put additional pressure on the prison's healthcare staff but they had done their best to provide the full range of services required. However, many prisoners continued to report that they were dissatisfied with the healthcare services provided.

Previous deaths at HMP/YOI Peterborough

20. Mr Coleman was the 16th prisoner to die at Peterborough since January 2020. Of the previous deaths, two were self-inflicted, two were drug related and 11 were from natural causes.

21. In an investigation into the death of a prisoner in 2022, we made a recommendation about ensuring healthcare staff offer prisoners a secondary health screen within a week of their arrival. We were told that staff were now running weekly reports to establish outstanding and declined secondary screenings.

Key Events

22. On 14 January 2023, Mr Mark Coleman was remanded in prison, charged with burglary, and sent to HMP Peterborough. It was not his first time in prison.

23. When Mr Coleman arrived at Peterborough, a nurse conducted his reception health screen and noted no physical health concerns. The nurse completed a full set of clinical observations which were all within normal range.

24. Mr Coleman had a history of drug and alcohol misuse and staff recorded that he was experiencing mild drug and alcohol withdrawal symptoms.

25. Mr Coleman was located on the Integrated Substance Misuse (ISMS) Wing (House block 3-X1). (The ISMS Wing delivers treatment and a first night centre for those requiring drug and alcohol detoxification or stabilisation.)

26. On 15 January, after his cell had flooded, staff offered to move Mr Coleman to a different cell. However, Mr Coleman became hostile and abusive, and asked to go to the segregation unit. Prison staff could not accommodate this request and offered Mr Coleman cleaning equipment. Mr Coleman continued to be hostile and abusive. Staff left Mr Coleman to calm down, and when they returned to speak with him, he initially was abusive, but then settled and apologised for his behaviour.

27. On the morning of 16 January, Mr Coleman refused to come out of his cell to collect his medication. (Mr Coleman's medication was controlled and so he was not allowed to have it in possession and had to collect it from the medications hatch. His medication included methadone and medication for alcohol detoxification and anxiety.)

28. At around 6.45pm, Mr Coleman told staff that a prisoner had thrown hot water over him while he was in his cell. Prison staff responded by moving Mr Coleman to another cell on the wing.

29. On 20 January, healthcare and ISMS staff visited Mr Coleman due to concerns about him not collecting his medication. Mr Coleman raised concerns about his safety and said that he would feel safer on W2 Wing, where his son was located. As a result, Mr Coleman was moved to share a cell with his son.

30. On 24 January, a prison custody officer (PCO) conducted a key work session with Mr Coleman. The PCO noted that they asked Mr Coleman if he was okay, and if he needed any help on the wing. Mr Coleman said he felt fine and did not need any help.

Events of 25 January

31. On 25 January, at around 9.30am, a PCO noted that he witnessed Mr Coleman take his medication at the pharmacy hatch. Mr Coleman told the PCO that he had a headache. The PCO advised Mr Coleman to speak to the healthcare team or make a GP appointment.

32. Mr Coleman had failed to attend an appointment with the mental health team. In response, a nurse visited Mr Coleman on the wing to conduct a mental health assessment. The nurse noted that Mr Coleman presented as drowsy, had slurred speech, and struggled to communicate effectively.

33. A senior prison custody officer (SPCO) noted that they saw Mr Coleman sitting on the sofa during the mental health assessment and noticed Mr Coleman's eyes looked red, and his speech was slurred. The SPCO asked Mr Coleman if he was okay and if he had taken anything he should not have. Mr Coleman said he had not, but he was on a high dose of pregabalin. (Pregabalin was prescribed to Mr Coleman to treat anxiety and pain relief.)

34. The SPCO noted a nurse confirmed that Mr Coleman was on a high dose of pregabalin. The nurse asked the SPCO if it was possible for Mr Coleman to be seen by healthcare staff about his eyes looking sore and red. The SPCO said that he would speak with healthcare staff that evening, with the possibility of Mr Coleman having an appointment the following morning.

35. At around midday, Mr Coleman and his son got into their bunk beds to watch television. Then Mr Coleman said that he was going to have a nap. Mr Coleman's son said that he could hear Mr Coleman snoring. When he later checked on him, he saw Mr Coleman's lips were blue and he was not breathing.

36. At 2.42pm, a PCO was in the main wing office and answered a call from Mr Coleman's son (using the in-cell call system). Mr Coleman's son said that he thought his father had stopped breathing. The PCO along with the SPCO immediately ran to the cell.

37. The PCO noted that when he arrived at the cell and opened the door, he saw Mr Coleman on the bottom bunk face down, he looked 'yellowy-grey' and mottled. He radioed a code blue medical emergency (used when a prisoner is unconscious or having breathing difficulties) and the control room called for an ambulance.

38. The PCO and SPCO immediately moved Mr Coleman to the floor. They then started CPR, which was continued by prison nurses who arrived a few minutes later. Staff applied a defibrillator to Mr Coleman, and it advised that there was no shockable rhythm. (A defibrillator is a device that send an electric pulse or shock to the heart to restore a normal heartbeat.)

39. Ambulance paramedics arrived at 3.03pm. They took over management of Mr Coleman's airways, while prison staff continued to do chest compressions.

40. At 3.17pm, paramedics pronounced that Mr Coleman had died.

Contact with Mr Coleman's family

41. On 25 January, the prison appointed a prison chaplain and an SPCO as the family liaison officers. Later that day, the chaplain visited the home of Mr Coleman's family and informed them that Mr Coleman had died.

42. The family liaison officers kept in contact with Mr Coleman's family over the following days, offering support and advice.

43. The prison contributed to the costs of Mr Coleman's funeral in line with national policy.

Support for prisoners and staff

44. After Mr Coleman'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.

45. The prison posted notices informing other prisoners of Mr Coleman's death and offering support.

Post-mortem report

46. The post-mortem report concluded that Mr Coleman died from ischaemic and hypertensive heart disease (a common but serious condition where the blood vessels supplying the heart are narrowed or blocked).

47. Toxicology results found no evidence that drugs or alcohol were involved in Mr Coleman's death.

Findings

Clinical care

48. The clinical reviewer found no history of heart-related issues in Mr Coleman's medical record.

49. The clinical reviewer found that the care Mr Coleman received at Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community. He made one recommendation about Mr Coleman not receiving a secondary health screen.

50. The National Institute for Health and Care Excellence (NICE) guidelines on the physical health of prisoners states that a secondary health screen should be offered within seven days of the first health screen, and include a review of the person's first and second-stage health assessment records, medical history, and GP and vaccination records.

51. In an investigation into the death of a prisoner at Peterborough in 2022, we found that a secondary health screen had not been conducted and made a recommendation. In March 2023, the Head of Healthcare accepted the recommendation and told us that a secondary screening report was now printed weekly by the clinical nurse manager to capture any outstanding secondary health screens. Given that Mr Coleman died in January 2023, predating the response to our previous recommendation, we are not repeating the recommendation. The Head of Healthcare will want to assure themselves that the new process is embedded and addressing the issue of missed secondary health screens.

Other findings

Good practice

52. CCTV footage shows that staff arrived at Mr Coleman's cell within ten seconds of Mr Coleman's son telling them that he thought his father had stopped breathing.

53. CCTV footage shows prison staff treating Mr Coleman's son with compassion. At one point an officer put his arm around Mr Coleman's son and appeared to comfort him as he led him away from the cell. Support given by staff to Mr Coleman's son after his father's death was commendable.

Inquest

54. The inquest, held on 13 November 2023, concluded that Mr Coleman died from natural causes.

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