Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Honnor, a prisoner at HMP Wandsworth, on 27 June 2024

A report by the Prisons and Probation Ombudsman

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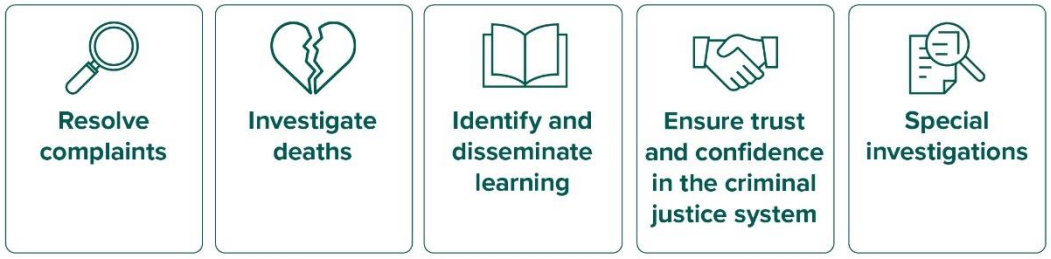
OUR VISION

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 Peter Honnor died of myocarditis (inflammation of the heart muscle making it harder for the heart to pump blood around the body) on 27 June 2024, while a prisoner at HMP Wandsworth. He was 55 years old. I offer my condolences to Mr Honnor's family and friends.

4. Mr Honnor had a complex medical history of heart disease, and was prescribed a range of medications for these when he was sent to Wandsworth in May 2024. During his short time in prison, Mr Honnor experienced at least three falls and healthcare staff identified other emerging clinical concerns, including low blood sodium levels (which might indicate exacerbated heart disease).

5. At around 4.18am on 27 June, Mr Honnor's cellmate alerted the night patrol officer that he was not breathing. The night patrol did not immediately radio a medical emergency and told us that he could not immediately enter the cell as he was not carrying a (mandatory) cell key in a sealed pouch. Other officers, followed by healthcare staff, arrived and began cardiopulmonary resuscitation, but paramedics later confirmed that Mr Honnor had died.

6. Following Mr Honnor's death, London Ambulance Service paramedics who attended the resuscitation identified concerns with the quality of resuscitation undertaken by prison and healthcare staff.

7. The clinical reviewer identified concerns with how the emergency response and other clinical events were managed and concluded that the clinical care Mr Honnor received at Wandsworth was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that staff understand and follow NICE guidelines for the management of head injuries and develop a protocol so that prisoners prescribed anticoagulants have a formal medical assessment after a head injury including recording a clear decision around the need for CT scanning.

- The Head of Healthcare, alongside doctors involved in Mr Honnor's care, should undertake a formal significant event analysis to identify weaknesses in the care provided and learning from these, and share these with all clinicians working in the prison.

- The Governor and Head of Healthcare should investigate the concerns raised by London Ambulance Service paramedics, identify any learning and develop an action plan for improvement for individual staff as required.

- The Governor should conduct a local investigation into the events of 27 June 2024, identify and share any learning with staff and the Ombudsman, and ensure that night patrol officers understand the equipment they are required to carry, when and how to use it, and how to properly communicate a medical emergency.

The Investigation Process

8. We were notified of Mr Honnor's death on 27 June 2024.

9. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with information to contact her. One prisoner responded, who the investigator and the clinical reviewer interviewed.

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

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

12. The investigator and clinical reviewer interviewed five members of healthcare staff and one member of prison staff on 17 September and 14 and 16 October. The investigator interviewed two members of prison staff via video conference on 18 September and 3 October respectively.

13. We informed HM Coroner for Inner West London 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 office contacted Mr Honnor's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They raised no concerns but asked for a copy of the report.

15. We also shared the initial report with Mr Honnor's family. They did not make any comments.

16. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at HMP Wandsworh

17. Mr Honnor was the 20th prisoner to die at Wandsworth since the end of June 2021. Of the previous deaths, six were from natural causes, ten were self-inflicted, and three drug related. To the end of November 2024, there has been one more self-inflicted death at Wandsworth. There are no significant similarities between our findings in the investigation into Mr Honnor's death and our investigation findings for the previous deaths.

Key Events

18. On 6 May 2024, Mr Peter Honnor was remanded in custody to HMP Wandsworth for threatening a person with a blade or sharply pointed article in a public place. It was his first time in prison. At the reception health screening, a nurse identified that Mr Honnor had a history of heart attacks and heart failure and arranged for him to see the GP. Mr Honnor had his medications 'in possession' (holding and taking his own medication). These included amlodipine, bisoprolol, ramipril and furosemide (all for high blood pressure), atorvastatin (for high cholesterol), edoxaban (an anticoagulant to prevent blood clots) and sertraline (an antidepressant). He also had GTN spray, which is used to stop chest pain during angina attacks.

19. On 8 May, healthcare staff assessed Mr Honnor after he experienced chest pain. They took Mr Honnor's clinical observations, which were within the normal range. Mr Honnor had an electrocardiogram (ECG) and no abnormality was detected. He told the nurse that he was starting to feel better and that the pain was easing. The nurse made an appointment for Mr Honnor to see a GP.

20. On 9 May, healthcare staff saw Mr Honnor in the long-term conditions clinic. He was examined for coronary heart disease, hypertension (high blood pressure), and *chronic obstructive pulmonary disease* (COPD, a group of lung conditions that cause breathing difficulties). Healthcare staff recorded that his observations were within an acceptable range but were a little hypotensive (indicative of low blood pressure).

21. On 21 May, a nurse visited Mr Honnor after an officer reported that he had fallen in his cell. Mr Honnor denied hitting his head, and there was a small graze to his elbow and thigh. He told the nurse he had got up to change the television channel, felt dizzy and fell. Mr Honnor said he had experienced previous dizzy spells. The nurse took Mr Honnor's blood pressure, which was low. The nurse liaised with a GP at Wandsworth, due to Mr Honnor's blood pressure reading. The GP reassured the nurse that Mr Honnor was already booked into the GP clinic in two days. The nurse started a falls assessment questionnaire, but there is no record that this was completed.

22. On 23 May, prison staff found Mr Honnor collapsed in his cell. Mr Honner said that he had got up from the chair, felt dizzy and fell down hitting his head. He denied any loss of consciousness. Healthcare staff took Mr Honnor's clinical observations, which were in the normal range other than low blood pressure. They ensured he was able to get himself up and on the bed. They encouraged Mr Honnor to take fluids.

23. On the same day, a GP at the prison reviewed Mr Honnor (while visiting his cellmate). He noted low serum sodium (sodium in the blood), completed an examination that was normal, but noted Mr Honnor's low blood pressure reading. The GP's impression was that Mr Honnor was overmedicated and the low sodium and low blood pressure could be a consequence of this. He advised that Mr Honnor stop some of his medications (furosemide and amlodipine).

24. A GP at the prison also saw Mr Honnor as part of the planned review. Her advice and plan were the same as that proposed by the previous GP. She also noted that

Mr Honnor asked to increase his dose of sertraline and decided to defer doing this as sertraline can be a cause of hyponatremia (low blood sodium). Mr Honnor was later admitted to the prison healthcare unit, where his blood pressure was monitored twice a day.

25. On 30 May, a GP at the prison advised fluid restriction for Mr Honnor. He said that apart from slightly low blood pressure with a persisting postural drop (drop in blood pressure when standing after sitting/lying down), Mr Honnor had no symptoms and was settled on the unit.

26. On 3 June, a GP at the prison noted that Mr Honnor still had a postural drop in his blood pressure. He reduced the dose of ramipril and bisoprolol.

27. On 9 June, healthcare staff reported that Mr Honnor engaged well and, although he had some dizziness, his health had improved and he had not reported any falls. Healthcare staff had a care plan in place for Mr Honnor, that included the provision of care for heart disease and high blood pressure. The plan instructed healthcare staff to refer Mr Honnor to the GP if they identified any concerns or complications.

28. On 11 June, Mr Honnor was seen in the ECG (electrocardiogram) clinic due to a low heart rate. A GP at the prison reviewed the results, and there were no concerns.

29. Mr Honnor remained on the prison healthcare unit where he had twice daily clinical measurements, and nurses described him as being well with no symptoms other than low blood pressure.

30. On 18 June, Mr Honnor asked healthcare staff for an appointment as he said he still felt dizzy when walking up stairs and felt like he was going to pass out. He was added to the GP waiting list for 25 June.

31. On 22 June, prison staff called a medical emergency code blue for Mr Honnor, who reported that he had got up from bed to use the toilet, felt dizzy, blacked out, then fell against the cell wall. Healthcare staff attended and reported a minor bruise to the left side of Mr Honnor's head. Mr Honnor told them he had no nausea or chest pain. Staff took a full set of clinical observations and by the time this was completed, Mr Honnor was back to normal. There was no further clinical intervention, the fall was not discussed with a doctor and there was no evidence in the records that any consideration was given to sending Mr Honnor for a CT scan (imaging test that helps healthcare providers detect diseases and injuries).

32. On 25 June, a nurse recorded that Mr Honnor said that he was well and that there were no issues or concerns identified. There is no record that he saw the GP.

Events of 27 June 2024

33. At around 4.18am on 27 June, an Operational Support Grade (OSG) responded to Mr Honnor's cell bell. He spoke to Mr Honnor's cellmate through the observation panel. The cellmate said that Mr Honnor was not snoring as he usually did when sleeping and did not appear to be breathing. The OSG asked the cellmate to move Mr Honnor's blanket to check for breathing. He did this and said Mr Honnor was not breathing.

34. The OSG radioed the control room for assistance and waited outside the cell for other prison staff to arrive. He did not radio a medical emergency code blue but told us that he said that a prisoner was not breathing.

35. At 4.19am, Officer A arrived, followed by Officer B and a third officer. They unlocked the cell and found Mr Honnor unresponsive with no pulse. Officer A radioed a medical emergency code blue and began chest compressions. Around a minute later more staff arrived. Three officers continued chest compressions on rotation.

36. A nurse attached defibrillator pads to Mr Honnor. The defibrillator advised no shock, so chest compressions continued. The nurse told us that he and a colleague initially struggled to locate Ambu-bag equipment to clear Mr Honnor's airway. They were able to locate it, but it was not connected to the oxygen supply until ambulance staff arrived.

37. At 4.31am, paramedics arrived and took over the resuscitation. They identified flaws in the resuscitation (as noted below) and provided guidance to prison and healthcare staff.

38. At 5.19am, paramedics pronounced Mr Honnor dead.

39. Following Mr Honnor's death, the paramedics who attended the emergency response identified concerns with the quality of resuscitation administered by healthcare and prison staff. Their specific concerns were:

- Chest compressions were performed at inadequate depth and at excessive speed.
- Defibrillator pads were attached in incorrect locations (despite pictures on the pads depicting the correct locations).
- Nasopharyngeal airway (NPA, a tube that is inserted into the patient's nostril to relieve airway obstruction) and i-gel (inserted in the mouth to provide an open airway during resuscitation) were applied, but Mr Honnor was not being treated with oxygen.

Post-mortem report

40. A post-mortem examination identified the cause of death as myocarditis (inflammation of the heart muscle making it harder for the heart to pump blood).

41. The pathologist noted that myocarditis can present in a range of symptoms, including dizziness or loss of consciousness.

Findings

Clinical findings

Falls and head injuries

42. At Wandsworth, Mr Honnor had three documented falls as well as other episodes of dizziness. The most recent fall was a few days before he died and the clinical reviewer noted that two of his falls included a description of a head injury. The nursing team assessed each of these falls and on one occasion there was an expectation of a GP review, although the clinical reviewer noted that no GP review of the head injuries took place.

43. The clinical reviewer found that NICE guidance suggests that a CT scan should be undertaken when patients prescribed anticoagulants experience a head injury, no matter how slight it is. The clinical reviewer noted that while this is guidance only, healthcare staff should have recorded a clear record of the assessment and the reasons for not sending Mr Honnor for a CT scan.

Hyponatremia

44. Hyponatraemia is a condition where the amount of sodium in the blood is too low. There are many possible causes, including heart disease.

45. In May, blood tests identified low sodium levels in Mr Honnor's blood. Although Mr Honnor had experienced other symptoms, including dizziness, falls and low blood pressure, the clinical reviewer noted that there were no clear pointers in his symptoms or presentation to determine the possible reasons for the hyponatremia and that this was an acute change since Mr Honnor arrived at Wandsworth.

46. Healthcare staff initially considered that the causes were overmedication and made changes to Mr Honnor's medication. The clinical reviewer found that the investigation and assessment of the hyponatremia stopped there. She noted that there was no assessment for other possible causes and the possible progression of Mr Honnor's heart failure was not considered at all.

47. The clinical reviewer found that a more structured approach to investigating Mr Honnor's hyponatremia should have taken place, including a case review among the clinicians in the prison and consideration of obtaining advice from Mr Honnor's cardiologist or heart failure team.

CPR intervention on 27 June 2024

48. The clinical reviewer noted that the resuscitation attempt was poorly recorded and it is not even clear who was actually present. She found that the paramedics' concerns were well founded.

49. Healthcare staff at Wandsworth are trained to immediate life support (ILS) standard, with refresher training every two years. Officers are trained to emergency first aid at work standard, which includes cardiopulmonary resuscitation.

50. A nurse told us that he recognised that healthcare staff present did not offer effective leadership during the resuscitation and that the approach was not compliant with current clinical guidelines. He said that he has since received additional training.

51. We have raised our specific concerns with prison managers to ensure that action can be taken to ensure more effective practice in real time. The Head of Healthcare told us that she has initiated an internal investigation. The then Head of Residence said that they were delivering more intensive first aid courses to custodial managers and continuing to deliver emergency first aid at work training to other staff.

52. The clinical reviewer found that Mr Honnor's heart had stopped at the beginning of the resuscitation attempt and given the post mortem findings, a successful resuscitation attempt was very unlikely. However, she noted that resuscitation should always be carried out according to the Resuscitation Council guidelines.

Conclusion

53. The clinical reviewer concluded that the clinical care that Mr Honnor received at Wandsworth was not equivalent to that he could expect to receive in the community. As well as the issues highlighted above, the clinical reviewer also found that the provision of care for Mr Honnor's ring finger fracture (which he came into prison with) and low haemoglobin level fell below expected standards and made additional recommendations that the Head of Healthcare should consider.

54. We make the following recommendations:

- **The Head of Healthcare should ensure that staff understand and follow NICE guidelines for the management of head injuries and develop a protocol so that prisoners prescribed anticoagulants have a formal medical assessment after a head injury including recording a clear decision around the need for CT scanning.**

- **The Head of Healthcare, alongside doctors involved in Mr Honnor's care, should undertake a formal significant event analysis to identify weaknesses in the care provided and learning from these, and share these with all clinicians working in the prison.**

- **The Governor and Head of Healthcare should investigate the concerns raised by London Ambulance Service paramedics, identify any learning and develop an action plan for improvement for individual staff as required.**

Emergency response by prison staff

55. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Wandsworth uses the emergency codes

'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when a prisoner has difficulty breathing or is unconscious.

56. When Mr Honnor died, PSI 24/2011 covered management and security at nights. It said that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer manager and an individual member of staff can enter the cell on their own. (It says that they should use keys that they carry in a sealed pouch.) Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

57. The policy framework Management of Internal Security Procedures has since replaced PSI 24/2011. It contains the same information about entering cells at night in life-threatening situations.

58. The OSG told us that he did not radio a medical emergency code blue when Mr Honnor's cellmate told him that Mr Honnor was not breathing. In these circumstances, staff should use the appropriate medical emergency code in line with national guidelines. As well as ensuring that control room staff telephone for an ambulance immediately, it alerts healthcare staff to the nature of an emergency and informs them about the equipment to bring. Instead, there was a delay before other officers arrived, opened the cell and requested an ambulance.

59. The OSG told us that he did not enter Mr Honnor's cell when he identified that he was not breathing because he did not have a key for the cell. He said that at night, staff did not have key access to cells. They had their own keys to the main landing but not for individual cells. He said he needed to wait at the cell door for prison staff to arrive after calling for assistance.

60. We asked Head of Security about the local emergency response policy for prison staff entering cells at night. They said that staff on wing patrol duties should be in possession of a cell key at night, in a sealed pouch to break in emergencies. The Head of Security told us that staff should perform a three-point check before opening a cell door alone, which includes a rapid risk assessment. They should inform the control room before entering the cell, stating the location of the cell and describing the circumstances that required intervention.

61. The OSG did not have a key to enter a cell at night in an emergency. This is a basic piece of equipment that should always be carried by night patrol staff and they cannot competently respond to a medical or other emergency without one. We have not identified a wider issue with night staff not carrying sealed cell keys at Wandsworth. It is also possible that the OSG was issued with a key but did not understand what it was for or when and how to use it. We make the following recommendation:

- **The Governor should conduct a local investigation into the events of 27 June 2024, identify and share any learning with staff and the Ombudsman, and ensure that night patrol officers understand the equipment they are required to carry, when and how to use it, and how to properly communicate a medical emergency.**

Inquest

62. The inquest into Mr Honnor's death concluded on the 12 September 2025. The coroner confirmed that Mr Honnor died of natural causes.

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

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