

**Investigation into the circumstances surrounding the
death of a man, a prisoner at HMP Peterborough,
in October 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2010

The man was serving a six year sentence of imprisonment at HMP Peterborough and had been in custody since 7 November 2008. He had previously been diagnosed with serious kidney problems and had been receiving medical treatment in the community.

Sadly, his condition continued to deteriorate during his time in custody and he eventually died of renal failure in hospital in October 2009. He was 47 years old.

I would like to convey my condolences to the man's family and others affected by his death. I hope that this investigation provides them with some understanding of the events surrounding his death.

An investigator was appointed as the lead investigator and he has been assisted by a Family Liaison Officer. I would like to thank the operations manager at Peterborough who acted as the investigator's liaison throughout the investigation.

I apologise for the delay in publishing this report. It is important, however, to include the clinical review of the man's medical treatment whilst in custody and this was not received by this office until July 2010. I am, however, grateful to the clinical reviewer who conducted the clinical assessment of the care received by the man. His findings are attached to this report.

There are four recommendations arising from this investigation, all relating to the medical treatment given to the man in the prison.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Prisons and Probation Ombudsman

December 2010

CONTENTS

Summary

The investigation process

HMP Peterborough

Key findings

Issues

Conclusion

Recommendations

SUMMARY

The man died in hospital in October 2009, the cause of death being “acute renal failure with a pericardial effusion”. He was a prisoner at HMP Peterborough at the time of his death and had been in custody since November 2008.

When he first arrived at the prison it was known that he was suffering from a serious kidney complaint for which he was being treated by the renal department of the local hospital. This medical treatment continued throughout his time in prison.

Although pleasant in manner and largely co-operative with prison staff involved in his medical treatment, the man refused to attend pre-arranged appointments at the hospital on a number of occasions. This meant he missed five consecutive out-patient appointments between January and July 2009. He also discharged himself early from hospital on two occasions in the same year.

The hospital eventually discharged him as an out-patient in response to the disruptive impact of his failure to keep appointments. He was reinstated shortly afterwards following a referral from the prison doctor and a firm commitment from the man to keep future appointments. It is clear that he found the need to be restrained with handcuffs on these outside visits humiliating. He explained to prison staff that part of the reason for refusing to attend clinics at the hospital was his dislike of being restrained in this way.

There were early problems supplying him with his prescribed medication in a regular and timely way. He instructed his solicitors to write to the head of the prison’s healthcare highlighting the issue on two separate occasions. The issue does appear to have been tackled more diligently after the second letter in March 2009, following the appointment of a pharmacy assistant to oversee the supply of his medication.

Communications between the hospital and prison healthcare were generally well managed apart from the failure on the part of the prison to stop prescribing calcium resonium (medication to lower blood potassium) once the man’s potassium levels had reduced. This drug continued to be prescribed several months after the hospital specifically advised it should be stopped. Although the clinical reviewer’s opinion was that this would have had no lasting damage, it is of concern that clear medical advice was not carried out and I make a recommendation to this effect.

On Friday 25 September 2009, the man returned to prison after a two week stay in hospital. The 500mg tablets of frusemide (medication designed to reduce fluid retention) prescribed by the hospital were taken away and not re-issued until after the weekend. He had a large enough supply of 40mg tablets in his cell to make up the dose, although it would have been more difficult to use these to make up an increased prescribed dose of 250mg. I make a

further recommendation regarding medication reviews when a prisoner returns from outside hospital.

He was admitted to hospital on 30 September, after experiencing chest pain and shortness of breath. His condition deteriorated and he moved to a specialist renal unit at another hospital on 5 October. He did not recover, and died in the afternoon two days later.

THE INVESTIGATION PROCESS

1. The investigation was opened on 8 October 2009 when the investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the investigation to come forward. One prisoner wrote to the investigator as a result.
2. The investigator was given access to the man's prison files, including the medical record. He visited Peterborough on 14 January and 24 February 2010 and interviewed seven members of staff. The report based on the investigation was written by a senior family liaison officer employed by my office as an investigator on a sessional basis.
3. A clinical review of the man's health care whilst he was in custody was led by a clinical reviewer, formerly medical director of the local Primary Care Trust. The report of his findings was received by the investigator in July 2010. The publication of the Ombudsman's report was delayed to some extent as a result in order to incorporate the clinical review.
4. The investigator and the senior family liaison officer visited the man's family at their request on 17 December 2009. His mother and brother were able to share their issues and questions arising from his death. These mostly concerned supply of medication, use of restraints and failure to let them know quickly of his last admission to hospital, and are summarised below:
 - He had complained about on-going problems in getting his medication. His solicitor had written to the prison twice earlier in 2009 about this issue. His family were concerned about the means of dispensing medication in the prison. They specifically asked why his medication was taken from him when he returned from a stay in hospital in September 2009 and only returned to him four days later.
 - The family wanted to know why it took so long to inform them that he had been re-admitted to hospital on the Wednesday before he died. They were not contacted until the Thursday morning.
 - The family questioned why it was necessary to use "a double manacle and chain" to restrain him during the previous two week stay in hospital when he had been on an open ward. They described this situation as embarrassing and distressing for all concerned.
 - He was handcuffed in the Intensive Care Unit when he was unconscious during his last stay in hospital. His family wanted to know the basis for this decision.
5. The man's family also expressed doubts about the authenticity of his signature on the disclaimer form on 30 September when he declined the chance to remain in healthcare before being admitted to hospital.

6. The investigation has attempted to address these issues and answers to the questions can be found in the Issues section of this report.

HMP PETERBOROUGH

7. HMP Peterborough is privately run by Kalyx (formerly UK Detention Services) who also run two other prisons in England and Wales. It opened in March 2005 and was the newest purpose built prison in the United Kingdom at the time. It is a category B prison (for prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult. All prisons which hold remand prisoners, as the man was when he arrived in prison, are at least category B) and was intended to serve counties in the East Midlands and East Anglia. Demand for places, however, now means that it has a significant population from outside the originally envisaged catchment area. Uniquely, it holds both men and women and these populations are kept separately. Both male and female sides of the prison have a separate healthcare facility. The male facility has 13 beds.
8. The most recent inspection by Her Majesty's Chief Inspector of Prisons (HMCIP), dated July 2008, highlighted improvements in healthcare after a previous inspection in 2006 revealed numerous deficiencies. The latest inspection report commented that:

“The appointment of a clinical manager meant that nursing staff were receiving clear clinical leadership ... [whilst] perceptions of the quality of healthcare were still very poor ... the overall service had improved. A new management structure was working effectively ... some progress had been made.”
9. The Chief Inspector recommended, however, that there needed to be more work to ensure that provision met the standard of medical care in the community. Among specific areas deemed to be falling short were the management of prescriptions and the need for regular specialist reviews of medication.
10. The Independent Monitoring Board (IMB) at Peterborough published a report of the 12 months ending March 2009. The report noted the improvements made in respect of healthcare including the introduction of a clear management structure and better staff training. It commented specifically that action plans were in place to address some of the main criticisms of the HMCIP report relating to management of the pharmacy. New formal agreements with a pharmacy had resulted in better stock control and a new post of Pharmacy Assistant had been created.
11. This was the second of five deaths that the Ombudsman investigated at Peterborough in 2009. There has subsequently been one further death in 2010. All but one of these other deaths were due to natural causes. The earlier death in 2009 involved a man with long-standing liver disease. The Ombudsman's investigation found that this man received a good standard of care at Peterborough. However, the Ombudsman considered the use of restraints whilst this man was undergoing a medical procedure to have been unnecessary.

KEY FINDINGS

12. The man was first remanded to Peterborough on 7 November 2008. At the first reception health screen (a standard medical assessment for all new entrants into custody) it was identified that he was diabetic and had kidney problems. He had an outstanding hospital appointment and was being considered for dialysis treatment. (Dialysis is the artificial replacement of kidney function for people with renal failure. This is usually done by a process known as hemodialysis, whereby a patient is connected to a machine in hospital for around four or five hours at a time. Blood is drawn from the body, usually from the forearm, and 'cleaned' by the dialysis machine, before being returned to the body through a second access point in the forearm. An access point can also be made in the chest instead of the forearm.) He was referred to the prison doctor in connection with these conditions and to write a prescription for his medication. He saw Prison Doctor A the next day and was briefly admitted to the healthcare unit as he had not received hypertension (high blood pressure) medication.
13. After moving onto a standard wing, the man appeared to settle well in prison. Other than an apparent disagreement with his cell mate over tobacco, he generally got along well with other prisoners on the wing.
14. He told the prison staff that he had an appointment to see his renal (kidney) consultant at hospital on 20 November. It is standard practice to reschedule any outstanding hospital appointments that are booked when a prisoner is received into custody. This is for reasons of security, as a prisoner is not permitted to know in advance of any time outside of prison. The hospital subsequently re-booked his appointment for 31 December.
15. Prison Doctor B saw the man on 18 December for a review. As well as listing his health problems, it was noted that an appointment with the renal consultant to create an arteriovenous fistula needed re-booking. (A fistula is a connection created between a vein and an artery designed to help the artery grow stronger thus making it easier to insert needles when giving dialysis.)
16. On 19 December, routine blood tests taken at the prison showed high levels of potassium at over 6mmol/litre and also high levels of creatinine, which was evidence of a deterioration in kidney function. No immediate action was taken in response to these results. On the same day a letter was sent to the hospital from the prison medical office to request the construction of the fistula.
17. After the man kept the appointment to see the renal consultant on 31 December 2008, he was admitted to the Medical Assessment Unit (also known as the Acute Assessment Unit or AAU) at the hospital on 1 January 2009. His stay was short lived as he then discharged himself from hospital on 2 January on the grounds that he was refused a sleeping tablet. He

signed a disclaimer to say that he had discharged himself against medical advice.

18. The renal consultant and Prison Doctor B discussed the man's medical situation on the telephone on 7 January. The former requested urgent blood tests, a hospital admission on 12 January for a review and an operation to create the fistula for dialysis.
19. Before this could happen, the man appeared before Crown Court on 9 January 2009. He was convicted and sentenced to six years imprisonment. It is recorded that a blood test requested by the renal consultant could not go ahead as he was in court that day.
20. The planned admission to hospital took place on 12 January 2009. A fistula was created and the man's condition was reviewed before he was discharged on 24 January. It was also decided to give him weekly Aranesp injections. (Aranesp is a synthetic version of EPO, a hormone produced by healthy kidneys to stimulate the production of red blood cells).
21. The man was initially admitted to the prison's healthcare centre for monitoring following his hospital stay. He had moved back to his wing on 27 January.
22. Although he was due to have an appointment with the renal consultant on 4 February, he refused to attend telling prison staff that he found wearing handcuffs too painful. (As is standard practice, he would have been required to wear restraints in any visit outside the prison). The consultant wrote to him in response to his absence, in a letter received on 10 February, outlining the severity of his condition and stressing that it was essential he attend appointments. The appointment was re-booked for 4 March.
23. On 13 February a letter was received from the man's solicitor suggesting that he had not been getting his medication in a timely fashion as he had to wait several days for a new supply when stock had run out. A reply to this letter was sent by the acting clinical lead on 26 February. She said that the pharmacy now had sufficient stock of all relevant drugs for the next four months and that he was now receiving medication as prescribed.
24. Prison Doctor B contacted the Head of Security on 17 February to say that the man could not be double cuffed on outside visits on account of the fistula in his left arm. (It is standard practice on any escort outside prison that a prisoner will be 'double cuffed'. This means that the prisoner's wrists are handcuffed together with a second set of handcuffs joining the prisoner's wrist with that of an escorting officer. His note indicated that 'single cuffs' should be used, meaning that restraints could only be applied between the man's wrist and that of the escorting officer).
25. On 16 March, Prison Doctor C, the duty doctor at the prison, expressed concern about the man's high potassium levels (the most recent test, on

13 March, showed a level of 7.1 mmol/L) and spoke to the hospital about an in-patient admission for further investigation. The man was asked to go to healthcare for an ECG (electrocardiogram, a test to measure the electrical activity in the heart). He refused to do so and also declined to go to hospital. He said he had had the condition for years and that he felt okay. He asked to be returned to the wing and signed a disclaimer form.

26. The following day, the renal consultant's secretary rang the prison to request an urgent admission for the man. Although he went to hospital, he apparently refused to be admitted to the ward and asked to return to the prison. The importance of receiving treatment for the increased levels of potassium was explained to him but he persisted with his wish to be discharged. He said that he did not want to be in the Acute Assessment Unit cuffed to officers "on display to the public".
27. The nurse manager at Peterborough recorded in the man's notes that his high potassium level meant he risked cardiac arrest if not treated. Calcium resonium (medication designed to lower blood potassium by drawing the potassium out of the blood) was prescribed and blood tests every 24 hours were advised until the level came down to below 5.3mmol/litre. She also requested that a low potassium diet be provided for him and warned healthcare staff that he could potentially "arrest at any time". By 20 March the potassium level was noted as 4.9mmol/litre.
28. A second letter was received from the man's solicitors on 26 March, again suggesting that he was not getting his correct medication. The healthcare manager replied to this letter on 3 April. She identified that the main concern had been the consistent supply of doxazosin (medication for high blood pressure). She explained that a pharmacy assistant had now been appointed to prepare and monitor in-possession medication to ensure that there would be no further interruptions for him.
29. Prison Doctor C discussed the man's care with staff at the hospital on 31 March. He was advised that calcium resonium should now be stopped as the potassium level had reduced to below 5.3mmo/litre. It appears that the man continued to take calcium resonium beyond this point.
30. On 8 April, the man refused to attend his hospital appointment and signed a disclaimer saying that there was "no need to attend as [the tests required are] being done at HMP". His absence was followed up by a letter from the consultant nephrologist dated 15 April. The consultant was prepared to offer one further clinic appointment at the next available date of 17 June. If the man did not attend then, the hospital would discharge him to the care of the prison.
31. In May, the man was given a job working in the wing laundry room. He was described as working "exceptionally well" in this role. In mid May, he slipped on the floor and hurt his ankle, which became swollen. An x-ray on 26 May revealed that there was no fracture but he had sprained his left wrist.

32. At a consultation with Prison Doctor D, on 18 May, the man asked for calcium resonium which he said had been stopped “without a reason”. On 29 May he complained that supplies of certain drugs had run out “days ago”. He mentioned calcium resonium in particular.
33. He refused to attend the hospital appointment on 17 June, repeating that there was nothing they could do for him that was not being done in prison. A handwritten note was made on the letter from the consultant nephrologists of 15 April which confirmed that the man did not attend and that the prison doctor would now have to refer him back to the renal department at the hospital.
34. An entry in the medical record for 29 June said that the man refused to attend the appointment on 17 June because he had been told by an officer that it was for a urine test. He thought this could be done at the prison. Nurse A explained to him that discipline staff were “not privy to reasons for appointments” with the implication it would be better to speak with medical staff.
35. Prison Doctor D referred him back to the renal department at the hospital on 8 July. The doctor explained that the man had not attended because he thought the appointment was for a urine test. He had now said he would not refuse to attend again if offered another appointment.
36. The hospital responded by letter on 14 July. It was noted that the man had missed the last five appointments having last attended the renal clinic on 31 December 2008. The letter emphasised that his repeated non-attendance badly affected the smooth running of the outpatient clinic. An appointment was booked for 22 July, which he kept.
37. In his follow up letter after that clinic, the renal consultant noted that the man had remained well during the seven months since he had last been seen. He had given up smoking and his chest was “remarkably clear”. He also noted “increasing ankle oedema” (swelling). The consultant expressed “astonishment”, however, to see that the man had been taking calcium resonium since March. He said that this should have been stopped as the medication was only ever prescribed in the short term. However, his renal function was unaffected. His dose of frusemide (medication to reduce swelling) was increased to 120mg.
38. The man also attended the next renal clinic on 12 August, when the renal consultant again expressed surprise to see him looking so well. Calcium resonium had indeed been stopped as advised previously. The ankle oedema had improved but blood tests showed a decline in renal function. He suggested a change to his medication to tackle the man’s high blood pressure. One area of concern raised here was the fact that blood pressure control remained poor. He asserted that checks should be done at least weekly.

39. On 3 September, the man complained of chest pain and was described as having “blood shot eyes”. His chest was checked by Prison Doctor E at the prison and proved to be clear. He did not have a cough and he was given painkillers and eye drops for possible conjunctivitis. Despite not feeling very well that week, he continued to work well in the laundry.
40. Three days later (6 September), the man collected a 28 day supply of frusemide in 40mg tablets. This was to be taken three times a day to make up the prescribed 120mg daily amount.
41. The man was admitted to hospital on 14 September after the hospital haematology department discovered high calcium levels in his blood. He was treated as an inpatient for the next 11 days until his discharge back to prison on 25 September. Records indicate that restraints used while he was an inpatient took the form of an escort chain attached to his right wrist and the bedwatch officer’s left wrist. During his stay, he was given antibiotics and the dose of frusemide was increased to 250mg a day. The hospital issued him with 500mg tablets on discharge so that he could take a daily dose of half a tablet.
42. On his return, the man saw Nurse B in healthcare. The nurse told the investigator that this meeting was “by chance”. As he knew the man quite well, he offered to help sort his medication and checked that he had enough frusemide tablets in 40mg form in his possession to take over the weekend to make up the increased dose. The man said he would be able to do this. As is standard practice, the 500mg tablets were taken from him so they could be added to his prescription by a prison doctor. The nurse told the investigator that it was unlikely that the prescription would be re-issued until the following Monday (28 September).
43. The 500mg frusemide tablets and other medication issued by the hospital were returned to the man on Monday 28 September. In interview with the investigator, Prison Doctor D could not remember a face to face meeting with him on that day although the medical record indicates that this did happen.
44. At around 8.30am on 30 September, the man reported feeling unwell with severe shortness of breath (dyspnoea) and chest pain. Prison Doctor D examined him at around 10.00am and noted “crackles” in his right lung. He thought he needed admission to hospital for further investigation but, on contacting the hospital for advice, found there were no beds immediately available in the Medical Assessment Unit (MAU). The man was offered the option of waiting in the prison healthcare unit until a bed was free in the MAU. He declined to remain in healthcare and signed a disclaimer form in front of a healthcare assistant and Prison Doctor D to this effect. He did confirm, however, that he was willing to go to an outside hospital.
45. The man waited on his wing until Prison Doctor D rang the hospital again at around 2.00pm. There were still no beds and Prison Doctor D therefore

decided to send him to the Accident and Emergency department. It is recorded that he left the prison at 2.30pm and arrived at hospital at 2.45pm. Prior to his departure, an escort risk assessment was authorised by the healthcare manager. In line with Prison Doctor B's note of 17 February, she instructed that he should be restrained using a single handcuff only.

46. Escort staff telephoned the Head of Security at Peterborough at 3.10pm and asked for permission to release the man from the single handcuff which had been used to restrain him on the journey to the hospital. Authorisation was refused. Later that afternoon permission was given for an escort chain to be used instead of the handcuffs.
47. The man's family were told of his admission and whereabouts early the following morning. His mother visited him shortly afterwards, followed later that morning by his brother.
48. The same morning at 11.10am, one of the hospital doctors asked the escort staff for the chain to be removed as it was cutting into his wrist. This request was refused by the duty director when he was telephoned at 11.35am on the grounds that he needed to make further enquiries about risk within the prison. However, he permitted the escorting staff to loosen the man's cuffs. A further request was made by the same doctor at 12.05pm, at which point the duty director agreed that the escort chain could be removed. The doctor was insistent that the handcuff was causing harm to the man's arm and affecting his blood pressure.
49. The man's condition continued to cause concern and he was transferred to another hospital on the evening of 5 October. Cuffs were not applied during the escort or following his arrival at hospital. Dialysis started soon after he arrived and this continued the next day. He was visited by his mother later in the afternoon of 6 October.
50. Although the man was encouraged to get out of bed the next day to sit in a chair, his blood pressure became very low and he had to be helped back into bed with the aid of a hoist. The nursing team became increasingly worried about him and, following a deterioration in his health, cardiopulmonary resuscitation (CPR) was administered at 2.20pm. Sadly, these efforts were not successful and he was pronounced dead at 2.30pm.
51. Shortly before his death, the man's family were contacted by telephone by prison staff and advised of his deterioration. His mother and brother were travelling to Leicester when he was pronounced dead. The news was broken to them on their arrival at the hospital.
52. In the following days the Director of Peterborough and the prison's family liaison officer visited the man's family to return his personal belongings. The man was buried in Italy on 30 October. The investigation found that the prison's contribution to the funeral costs was in accordance with PSO

2710 (the Prison Service Order that sets out the actions to be taken following a death in custody).

ISSUES

Issues raised in the clinical review

53. The clinical reviewer notes that Peterborough used blood sugar measures to manage the man's diabetes, which he describes as "unusual". He recommends that the adoption of the HbA1c measure (a measure of the amount of glucose being carried by the red blood cells in the body) be introduced by clinical staff. He notes that this measure is in standard use by clinicians and he considers it to be a better assessment tool. I endorse this recommendation.

The use of the HbA1c measure in type 2 diabetes should be a standard measure.

54. The clinical reviewer also outlines the length of time it took before the man was seen by a renal specialist at the hospital after blood tests on 19 December 2008 revealed a "potentially dangerous" deterioration in his renal function. He was not seen until 31 December. Whilst the clinical reviewer does not think it likely that permanent damage resulted, he recommends that the prison should review their processes in this area. I again endorse his recommendation.

Clinical staff should review methods for assessing and acting on abnormal blood results

Problems receiving medication

55. It is clear the man was not happy with the regular supply of his medication in the early part of his sentence. He instructed his solicitor on two occasions to write formally to the prison to complain.

56. The then healthcare manager replied to the last letter on 3 April 2009. She said that the appointment of a pharmacy assistant to oversee the regular management of the man's prescribed medication would ensure no further problems. Some problems continued in May, however, when he was again recorded as finding fault with the supply of certain drugs.

57. After this, there is no further written account of problems. Records show a good relationship between the man and healthcare staff and this was echoed in their interviews with the investigator. The healthcare manager described him as "polite" and "likeable" and someone she judged well able to ask for what he needed. He was a prisoner who was considered responsible enough to be trusted with in-possession medication. Following his death, an amount of unopened medication was found in his cell, some dating back to 2008. This suggests that he was himself sometimes erratic in taking his medication. The quantity found by the police is evidence, however, of regular supply.

58. The appointment of a pharmacy assistant to oversee the supply of the man's medication and his ability to handle this in-possession was a positive step. However, the fact that amounts of unopened and unused medication supplied to him was found later in his cell indicates that the second part of the role was not completely effective.

Continued prescription of calcium resonium

59. Calcium resonium was first prescribed following the man's hospital admission on 17 March, due to high levels of potassium in his blood. He discharged himself against medical advice and no formal discharge note was received at Peterborough. However, it is clear from an entry in the medical record on 18 March that it was understood that the medication was only to be used until the potassium level fell below 5.3 mmol/litre.

60. On 31 March, Prison Doctor C telephoned the hospital to discuss the man's potassium levels, which had fallen to 4.9 mmol/litre. He was advised to stop calcium resonium.

61. However, this medication continued to be prescribed to the man and additional prescriptions were supplied in April, May and July. It should also be noted that the man requested a further prescription on 18 May, as it "had been stopped without a reason". He was advised by Prison Doctor D to discuss with his consultant at the next appointment. Despite this, the May prescription was completed two days later. It is not clear which doctor signed for these additional prescriptions.

62. The man chose not to attend scheduled appointments with the renal consultant on 17 June and 29 June. He next saw the consultant on 22 July. In his discharge note of 27 July, the consultant expressed "astonishment" that the man was still taking calcium resonium. It was immediately stopped.

63. It is unclear why he was still taking calcium resonium several months after staff at the hospital advised it should be stopped. The clinical reviewer notes that the man "does not appear to have come to significant medical harm due to this". However, it is clearly unsatisfactory that he took this medication for such a long period of time against hospital advice.

The healthcare manager should ensure that systems are in place to carry out instructions received from outside hospitals regarding the continued prescription of medication.

Medication on return from hospital on 25 September 2009

64. Prior to his admission to hospital on 14 September 2009, the man was prescribed 120mg of frusemide per day. He took three tablets of 40mg frusemide to make up this dose. On his discharge, his prescription was increased to 250mg per day. He was given a supply of 500mg tablets to make up this dose, to take half a tablet per day.

65. Nurse B said that he saw the man “by chance” as he passed through the healthcare unit following his return from hospital on 25 September 2009. As he knew him well, he offered to “sort out” his medication. This appears to have been done more in the spirit of doing him a favour rather than being part of a planned process instigated whenever a prisoner returns from an outside hospital.
66. The healthcare manager said, however, that the man should have been assessed as part of standard procedure and that it was part of Nurse B’s duties to do so. Once he had dealt with the medication there does not appear to have been any planned assessment of the man’s condition at that point, although he did see the doctor on the following Monday.
67. Nurse B said that the man accepted as a matter of course the removal of his medication until the prescription could be “re-written” by the prison doctor. The difference between the dose of the new tablets and the previous ones was acknowledged and the nurse checked that the man already had enough 40mg tablets to make up the increased dose over the weekend. (The man had collected a 28 day supply of 40mg tablets on 6 September, totalling 84 tablets). He was known to be an intelligent, able man with good knowledge of his own medical needs and the nurse assumed that there was no problem. However, I am concerned that the nurse considers his consultation with the man to have been “by chance” rather than the formal review that the healthcare manager considers should have taken place.

The healthcare manager should ensure that a formal review of medication is undertaken when a prisoner returns from outside hospital with a change to their prescription, to ensure that the correct dose is understood by all and available to the patient. All relevant staff should be made aware of their responsibilities in relation to these reviews.

Use of restraints in hospital during the period 14-25 September 2009

68. That the man found the use of handcuffs and other restraints when visiting hospital as an outpatient humiliating is well documented in the records. He refused to go to hospital on at least one occasion citing the thought of being “cuffed” to officers as the reason for his wish to stay at the prison. His family were also upset that he was “double handcuffed” and attached to an officer with a chain when on an open ward during his hospital stay in early September 2009. They saw this level of restraint as unnecessary and unduly stigmatising.
69. It is not always easy for prisons to balance the need for security with the need for compassionate treatment of sick prisoners who need outside medical treatment. The security manager told the investigator that it would be usual for any prisoner to be “double cuffed” on a routine appointment or a day visit to hospital. Once it becomes clear that a prisoner may need to

stay overnight or longer she said that the double cuffs would usually be removed and the restraint would be on one arm only.

70. Following the creation of his fistula in January 2009, Prison Doctor B wrote to the Head of Security to ask that the man not be double cuffed on outside visits. The risk assessment (a form completed at the prison to determine the security level needed for an escort outside the prison) completed for his inpatient stay from 14 September reflects this. It is noted that "single standard cuff" should be used due to a "problem with left wrist". The risk assessment went on to say that "on admission [to hospital] escort chain can be applied". However, it goes on to say that "any movement from allocated area must be double cuffed".
71. Written evidence in the bedwatch log indicates that instructions in the risk assessment were being applied. For example, on 16 September, a Senior Prison Custody Officer (SPCO) wrote that "as per risk assessment is on [escort] chain only due to wrist injury".
72. On balance, I am satisfied that the level of restraints used during this hospital stay were consistent with the risk assessment carried out at the time. Given that the man was fully mobile at the time, I do not consider the use of an escort chain to be unreasonable. However, given the doctor's request, it is concerning that double cuffs were applied when he left his bed for any reason (for example, to walk to the shower). Whilst this might only have been for a short period at a time, and the man himself apparently did not complain about the measures, the Director will wish to satisfy himself that doctor's advice is fully considered in future.

Family concern about the disclaimer completed in September 2009

73. The man's family voiced their concerns to both the police and the investigator that it was not his signature on the form saying he did not want to wait in the healthcare unit on 30 September 2009. They were suspicious that the disclaimer had been signed on 25 September when he had returned from hospital, indicating that he did not wish to be admitted to the healthcare centre on that date. Whilst sympathetic to the concerns of his family, the investigation could find no basis for their suspicions. The two witnesses to the signature, healthcare assistant and Prison Doctor D, were adamant that he signed the form in front of them. They were also clear that the form was signed on 30 September and indicated that he did not wish to remain in the healthcare centre whilst he waited for a place in the hospital MAU to be available.
74. The police also looked at a number of examples of the man's signature on prison documents. Their conclusion was that the signature on this form was consistent with other signatures provided by him in the past. The police could find no grounds for thinking the signature had been falsified.
75. The man's decision to remain on the wing while he waited for a hospital bed is entirely in keeping with previous decisions he had made. He had

mostly shown a strong preference for staying on the wing and, despite feeling unwell on this occasion, it seems he again opted for the support of that familiar environment.

Use of restraints following hospital admission on 30 September 2009

76. In line with Prison Doctor B's request, single handcuffs only were applied on the escort to hospital on 30 September. Later that afternoon, the handcuff was removed and an escort chain applied in its place.
77. The following morning, at around 11.10am, the escorting staff were asked by a hospital doctor to remove the escort chain as it was "cutting into" the man's wrist. At the time, he was in the Intensive Therapy Unit (ITU) and required breathing support. As is standard practice, the escorting staff contacted the duty director to ask for advice. The duty director initially refused this request. He explained at interview with the investigator that he needed to make further enquiries within the prison about possible risk, so as to make a more informed decision. However, he permitted the escorting staff to loosen the man's handcuffs whilst he made these enquiries.
78. At 12.05pm, the hospital doctor again asked for the cuffs to be removed and was reportedly "insistent that they are causing harm to arm and blood pressure". The escorting staff again contacted the duty director for advice. On this occasion the escort chain was removed.
79. It is entirely reasonable that the duty director would want the fullest information possible before making the decision to permit removal of handcuffs. However, I do not consider it unreasonable that the duty director would have some knowledge of the prisoners out on bedwatch, as it is likely that they would be asked a question about such a prisoner at some point during the day. Were this to be the case, he might have been in a position to authorise removal of the man's escort chain at the time of the first request. Whilst I make no formal recommendation, the Director might wish to remind his senior managers that it is helpful to familiarise themselves with the details of any prisoners on a bedwatch at the start of their period as duty director.

Informing the family of admission to hospital

80. The man's family were distressed not to be informed of his admission to hospital on 30 September until the following morning. He arrived at the hospital at around 2.45pm on 30 September. This was not an emergency admission, however, and it was not until later in the day that it became clear that he would be staying overnight. The following morning he was given oxygen to help him breathe and, later, was admitted to the Intensive Therapy Unit. His mother was told of his admission that morning and visited at around 10.00am.

81. It was known that the man had on-going and potentially serious medical problems. That his family would appreciate knowing his whereabouts as soon as possible is completely understandable. During his previous inpatient stay they had visited him on a number of occasions. Although this was not an emergency admission and his condition did not deteriorate until the following morning, I do not think it would have been unreasonable to notify his family once it became clear that he was to stay in hospital overnight.

CONCLUSION

82. That the man was already in poor health when he first arrived at Peterborough in November 2008 was understood and addressed. The prison made consistent efforts to assist him receiving on-going medical treatment from renal specialists in the community. These efforts were affected by his aversion to the unavoidable use of restraints when escorted on visits outside the prison. This dislike formed part of his refusal to attend appointments for the first six months of 2009. It was only when these resumed in July 2009 that it was noticed that he was still being prescribed calcium resonium against the previous advice and instruction of the hospital. The clinical reviewer has judged, however, that "it is unlikely that permanent damage occurred at this time."
83. It was acknowledged by the prison that there were problems in the regular supply of medication to the man early on in his imprisonment. The Head of Healthcare attempted to address this issue by appointing a pharmacy assistant to supervise this aspect of his medical treatment and there were improvements as a result.
84. It has been established that the man did have enough supplies of frusemide in his cell to make up the increased level prescribed over the weekend between his last hospital admissions. However, I am concerned that a more formal review of his medication did not take place. Nevertheless, I am unable to say that this, or any other factor considered, could have contributed adversely to his death.

RECOMMENDATIONS

1. The use of the HbA1c measure in type 2 diabetes should be reviewed by clinical staff at the prison.

Accepted – (1) We have recently run a recruitment campaign and have recruited a nurse with specialist training in diabetes. (2) We have planned to re-train GP's as to their role in this area.

2. Clinical staff should review methods for assessing and acting on abnormal blood results.

Accepted – As above. Further training is planned for all clinical staff.

3. The healthcare manager should ensure that systems are in place to carry out instructions received from outside hospitals regarding the continued prescription of medication.

Accepted – Escort staff to be briefed on the importance of collecting discharge papers from the hospital and handing them to the shift leader on return to the prison. Shift leaders are to be made aware of the need to input details onto System One and to make follow up appointments with the GP where appropriate.

4. The healthcare manager should ensure that a formal review of medication is undertaken when a prisoner returns from outside hospital with a change to their prescription, to ensure that the correct dose is understood by all and available to the patient. All relevant staff should be made aware of their responsibilities in relation to these reviews.

Accepted – Escort staff to be briefed to ensure medication is brought back from the hospital and handed to the shift leader. All clinical staff are to be trained to ensure medication is administered to prisoners on return from hospital in line with national instructions.