Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Jones, a prisoner at HMP Peterborough, on 5 May 2024

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

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. 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.

3. Mr Stephen Jones died of hypoxic brain injury (brain damage from lack of oxygen) caused by cardiac arrest due to hypertensive heart disease on 5 May 2024, while a prisoner at HMP Peterborough. He was 66 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Jones received in prison was of a reasonable standard and partially equivalent to that which he could have expected to receive in the community. She found that Mr Jones did not have a cardiac care plan and that his blood pressure (which was outside the normal range on arrival at Peterborough) was not reviewed.

5. Shortly before he died, Mr Jones was admitted to hospital in an emergency. The control room operator did not call an ambulance immediately and recorded that it was his first solo shift in the role and that he was "very stressed".

Recommendations

- The Head of Healthcare should ensure that care plans are created for all patients with suspected coronary heart disease.
- The Head of Healthcare should ensure that healthcare staff routinely review patients with high blood pressure results.
- The Director should review the local training programme for control room staff to ensure that it is sufficiently rigorous, includes the full range of frequently occurring events and an understanding of the actions required by national instructions, and involves an objective test of readiness to work alone.

The Investigation Process

6. HMPPS notified us of Mr Jones's death on 5 May 2024.

7. NHS England commissioned an independent clinical reviewer to review Mr Jones's clinical care at HMP.

8. The PPO investigator investigated the non-clinical issues relating to Mr Jones's care.

9. 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.

10. The Ombudsman's office contacted Mr Jones's daughter to explain the investigation and to ask if she had any matters she wanted us to consider. She asked one question, which we have addressed in separate correspondence.

Previous deaths at HMP Peterborough

11. There were fourteen deaths from natural causes at Peterborough in the three years before Mr Jones's death, one of which was from COVID-19. There are no significant similarities between our findings in the previous investigations and our findings in the investigation into Mr Jones's death.

Key Events

12. On 27 September 2023, Mr Stephen Jones was sentenced to two years and eight months in prison for a fraud offence. Mr Jones initially served his sentence at HMP Norwich, before transferring to HMP Wayland on 10 November.

13. On 22 March 2024, Mr Jones was transferred to HMP Peterborough.

14. Mr Jones was diagnosed with the following conditions; angina (chest pain caused by reduced blood flow to the heart muscles), hypertension (commonly known as high blood pressure, where the force of blood against the walls of the arteries is consistently too high), and Chronic Obstructive Pulmonary Disease (COPD, a lung disease characterised by long-term breathing problems and poor airflow in the lungs, it is a progressive disease which means that it worsens over time). Mr Jones's blood pressure was recorded as high during reception screening however no plans for a follow-up were recorded on prison records.

15. On 10 April, Mr Jones reported difficulty breathing and a dry persistent cough. He was taken to Peterborough City Hospital by emergency ambulance. In hospital, Mr Jones was treated for an infected exacerbation of COPD and right-side underlying pneumonia. (An exacerbation is a sudden worsening of symptoms related to a specific condition. Pneumonia is an infection that inflames the air sacs in one or both lungs.) He returned to Peterborough on 23 April, with a nebuliser machine (which administers medication directly and quickly to the lungs).

16. On 3 May, a Prison Custody Officer (PCO) recorded that she spoke to Mr Jones, who said that he was okay. Mr Jones said that he had had a "coughing fit" overnight but had used his nebuliser.

Events of 4 May 2024

17. At around 5.00pm on 4 May, prison staff found Mr Jones struggling to breathe. They called for the duty nurse to attend, during which time Mr Jones sat on his bed and used his nebuliser. A nurse attended and checked Mr Jones's clinical observations. Other than his blood pressure, which was slightly high, all of the observations were within the normal range. The nurse also calculated Mr Jones's National Early Warning Score (NEWS2, a system for scoring clinical observations to determine whether an escalation in treatment is required), which indicated that Mr Jones was at low risk of clinical deterioration. The nurse asked wing staff to monitor Mr Jones.

18. At around 5.50pm, two PCOs were with Mr Jones when he stopped speaking to them and began to shake. At 5.52pm, a PCO radioed a medical emergency code blue (to signify a potentially life-threatening situation). Two nurses attended.

19. At 5.57pm, a nurse radioed the control room and asked them to call an ambulance. An Operational Support Officer (OSO) made the call at 5.58pm. The OSO recorded (in a statement completed later on 4 May) that his recollection of the events was very unclear as he was "very stressed" at the time. He noted that he had not had any formal control room training and that this was his first shift without supervision.

20. Shortly afterwards, Mr Jones stopped breathing and the response nurses began cardiopulmonary resuscitation.

21. At around 6.06pm, paramedics arrived and took over the care of Mr Jones supported by the prison healthcare team. Mr Jones was transferred to Peterborough City Hospital.

22. Prison staff completed an escort risk assessment before Mr Jones left for hospital and concluded that he should not be restrained due to his medical condition.

23. At 11.13pm on 5 May, Mr Jones died.

Contact with Mr Jones's family

24. On the evening of 4 May, a prison family liaison officer telephoned Mr Jones's daughter and told her that he was in hospital. Mr Jones's daughter visited him that evening and was present when he died.

Support for prisoners and staff

25. After the emergency, an operational 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.

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

Post-mortem report

27. The post-mortem examination found that Mr Jones died of hypoxic brain injury (brain damage from lack of oxygen) caused by cardiac arrest due to hypertensive heart disease.

Findings

Clinical care

28. The clinical reviewer found that the clinical care Mr Jones received in custody was of a reasonable standard and partially equivalent to that which he could expect to receive in the community. The clinical reviewer found that appropriate care planning was in place in relation to Mr Jones's diagnoses of hypertension and COPD. However, there was no reference to an angina/cardiac care plan, despite Mr Jones having had investigations relating to chest pain. The clinical reviewer found that a care plan should have been prepared, in line with national guidelines.

29. The clinical reviewer also found that Mr Jones's blood pressure was not routinely checked or reviewed when it was found to be outside the normal range at his reception health screen. This is also a requirement of national guidelines. We make the following recommendations:

The Head of Healthcare should ensure that care plans are created for all patients with suspected coronary heart disease.

The Head of Healthcare should ensure that healthcare staff routinely review patients with high blood pressure results.

Control room operations

30. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, describes the actions that prison and control room staff must take in a medical emergency. It states that, on receipt of a medical emergency code blue call, the control room operator must immediately telephone for an ambulance.

31. Rather than telephoning for an ambulance on receipt of the code blue call, the control room operator did not do so until a nurse on the scene explicitly asked for one. The OSO recorded that this was his first shift as control room operator without supervision, that he had not received formal training, and that he was "very stressed" at the time.

32. The Operations Manager at Peterborough told us that there is a three-day national control room operator course, with a substantial waiting list. He said that, before attending the national course, local training is based on shadowing experienced colleagues. Trainee operators then undertake duties themselves alongside an experienced colleague. He said that there is no set time period or number of sessions that a trainee will receive before they can take on the role unsupervised. Instead, this is based on when the operator feels comfortable to take on the role themselves.

33. We appreciate that places on the national control room operator course are limited, and that staffing and resource issues at prisons might mean that individuals need to take on the role without having received this training. However, prisons should ensure that their local training is robust and that staff are properly prepared for the role. It is unfortunate that the OSO had to deal with a medical emergency during his first unsupervised shift, but these events are not uncommon. Rather than relying on

an operator to determine for themselves when they are ready to work unsupervised, Peterborough should consider how else they might test whether the individual is fully prepared for what is an important role including checking that they have experienced a range of frequently occurring incidents and events. We make the following recommendation:

The Director should review the local training programme for control room staff to ensure that it is sufficiently rigorous, includes the full range of frequently occurring events and an understanding of the actions required by national instructions, and involves an objective test of readiness to work alone.

Inquest

34. The inquest into Mr Jones' death concluded on 4 April 2025, returning a verdict of natural causes.

Adrian Usher
Prisons and Probation Ombudsman **July 2025**

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