PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a woman at outside hospital in October 2012, while in the custody of HMP Peterborough

Our Vision

‘*To be a leading, independent investigatory body,*
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision’

This is the report of the investigation into the death of a prisoner at HMP Peterborough. The woman died from blood clots on the lungs and a heart condition, at outside hospital in October 2012. She was 58 years old. I offer my condolences to the woman's family and friends.

The investigation was carried out by one of my investigators and a clinical reviewer conducted a review of the woman's clinical care in custody. Peterborough prison cooperated fully with the investigation.

At times, the woman was difficult to manage in prison and it was not clear if her many problems, which included incontinence, were behavioural or related to her physical or mental health. During her time at Peterborough, she had been managed as an inpatient in the healthcare unit and on a residential wing. She had also spent some time in the segregation unit. She had been in prison for three months when she was taken to outside hospital on 26 September 2012, because of concern about her deteriorating health. Doctors suspected that she had pancreatic cancer. Tests did not indicate cancer but showed that she had cirrhosis of the liver, pulmonary emboli and had suffered a recent heart failure. Her health continued to decline and she died in hospital in October.

Overall, the woman appears to have received reasonable interventions for some of her medical conditions at Peterborough, but the clinical reviewer has drawn attention to the need for improvement in some healthcare practice. Moreover, while she was evidently a complex and difficult prisoner to manage, the investigation raises serious concerns about whether prison and healthcare staff always gave appropriate priority to meeting her basic care needs, which could have been addressed in a much more holistic way. In particular, not enough appears to have been done to get a proper understanding of her mental health and behavioural issues. Finally, I do not consider that the use of restraints while she was in hospital was justified by fully considered risk assessments and it is wholly unacceptable that an immobile, terminally ill, 58 year old woman should have died while still chained to a prison officer.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **May 2013**

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SUMMARY

1. The woman was remanded to custody on 25 June 2012, charged with arson. During her reception screen at HMP Peterborough, she reported a range of health problems, including a previous stroke, emphysema, and a leg ulcer. At first she went to a residential wing but a doctor subsequently admitted her to the healthcare inpatient unit to monitor possible alcohol withdrawal. The woman had been living in a care home just before her imprisonment to ensure the dressings on her leg ulcer were attended to. She also said that she suffered from incontinence.

2. The woman's behaviour and compliance with prison rules and routine was variable over the next few months. She often did not collect her food or medication. Her incontinence was a difficult management problem, as she did not dispose of her pads appropriately and left them lying in her cell.

3. The woman spent periods as an inpatient in the healthcare centre, on a residential wing and in the separation and care unit (the segregation unit.) At first, healthcare staff could not establish a medical reason for her incontinence and advised wing staff to use disciplinary procedures to try to modify her behaviour. Later tests suggested that she had blood and liver function problems. She was referred to a specialist, but refused to attend the hospital appointment that was arranged for her.

4. On 25 September, a prison doctor carried out a disability assessment and was concerned that the woman was jaundiced, breathless, her liver was enlarged and her leg ulcer was causing a lot of pain. The doctor was concerned that it was possible that she had pancreatic cancer and arranged for her to go to outside hospital the next day. Tests indicated that she did not have cancer, but had cirrhosis of the liver, pulmonary emboli and had recently suffered heart failure. Her health declined in hospital and, by 4 October, she was unable to get out of bed

5. On a day in October, the woman's condition significantly worsened and she died that evening. Throughout her time in hospital the woman was handcuffed to an officer, mostly by an escort chain which was not removed before she died.

6. Overall, the clinical reviewer concluded that the medical care received by the woman in the weeks and months before her death, in prison and in hospital, did not contribute to her death. However, he felt the wound care for her leg ulcer, prescribing practices and management of her inhaler use fell short of the expected standards. We make recommendations about some of these aspects of the woman's care and also about the inappropriate use of restraints.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the woman's death on 8 October 2012. The investigator visited Peterborough on 12 October and met members of the prison management team and staff involved in the woman's care. She visited the living units, the separation and care unit and the healthcare centre. She issued notices informing staff and prisoners of the investigation and asking them to contact her with any relevant information. No one responded.

8. The investigator obtained copies of the woman's medical and prison records. Peterborough Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care the woman received at Peterborough.

9. The investigator returned to Peterborough on 5 and 6 November and conducted interviews with 11 staff and was joined by the clinical reviewer for those with healthcare staff. The Director was given verbal feedback.

10. Her Majesty's Coroner for Peterborough was informed of the investigation and he provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

11. As part of the consultation period, the family received a copy of the draft report. The family felt the report contained conflicting evidence and statements from staff. The family felt prison staff overlooked their relative's mental health needs, putting this down to bad behaviour. The family also commented they found the use of restraints on her particularly distressing, and not a refection of the level of risk she presented. Finally, the family also commented the level of liaison and communication with the family was poor when their relative was in hospital, this led to delays in getting information and only arriving at the hospital after the woman had died.

HMP PETERBOROUGH

12. HMP Peterborough opened in March 2005 and is run by Sodexo Justice Services. It houses both male and female prisoners in separate sides of the prison. The residential unit for women is made up of two house blocks. Each house block has five wings and each wing has two landings.

13. The prison has 24 hour healthcare cover. Prison healthcare staff are employed directly by Sodexo Justice Services, although there is collaboration with Cambridgeshire and Peterborough NHS Trusts. General Practice (GP) services are commissioned through an agency called Cimarron.

HM Inspectorate of Prisons

14. The Inspectorate of Prisons last conducted an announced inspection of the prison in April 2011. In respect of healthcare, inspectors noted that the quality of health care services was good, but there were problems with the appointments system and a high rate of non-attendance at clinics. Inspectors also commented that it was unacceptable that women did not have the option of seeing a female GP.

15. Inspectors also noted that the segregation unit was decent and professionally run with a focus on care, and that staff-prisoner relationships had much improved since the last inspection and were mostly very good.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their most recent report for the year ending 31 March 2012, the IMB reported that there had been good progress with healthcare at the prison.

Previous deaths in custody at Peterborough

17. There have been two previous deaths from natural cause deaths at Peterborough in the past year, both were male prisoners. One of those reports included a recommendation about ensuring the use of restraints is fully justified by a risk assessment and that the prisoner's medical condition is taken into account in the risk assessment.

KEY EVENTS

18. The woman was remanded into custody on 25 June 2012 charged with arson with intent to endanger life. She had not been in prison before. Her person escort record (PER, which accompanies prisoners on all journeys between prisons, police stations and courts and lists a prisoner's risks) noted a current health risk of "manic depression". The woman's police national computer printout also included a warning mark of manic depression, dating back to 2006.

19. The woman went to HMP Peterborough. During her initial health screen, she told a healthcare assistant (HCA) that she did not drink much alcohol and that she did not take medication for mental health problems. She said she had previously tried to harm herself by making cuts to her arm and pouring petrol over herself. She told the HCA she did not have a psychiatric nurse or care worker in the community, although she had previously been a day patient at a psychiatric hospital. The HCA noted that the woman appeared frightened. She said she had previously suffered a stroke and used crutches to get around. She said she suffered with emphysema (a chronic lung disease). The HCA noted that she had an ulcer on her left leg. She tested negative for drugs.

20. A nurse from healthcare then saw the woman, who said that the arson charge was the result of an accident and that she had not intended to harm herself. The nurse decided that the woman was not suitable to share a cell because she had been charged with arson.

21. The woman went to D wing. That evening, she asked for some incontinence pads and for her leg to be dressed. As the prison was in night patrol state (when cells are usually unlocked only in an emergency), the nurse passed her a dressing to apply herself and gave her sanitary towels until incontinence pads could be arranged. The next day, a prison custody officer (PCO) explained the rules and procedures to the woman and referred her to the mental health team as she reported having mental health problems.

22. A prison doctor saw the woman that morning. She told the doctor that she had suffered a stroke in 2004, and had damaged her left shin in a serious fall 25 years previously, which meant she needed crutches. She said a previous burst stomach ulcer had led to a burning sensation in her stomach coming back. The doctor continued the medication her GP had prescribed before she came to prison. These were fluoxetine (an antidepressant), folic acid and a vitamin B tablet (usually given when a liver problem is suspected), lansoprazole (often used to treat ulcers), clenil modulate inhaler and salbutamol inhaler (for chronic obstructive pulmonary diseases and asthma) and paracetamol (a pain reliever). He also prescribed cefalexin (an antibiotic) for a chest infection. This was changed a few days later to clarithromycin. The woman said she did not misuse alcohol. No reference was made to her leg ulcer.

23. A nurse saw the woman on 27 June and cleaned and dressed the ulcer on her left leg. She told the woman to return every four days for it to be re-dressed. She said she would discuss the woman's incontinence problem with her GP.

24. The next day, the woman told a nurse that she had not had her medication. The nurse had to explain to her that she needed to go to the treatment hatch to collect it when the officers called treatment time. The woman said she had been eating her dinner when they called.

25. A senior PCO noted in the woman's wing file on 1 July that all staff needed to monitor her mental health. She had set fire to the bin in her cell the night before and then put it out. That morning she had been sick into the bin and then used it as a toilet. The mental health in-reach team wanted her to see the doctor before they assessed her so she could be screened for any physical illnesses.

26. That morning, the woman told a prison doctor that she felt sick, had difficulty breathing and had abdominal pain. The doctor thought she was withdrawing from alcohol but the woman said she did not drink a lot. She had been in prison for five days and denied abusing alcohol, but the doctor decided to prescribe diazepam (a sedative) and admitted her to the healthcare unit as an inpatient so she could be monitored for any signs of alcohol withdrawal. In relation to her alleged offence, the woman told the doctor that she had fallen asleep with a cigarette, which she had done before. He thought this might indicate someone who drank heavily. She told him that she had diarrhoea but did not refer to problems of incontinence

27. A prison doctor saw the woman in the inpatient unit on 2 July. She told him she had urinary incontinence and that she had been living in a care home. The doctor saw her again on 3 July. He considered her chest infection was better than the previous day and discharged her to D wing.

28. The Sister in the healthcare department established that the woman had recently had respite care as she had not been attending surgery to get her ulcer dressings changed. The care home manager did not think that the woman's incontinence had been a major problem and said the woman bought her own pads. She told the Sister that the woman was mobile and used crutches.

29. The woman seemed to find it difficult to comply with the regime on D wing and often wanted staff to collect her meals for her. She was admitted to the healthcare unit on 8 July after she had spent much of the night shouting and screaming. She told a prison doctor on 9 July that she could not move, was not coping and needed to be cared for. The doctor said she had been able to collect her breakfast that morning without using her crutches, that her chest was now clear and that she was capable of looking after herself as she used to do at home.

30. The woman moved to C wing on 11 July, but still often refused to comply with the regime, despite being given more time to collect her meals and

medication. She was warned that staff would use the disciplinary system to sanction her.

31. At about 8.30pm on 14 July, a nurse went to give the woman some paracetamol. She was lying on the floor and asked to be helped to be put to bed but staff refused as there was no evidence of a fall. She threw her shoe at the door when the nurse asked if she was going to collect the paracetamol from the cell door. At 9.17pm, prison staff discovered that she had set fire to her shoe and other belongings. They put the fire out and took her from the cell. The nurse examined her but she did not appear to have inhaled much smoke. The woman was given new inhalers and she walked to the segregation unit using her crutch and supported by an officer.

32. The Sister from the healthcare department saw the woman in the segregation unit on 17 July, when she said she could not move. The Sister noted that her assessments had shown she could be mobile and the woman then walked to the shower using one crutch. However, she noted that the woman moved slowly because of her emphysema and needed time to rest if she was walking any distance. A nurse with a particular expertise in wound care also saw the woman that day and advised how the wounds on her legs should be treated.

33. The woman moved back to C wing on 20 July. The head of the women's side of Peterborough noted that the woman had been assessed as being able to live independently and that she had warned her about the seriousness of setting fires in the prison.

34. A blood test result on 24 July showed that the woman's haemoglobin was slightly low at 116 g/dL. Her kidney function and blood sugar levels were normal. The woman's legs were noted to be swollen with fluid and the ulcers were wet. Dressings to absorb the fluid in the ulcers were applied and a light bandage was put on the legs from toe to knee.

35. Later that day, a PCO introduced himself as the woman's personal officer. (Each officer on C wing has particular responsibility to support eight prisoners and is expected to make an entry in the prisoner's record each week.) He wrote: "I find her to be rude, argumentative and uncooperative, she takes no responsibility for herself…" During interview, he said he wrote this when he had gone to introduce himself but she had told him to get out of the cell and had thrown a bowl at him. He said she only ever seemed to want to talk to healthcare staff.

36. The treatment hatch, from which prisoners collect their medication, was about 20 metres from C wing, on the wing next door. Her personal officer said she often refused to go and collect her medication and wanted nurses to bring it to her, which they did not do. She did not attend for her morning or afternoon dose of thiamine from 1 to 3 August or 14 to 22 August. (Between 3 and 13 August she was an inpatient in the healthcare centre.)

37. A nurse sought advice from a prison doctor on 4 August about how her leg ulcers should be cleaned and dressed. The woman continued to have

diarrhoea and a prison doctor arranged tests on 5 and 7 August for C. difficile, e.coli 157, salmonella and other toxins. The tests came back negative. On 8 August, tests for liver problems suggested inflammation of the tissue of the liver and a possible obstruction to the flow of bile from the liver to the gall bladder.

38. On 13 August, a prison doctor arranged for more blood tests. The woman had a slightly higher blood bile level than on 8 August but the indicator of liver inflammation was now normal. She had continued to be incontinent during her stay in healthcare, but the staff considered that she could get to the toilet without help and that there was no physical reason for the incontinence. She returned to C wing that day with a care plan which included targets for her to be mobile, and for staff to understand her issues about not using the toilet and keeping her cell clean. To encourage her to comply, wing staff were told to use the Incentives and Earned Privileges Scheme (IEP, which is designed to encourage good behaviour by awarding additional privileges and discourage poor behaviour by withdrawing privileges) and the formal prison disciplinary system. The next day, her personal officer wrote that nothing had changed and that her cell was not clean. She told him that staff were refusing her food and water. He explained that she had to make an effort to collect her meals from the servery and that staff would help her carry them back. He told the investigator that there were some days when she did not eat because she refused to leave her cell to collect her meals. When she did go to get them, he helped her take them back to her cell. No record was kept of when she missed meals.

39. The woman was given IEP warnings in August for being rude, disobeying a direct order, misusing her cell intercom and urinating in her cell. She signed an agreement to say she understood she had to keep her cell clean and tidy and comply with the prison rules and her care plan, otherwise disciplinary action would be taken. Nurses saw her often because of her continuing incontinence problems. On 22 August, she was found to be hiding faeces in her cell and was charged with endangering the health and safety of others. She was taken to the segregation unit. The charge was dropped the next day and she returned to C wing. On 23 August, she was given a warning for throwing her tooth brush at an officer.

40. On 24 August, the woman had further blood tests as she appeared pale and jaundiced. Her blood count and kidney function showed no change. The liver function showed a bile level slightly lower than previously (but still above the normal range) and both enzyme levels (the markers of possible inflammation) were elevated. The tests indicated an inflammatory process in her body, such as an infection.

41. On 28 August, a prison doctor faxed a doctor at outside hospital to say that the woman's liver function was causing concern and that her blood tests did not seem to be improving. He asked that she should be assessed as soon as possible.

42. On 30 August, faeces were found in the woman's bed, and on the floor and wash basin in her cell. Later that day, she complained of discomfort passing urine. A test showed protein in her urine but no strong evidence of an infection and she was treated with antibiotics (cefalexin).

43. Over the next days, the woman was charged with three disciplinary offences for failing to comply with rules and damaging prison property. She was also put onto the basic level of privileges, the lowest IEP regime level when prisoners lose their televisions and have their opportunity to mix with other prisoners restricted. Two of the disciplinary charges were discontinued but she was found guilty of destroying or damaging prison property and punished by three days cellular confinement in the segregation unit, as well as withdrawal of other privileges for seven days.

44. The woman made a small number of telephone calls to her ex-partner during her time in Peterborough. On 30 August, she said she had diarrhoea and that her ulcer was getting worse. She said that most of the staff were nice but that a few "had it in for her". She said some of the other women prisoners called her names because of her incontinence.

45. On the morning of 10 September, the woman left the prison to attend a Crown court. The hearing was adjourned in her absence as she was unable to go into the court room on her crutches. She told her solicitor she was upset about the adjournment and that she would kill herself if she went back to Peterborough. The solicitor passed on her concerns and the PCO at the court completed a suicide and self-harm warning form and informed the prison. When the woman returned to Peterborough later that day, the PCO wrote in her wing file that suicide and self-harm prevention procedures had not been started as the woman had said that she "was in the best place and isn't going to self-harm".

46. On 13 September, the woman had an appointment at outside hospital with a doctor for a scan. When the PCO went to collect her, the woman said she was "paralysed" and would go only if she was carried. After speaking to nurses, she signed a disclaimer that she had refused to attend the appointment. (A new appointment was scheduled for Monday 1 October).

47. The next day, the Sister from the healthcare department noticed that the woman had not collected her medication since 5 September. She also thought the woman appeared more jaundiced. The woman was then admitted to the healthcare centre to get her started on her medication again, which she began to take immediately.

48. On 15 September, the woman asked for cereal as she said she could not swallow much solid food. The Sister noted it was apparent that the woman had not been eating properly, and that her weight needed to be monitored. There were no subsequent entries on her medical record that this was done. A prison doctor asked for more blood and liver function tests on 17 September. Though slightly abnormal, there was no further deterioration in her blood count, and minimal changes in her mildly abnormal liver enzyme and

bile levels. Later, the Sister found incontinence pads thrown around her cell and spoke to the woman about the importance of hygiene. The prison doctor discharged the woman back to C wing the next day, 18 September. The Sister noted that the woman's mobility and incontinence problems had not improved.

49. A nurse saw the woman on 20 September and, because of her lack of progress, arranged a full disability assessment with a prison doctor at his next clinic. On 21 September, the Sister from the healthcare department agreed to readmit the woman to the healthcare inpatient unit for the weekend, as C staff wing felt unable to cope. Other nurses did not agree there was a clinical need for her to be admitted and she moved to D wing the next day, 22 September.

50. On 24 September, the woman went to the segregation unit for a disciplinary charge of endangering the health and safety of others by covering her bed and floor with urine and faeces. A nurse did not consider that the woman was fit for segregation, and the head of the women's side at Peterborough adjourned the disciplinary hearing. The woman moved to the healthcare inpatient unit. The head of the women's side at Peterborough hoped that the planned assessment would determine whether the woman's incontinence was behavioural, psychological or physical. She noted that three referrals had been made to the mental health in-reach team (MHIT) but as the woman would not engage with them, no assessment had been completed. The prison doctor was asked to explore concerns about possible dementia and the Sister from the healthcare department submitted an alert to the mental health in-reach team later that day.

51. On 25 September, the woman was helped to shower. A nurse cleaned her cell and bedding. The nurse told the investigator that she had been concerned about the care the woman had received and that she had not seen someone in that state of neglect since she had qualified. She said that the ball of the woman's foot was purple and swollen and that she could not walk. She said the bandages were pressure dressings for venous leg ulcers, but that she had an arterial ulcer. The GP on duty that day examined the woman's legs, took a swab and prescribed an antibiotic. The nurse said the woman was passing wind and, every time she did so, a small amount of watery faeces came out. She thought the woman was malnourished and probably dehydrated and described her as being in a really dishevelled state. She did not want to eat anything but was encouraged to sip water.

52. After lunch on 25 September, the woman was taken in a wheelchair to see a prison doctor, who noticed a significant deterioration since he had last seen her. She was jaundiced, breathless and in discomfort as the ulcer on her leg was causing a lot of pain. The doctor thought that she had both inflammation in the liver and a blockage of the liver. She told the doctor that before she came to prison she had been able to walk between 100 to 200 metres before she had to stop because of pain in the legs. He thought that she needed to go to hospital, as he thought she might have pancreatic cancer. He spoke to her about going to hospital as she had previously refused to go. She said the previous appointment had come as a surprise and she had panicked. The

doctor reassured her about what would happen. That night, the woman called staff as she had fallen out of bed. Her mattress was put on the floor to prevent any further falls.

53. On 26 September, the senior mental health practitioner noted that she had discussed the woman with nurses and a prison doctor. She said that as the woman was thought to be physically unwell it was not feasible for the team to carry out a mental health assessment.

54. The woman was taken to outside hospital just after 2.00pm on 26 September. She was escorted in a taxi by two officers, handcuffed to one of them as she had been assessed as being of medium risk to the public, because of her alleged offence. She was admitted with a suspected diagnosis of sepsis (blood poisoning), and mild jaundice, nausea and diarrhoea. During the next week at hospital, she had a chest X-ray, ultrasound scan and blood tests.

55. On 28 September, the use of restraints was reassessed by a PCO and the duty manager who decided that officers should use an escort chain rather than handcuffs. (An escort chain is a chain with a handcuff at each end, one of which is worn by the prisoner and the other by an officer.) She was able to move herself between the bed, chair and commode, and nurses did not note any problems with incontinence. The escort chain was removed when she showered.

56. The woman was warned by the escorting officers about misusing the nurse call button and the emergency cord in the early hours of 1 October. Scans taken on 4 October, unexpectedly showed an enlarged heart, signs of heart failure and multiple blood clots in the lungs and narrowing of a kidney artery. Treatment for the blood clots was started. That evening, one of the escorting officers noted that permission had been given to move the escort chain to the other hand while the woman's night gown was changed.

57. The next day, doctors told the woman that the tests and scans indicated she had cirrhosis of the liver, pulmonary emboli and had suffered recent heart failure. They discussed resuscitation and the woman said she would like resuscitation to be attempted in the event of heart failure.

58. On 6 and 7 October, the woman did not get out of bed. Nurses gave her incontinence pads and a bed bath. The head of the women's side at Peterborough visited her both mornings and told the investigator that she asked if there was anyone she wanted to be informed that she was in hospital, and whether she needed any clothes or canteen items bringing in. She said the woman did not raise any concerns.

59. A PCO described the woman as "quite chatty" and amenable on 6 October. He said her breathing seemed very laboured and that she would drift in and out of sleep, often talking about her family. On 7 October, he said he remembered the woman watching the television. She continued to suffer with diarrhoea and sickness. At 11.50am, the PCO noted that she appeared very

quiet, that her breathing seemed laboured and that she was using an oxygen machine. Later in the afternoon he noted that she was restless.

60. Later that day, the medical registrar saw the woman as she had become drowsy and unresponsive, possibly from a recurrence of the blood poisoning. The registrar discussed the case with the duty consultant, who agreed that this was likely to be overwhelming sepsis (an immune system response to a severe infection, often resulting in sever inflammation). She was by this time unable to join in a second discussion about whether she should be resuscitated in the event of a cardiac arrest. Because of the severity of the suspected sepsis and her overall condition, the doctors decided not to attempt to resuscitate her if her heart stopped as treatment for her heart condition was likely to cause her kidneys to fail.

61. A further PCO took over the escort around 7.00pm. He said that it appeared the woman was finding it difficult to breathe and was being given oxygen. At 7.15pm, a doctor asked him for details of the woman's next-of-kin. The PCO rang the prison and spoke to the person who was in charge of the prison that night along with a colleague. The prison only had the address of the woman's brother, her listed next of kin, and were unable to find a telephone number. The other person in charge of the prison rang the PCO a short time later with the telephone number of the woman's ex-partner. The hospital called her ex-partner who in turn contacted her brother.

62. The duty manager at Peterborough that night was informed of the deterioration in the woman's condition. He told the investigator that he could not specifically remember what he was told, but understood that things were serious. He said he was not given a definitive answer as to whether it was an end of life situation and did not discuss the use of restraints.

63. At 9.41pm, the PCO noted that the woman had been given pain relief. At 10.30pm he rang one of the people in charge of the prison that night and told him the woman was not responding to antibiotics. Her brother had telephoned the hospital and said he was on his way. She was given morphine at 10.50pm and, shortly afterwards, was given midazolam (a drug sometimes used to alleviate agitation or anxiety in the last hours of life).

64. The PCO described the woman as looking as though she had fallen asleep. Her breathing was not as rapid as it had been but was still quite shallow. He called the prison again at 11.10pm as a nurse had asked for the escort chain to be removed to give the woman some dignity during her final moments. The night orderly office contacted the duty manager who gave permission for the escort chain to be taken off. The PCO was told at 11.20pm, but by that time the woman had died. A doctor formally certified her death at 11.35pm. Members of her family arrived shortly after her death.

Liaison with the woman's family

65. The head of the women's side at Peterborough met the woman's brother, son and daughter at the hospital during the early hours of 8 October. She

explained what had happened and said the prison's family liaison officer would contact them the next day.

66. The prison chaplain and a senior officer acted as the prison's family liaison officers and, on 8 October, the chaplain spoke to the woman's brother who suggested that he should visit his sister's son and daughter. This was arranged for Wednesday 10 October and the chaplain and the senior officer told them about the woman's time at Peterborough and in hospital.

67. The prison offered financial assistance towards the funeral. The prison chaplain maintained contact with the woman's family and, at their request, led her funeral service on 9 November 2012.

Support for staff

68. The head of the women's side at Peterborough said that after she heard the news that the woman had died she went immediately to the hospital to offer support to the escorting officers and discussed what had happened. The prison's care team subsequently offered them further support.

Post-mortem report

69. A post-mortem examination was undertaken on 19 October. He concluded the cause of death was from two factors. First, the presence of bilateral pulmonary thromboemboli with associated pulmonary infarction (blood clots in the lungs which caused them to fail). Second, that the woman's heart was grossly dilated and its weight was greater than would normally be expected. This was attributed to dilated cardiomyopathy, which might have no identifiable underlying cause but could possibly be related to poor blood supply through narrowed coronary arteries or as a result of chronic alcohol misuse. (Cardiomyopathy is heart muscle disease, when the heart becomes weakened and enlarged and cannot pump blood efficiently.) The forensic pathologist also noted that the woman's liver was congested, which he attributed to poor heart function.

ISSUES

Clinical review

70. The clinical reviewer in his review said that the root cause of the woman's death was enlargement and weakening of the heart muscle and blood clots to the lung. Although she had other health problems while she was in prison, these do not appear to have contributed to her cause of death. Doctors were unable to treat her cardiac problem because of her poor overall condition and unable to treat her kidney problem as the drugs used to treat this heart condition were incompatible with kidney damage.

71. The clinical reviewer said that, in general, the medical treatment the woman received was appropriate for her symptoms. He was critical of the management of her wounds (discussed below). He made a number of detailed recommendations about healthcare which managers at Peterborough will need to consider.

72. The clinical reviewer noted the concerns of one of the nurses about the woman's general health and the possibility that she had not been properly treated in the days before her admission to outside hospital. He thought that her incontinence problems, difficulty in walking and her lack of personal responsibility in the care of her leg ulcers made it understandable that some of the real symptoms of illness were overlooked. When doctors thought that she had developed jaundice, appropriate blood tests were done in an acceptable time scale and the results returned with marginally abnormal figures. She was not seriously ill with symptoms of liver disease and her weight was quite stable. The clinical reviewer said that there were no apparent danger signals for urgent investigation and treatment.

73. Nevertheless, we are concerned that there were some indications of a lack of a caring approach to meeting the woman's basic nursing and social care needs indicated by incidents such as the unwillingness of some nurses to have her remain as a patient in the healthcare centre when the Sister in healthcare had admitted her on 21 September. We understand that the woman might have been difficult to manage at times but there was also a lack of appropriate care in healthcare staff's advocacy of the use of disciplinary procedures without a full investigation of possible underlying physical, mental health and behavioural problems. The clinical reviewer believed that the woman 'could have been better looked after by all parties had there been co-ordinated management.'

The Head of Healthcare should ensure that all nursing staff provide a high standard of care and put the welfare of patients first when dealing with those with complex needs.

Wound care

74. Both the Sister and a nurse thought that the woman's ulcer should have been managed better. Although a specialist nurse saw her on 17 July and

suggested how the wounds should be treated, nurses did not always follow the advice.

75. The clinical reviewer said that, notwithstanding the potential effect that the woman's incontinence had on the healing of her leg ulcers, he did not believe the quality of nursing care equated to that expected by primary care and district nursing staff. There were no records that there had been a diagnosis of the underlying cause of the ulcer and the standard of care was variable and at times confused. This showed a poor understanding of the basic principles of ulcer care. Some of the methods used might have constricted the blood flow or restricted oxygen supply to the tissue, thus reducing the chance of the ulcer healing. In addition, a suspected allergy to one of the dressings was repeatedly ignored. We make the following recommendation:

The Head of Healthcare should ensure that all nurses have refresher training in the principles of wound management in general, and leg ulcers in particular.

Mental Health referrals

76. Before the woman arrived at the prison her escort record indicated that she had been identified as having mental health problems in the form of manic depression (usually referred to as bi-polar disorder.) An entry from a PCO in the woman's wing file the day after she arrived at Peterborough indicates that a mental health referral had been made but the investigator did not find a copy of this form nor a record of any mental health assessment.

77. On 24 September, the head of the women's side at Peterborough noted there had been "at least three alerts" to the mental health in-reach team. It is not apparent where that information came from. The Sister referred the woman that day, but this is the only referral we were shown when we asked for copies of mental health referrals or assessments. In the event, this assessment was not completed as the woman was taken to hospital.

78. The clinical reviewer concluded that he saw no evidence of any serious psychiatric illness from his review of the woman's records, although she appeared to have significant behavioural problems. We are concerned that it is not clear whether or not she was referred to the mental health team shortly after arriving at Peterborough. It is apparent that there were some identified concerns about her mental health but there was never any formal assessment during her time at the prison. We make the following recommendation:

The Director and Head of Healthcare should ensure that the needs of women with evident behavioural and possible mental health problems are identified and met through appropriate and recorded referrals and treatment.

The woman's management in prison

79. The woman arrived at Peterborough with some degree of incontinence. Investigations for infections of both bowel and urinary tract were done and found negative. It is therefore unclear whether her incontinence was behavioural or medical in origin. She did not dispose of her incontinence pads hygienically, which was regarded as a behavioural issue (although as noted there had been no mental health assessment.)

80. At one time while she was on C wing, the woman did not collect her medication (including an anti-depressant) for seven days. A prison doctor said that nurses tried to encourage her to collect her medication but that it was not usual practice for nurses to take medication to anyone who did not turn up at the treatment hatch to take it. Similarly, she did not always collect her meals from the servery and thus missed several meals. The woman's personal officer said that this was sometimes for days in a row. The dates and times she missed meals for this reason were not recorded.

81. We think that it was reasonable that the woman was managed on a standard residential wing rather than in the healthcare unit. However, there were elements of her care that suggest that a more holistic approach was needed. It is a concern that her failure to collect meals and medication was not recorded properly to allow healthcare and wing staff to agree an appropriate care plan. Prison staff tried to manage her using the incentives and earned privileges scheme and formal disciplinary procedures but there should have been a point at which her need for food and medication overrode this approach.

82. The nurse considered that the woman has been unacceptably neglected when she examined her on 25 September. Whether or not this was self-neglect, the prison has an over-riding duty of care towards prisoners which it did not appear to fulfil. Responsibility for the woman's care kept passing between operational and healthcare staff at the prison and there was no holistic assessment of her individual needs and no single person with responsibility for ensuring her needs were met. A more considered assessment of her care was needed. We make the following recommendation:

The Director and Head of Healthcare should ensure that prison and healthcare staff jointly identify prisoners with complex medical, physical, behavioural or social care needs and compile a holistic care plan to ensure their multiple needs are met.

Use of restraints

83. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and

which also takes into account factors such as the prisoner's health and mobility.

84. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. The judgement required that risks during stays in hospital needed to be assessed separately and should be reviewed regularly during a hospital stay or when circumstances changed.

85. The escort risk assessment for the woman's hospital visit on 26 September was completed by a PCO and authorised by the head of the women's prison. It concluded that the woman posed a low risk of escape and medium risk to the public. Her use of crutches was noted, although it was also noted that she could walk unaided. The decision was that she would be escorted by two officers (one of whom should be a female member of staff) and restrained with a ratchet handcuff. The head of the women's prison told the investigator that the first consideration was the risk of escape and that around 98 per cent of women go out restrained using a ratchet cuff. Although the woman's risk of escape was assessed as low, she was satisfied that the restraint arrangements were appropriate as at that time the woman's condition was not regarded as life threatening.

86. A prison doctor told the investigator that when he assessed the woman on 25 September, he did not think that she would have been able to escape from two officers, given her physical condition. The nurse said "This woman had absolutely no chance of escaping [from] anybody". She said she raised the handcuffing issue with the staff in reception before the woman left the prison but that staff said the decision had been made.

87. The Sister agreed with the other medical staff who saw the woman before she went out to hospital that she would not have been physically capable of escape. She explained that healthcare staff are usually asked only to assess whether there are any medical reasons why restraints should not be used, such as injuries to wrists. This is not what the High Court judgement and subsequent Prison Service guidance requires. There is a need to take account of medical opinion about risk of escape, not just whether there is any medical objection to the use of restraints. The head of the women's prison also seemed to be using an inappropriate test of whether the woman's condition was "life-threatening" rather than taking into account the fact that her risk of escape had been assessed as low.

88. On 28 September, two days after the woman had been admitted to hospital as an inpatient, the risk assessment was reviewed. It still said that she was a low risk of escape and medium risk to the public, but the level of restraint was reduced from handcuffs to an escort chain which could be removed for planned scans but was to be used at all other times. There was still no

consideration of medical opinion. The head of the women's prison said the assessment was reviewed daily as part of a routine management check, but even when on the 4 October it was noted she was unable to get out of bed to go to the bathroom the level of restraint remained unchanged. The head of the women's prison suggested that she could have been feigning.

89. We believe that Peterborough needs to fundamentally reassess its use of restraints. In particular, all staff responsible for authorising the use of restraints should be aware of the implications of the 2007 judgement and Prison Service guidance. As the woman was always assessed as at low risk of escape, we consider that the use of restraints without taking into account her medical condition was never properly justified. The subsequent failure by managers to adequately reassess the situation as her health deteriorated ultimately led to her dying still chained to a prison officer. This lack of humanity towards a dying woman is unacceptable. We make the following recommendation:

The Director should ensure that use of restraints for prisoners in hospital is fully justified by a risk assessment that takes into account and records how the prisoner's health and physical condition impact on the risk of escape, and that assessments are reviewed regularly and whenever there is a change in circumstances.

Family liaison

90. The prison had some initial problems in trying to obtain a telephone number for the woman's listed next of kin, her brother. She had given only his name and address to the prison and had not telephoned him during her time in custody. The hospital therefore got in touch with her ex-partner and obtained the brother's number from him. The woman's brother in turn, contacted her son and daughter. All three family members went to the hospital that night, but unfortunately arrived after she had died.

91. Prison Service Instruction 2011/64 gives guidance that prisons should ensure that they arrange for an appropriate member of staff to engage with the next of kin of a prisoner who is either terminally or seriously ill. Prison Rule 22 also requires governors to inform the prisoner's spouse or next of kin "at once" if a prisoner becomes seriously ill. Although the woman's health deteriorated quite quickly before her death, she had been in hospital for over a week, and was so ill that medical staff had discussed resuscitation with her. In these circumstances we believe that she should have been regarded as "seriously ill" several days before she died. Efforts should have been made to contact her family earlier rather than waiting until she had very little time left to live. The prison left this responsibility to the hospital rather than contacting her family themselves. We make the following recommendation:

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The Director should ensure, in line with Prison Rule 22 and Prison Service Instruction 2011/64, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all nursing staff provide a high standard of care and put the welfare or patients first when dealing with those with complex needs.

   NOMS accepted the recommendation and commented:

   We have issued guidance to staff on escalating, challenging or disputing clinical concerns.

   We have reviewed and improved the framework for managing outreach care plans.

   We have recently run a joint prison / RCN Principle of Nursing Practice Day to reinforce appropriate clinical and professional standards.

   We have reinforced appropriate and clinical supervision independently of reporting structures to oversee clinical practice.

   We have reviewed and will publish a new complex and additional needs management practice for offenders at HMP Peterborough. This deals with concerns outlined in the PPO report.

   The Director will raise these issues at a full staff meeting to reinforce the learning that above procedures have provided.

2. The Head of Healthcare should ensure that all nurses have refresher training in the principles of wound management in general, and leg ulcers in particular.

   NOMS accepted the recommendation and commented:

   Those who did not provide treatment correctly have been given written guidance.

   All staff will be advised / reminded of how to gain clinical advice / support if they are unclear or unable to discharge clinical duties expected of them.

   Management shortcomings have been reaffirmed with appropriate senior nurses.

   We have sourced wound management training to ensure training is dated.

   Further to this we have scrutinised and improved stock control procedures to improve range and availability of appropriate dressings.

3. The Director and Head of Healthcare should ensure that the needs of women with evident behavioural and possible mental health problems are identified and met through appropriate and recorded referrals and treatment.

NOMS accepted the recommendation and commented:

CPFT have revised and improved the mental health alert problem that been further referred for consideration / endorsement by the Clinical Governance Team.

A new comprehensive complex and additional needs policy has been produced and referred for consideration / endorsement by the Clinical Governance Team.

4. The Director and Head of Healthcare should ensure that prison and healthcare staff jointly identify prisoners with complex medical, physical, behavioural or social care needs and compile a holistic care plan to ensure their multiple needs are met.

NOMS accepted the recommendation and commented:

Comprehensive guidance to prisoners, peer support workers, staff, partners and visitors has been produced to advise all of the new procedures.

The Director will raise and promote further awareness in his weekly briefing and at a full staff meeting in May 2013

5. The Director should ensure that use of restraints for prisoners in hospital is fully justified by a risk assessment that takes into account and records how the prisoner's health and physical condition impact on the risk of escape, and that assessments are reviewed regularly and whenever there is a change in circumstances.

NOMS accepted the recommendation and commented:

New Risk Assessment process and escort/bedwatch paperwork that underpins these standards has been drafted. To be reviewed and approved for introduction by the Tactical Tasking Group and Clinical Governance Team.

Operational managers have been advised of the requirements for this work and need for attention when carrying out management checks.

6. The Director should ensure, in line with Prison Rule 22 and Prison Service Instruction 2011/64, that the next of kin of seriously ill prisoners are informed as soon as possible after they are admitted to hospital.

NOMS accepted the recommendation and commented:

New Risk Assessment process and escort/bedwatch paperwork that underpins these standards has been introduced.

New FLO training is to be undertaken to increase awareness of and skills in relation to family contact.

Operational managers have been advised of the requirements for this work and need for attention when carrying out management checks.