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 man at HMP Peterborough in September 2011

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 a report into the death of a man at HMP Peterborough in September 2011. He was 76 years old and died from a cardiac arrest. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local PCT appointed a clinical reviewer to review the standard of clinical care the man received at Peterborough. The prison cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was admitted to hospital in July 2011, and had a cardiac arrest two days later. He recovered, but his condition was considered to be terminal. He was discharged back to prison in September, where he was well supported by prison staff and community health services. He died within a week of his discharge from hospital.

We agree with the clinical reviewer that the medical care the man received at Peterborough was equivalent to that he could have expected in the community. In addition, family liaison was of a good standard. However, the level of restraints used when he was taken to hospital was not justified by the risk assessment.

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.

Nigel Newcomen
Prisons and Probation Ombudsman **February 2013**

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SUMMARY

1. The man arrived at HMP Peterborough on 18 June 2009, after he had been sentenced to five years imprisonment. When he arrived he was 74 years old and in poor health. He used a wheelchair, suffered from frequent blackouts and had long-term heart problems.

2. During his time at Peterborough, the man was admitted to hospital and the prison's inpatient unit a number of times. He was once admitted to hospital after he had had a fall. On 29 July 2011, he was admitted to hospital with a chest infection that did not improve with oral antibiotics. On 31 July, he had a cardiac arrest in hospital and had to be resuscitated. He remained in hospital until 5 September. Doctors at the hospital decided that he was too unwell to survive any major heart attack or serious infection in the future, and discharged him with a limited prognosis. Doctors put in place a 'Do Not Resuscitate' (DNR) order while he was in hospital.

3. The man was restrained in double cuffs when he was first taken to hospital. This was reviewed on 2 August, but only reduced to an escort chain on 4 August, when he was considered immobile. His restraints were eventually removed on 11 August due to his failing health. We are concerned that insufficient weight was given to his health, security category or risk and, as a result, the level of restraints used was not justified.

4. A clinical manager visited the hospital before the man's discharge to ensure that the prison had all the necessary equipment to manage his care. When he returned to prison, healthcare staff involved specialist palliative care nurses in his care plan. His cell was left unlocked to allow staff access to care for him 24 hours a day. His wife visited him in the healthcare centre. An end of life care plan was put in place for him and he agreed that he should be allowed to die in the event of a cardiac or respiratory arrest. One evening in September, at approximately 9.00pm, he stopped breathing. He was pronounced dead at 11.30pm.

5. We are satisfied that the man was well cared for at Peterborough and his wife received good support from the prison.

THE INVESTIGATION PROCESS

6. The Ombudsman was notified of the man's death on 10 September. An investigator issued notices to staff and prisoners informing them of the investigation and asking anyone with relevant information to contact him. No responses were received.

7. The investigator visited Peterborough on 29 September 2011, when he met the investigation liaison officer and the Director. He also reviewed the man's prison and medical records.

8. The local PCT appointed a clinical reviewer to review the clinical care that the man received at Peterborough. He was given the man's medical record.

9. HM Coroner for Peterborough was informed of the investigation and a copy of this report has been sent to him.

10. One of the Ombudsman's family liaison officers contacted the man's wife to explain the purpose of the investigation. His wife was concerned that he had fallen out of bed shortly before he died. She wondered if that contributed to his final heart attack and whether he should have had a rail on his bed.

11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided. We apologise for the late issue of this draft report which, because of staffing difficulties, was one of a number of delayed cases in the office which we are striving to clear.

12. The investigation report was issued in draft for consultation with the man's family, the prison, and healthcare providers. The report has been updated with the prison's response to the recommendation at the last page. The family raised no other concerns during the consultation.

HMP PETERBOROUGH

13. HMP Peterborough opened in March 2005 and is run by Sodexo Justice Services (SJS). It houses both male and female prisoners in separate sides of the prison. For male prisoners, the establishment serves as a local prison (a prison that sends and receives prisoners directly to and from the courts) and holds up to 624 men.

14. The prison has 24 hour healthcare cover, and prison clinical staff are employed directly by a private company, although there is collaboration with NHS Trusts. General Practice (GP) services are commissioned through an agency.

HM Inspectorate of Prisons (HMIP)

15. The Inspectorate of Prisons last conducted an inspection of Peterborough in April 2011. HMIP concluded:

> "Overall, it is clear that Peterborough men's prison is an improving institution that has made commendable progress. The good environment and staff-prisoner relationships create the necessary foundation for further development."

16. HMIP found that palliative care was rarely required but was delivered with support from local services. Nursing and specialist clinics were equivalent to that available in the local community. Health care facilities were considered good, and staffing was appropriate with an adequate skills mix.

Independent Monitoring Board (IMB)

17. Each prison in England and Wales has an Independent Monitoring Board (IMB), made up of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained.

18. In its annual report for 2011, the IMB found that healthcare provision continued to improve under new leadership. Although palliative care is not explicitly mentioned in the report, the IMB recognised a strengthening relationship between the prison and the hospital.

Previous deaths in custody at Peterborough

19. The man's death was the only death at HMP Peterborough in 2011. There was one death through natural causes at the prison in 2010. There are no similarities between the issues raised in that investigation and the findings of this report. Subsequently there were four deaths at Peterborough in 2012, in one of which we were concerned about the escort risk assessments, which is also an issue in this report.

ISSUES

The diagnosis of the man's terminal illness

20. The man was sentenced to five years imprisonment and was taken to Peterborough on 18 June 2009. He was a heavy smoker, with a history of heart problems and frequent blackouts, which were under investigation. He used a wheelchair to limit the impact of falling when he blacked out. He was initially admitted to the prison's inpatient unit for further assessment.

21. On the 19 June, the man collapsed. Although his heart was beating, he was not breathing. Nurses inserted an airway and called an ambulance. He was admitted to the local hospital overnight where he was diagnosed with ischaemic heart disease (a lack of sufficient oxygenated blood to the heart muscles) and discharged. In the next few days, he collapsed several times, but did not need to be admitted to hospital. Prison doctors obtained his GP and hospital records.

22. Over the next two years, the man collapsed many times. He was occasionally admitted to the prison's inpatient unit, but was generally settled on his wing. His condition remained stable. The clinical reviewer considers that these episodes were well managed by the prison.

23. On 20 July 2011, the man started to suffer from a chest infection, which was treated with antibiotics. By 29 July, his condition had deteriorated and he was admitted to hospital where he was initially diagnosed with pneumonia. On 31 July, shortly after he first arrived in hospital, he had a cardiac arrest and was successfully resuscitated. He remained in hospital until 5 September.

24. The man's chest infection got better, but it had left him weak. Doctors at the hospital concluded that, because of his heart disease, he was unlikely to survive any further serious illness. The clinical reviewer writes in his clinical review:

> " … the cause of his admission to hospital was diagnosed and managed appropriately in prison and hospital. His cause of death was heart disease which was long standing and had been appropriately managed throughout. He was at risk from a fatal heart attack at any time due to his heart disease."

25. We agree with the clinical reviewer that the man's condition was appropriately diagnosed.

Informing the man about his condition

26. After his cardiac arrest on 31 July, the man was considered at risk of a further cardiac arrest at any time. Doctors at the hospital concluded that, should he have any further cardiac or respiratory arrests (either his heart stopped beating or he stopped breathing), they would not attempt resuscitation and a Do Not Resuscitate (DNR) order was implemented. There is no evidence that he was

aware of the DNR and the hospital did not mention the DNR order in his discharge letter on 5 September.

27. The Clinical Manager recorded that she had a frank discussion with the man on 6 September, about the seriousness of his condition. She held a multidisciplinary meeting the next day to discuss his resuscitation status and his future clinical needs. It was agreed that he would begin the palliative care pathway for terminally ill patients after he had seen his wife. He said he did not want his wife to know that he would not be resuscitated, and he wanted to see her first before he would agree a DNR instruction. She visited him in his room that afternoon. That evening, the Liverpool Care Pathway was started and his DNR order was reinstated. (The Liverpool Care Pathway is a palliative care plan for patients in the final hours or days of their life.)

28. In his clinical review, the clinical reviewer comments:

> "The man was not involved in the original decision not to resuscitate him in hospital, possibly due to the severity of his pneumonia at the time. However, he was clearly involved in the decision taken by him and the whole palliative care team on 7 September after his return to prison."

29. We are satisfied that the man was appropriately involved in his care plan once he returned to prison. He was kept informed and reassured by staff that his medical condition would be managed in line with approved guidelines.

The man's medical appointments and treatment

30. The clinical review notes:

> "Treatment prior to, during, and after the hospital stay was all of a good standard. There was excellent liaison between prison health care and the hospital throughout the hospital stay and particularly during the discharge planning period."

31. The man's complex medical needs were well managed by the prison. He was assessed at hospital for kidney stones and the ongoing investigation of his blackouts. All hospital visits were facilitated. We agree with the clinical reviewer that his medical appointments and treatment were well managed by the prison.

The man's location

32. The man was occasionally admitted to the inpatient unit at Peterborough prison, but mainly lived on the wing. When he was in hospital after being diagnosed with a terminal condition, a nursing sister from the prison's healthcare team visited him on 2 September to assess his medical needs before his discharge and arranged for necessary equipment and an adapted double cell to be available for his return. The Head of Security and Operations

at Peterborough agreed that his cell could remain open during the night to facilitate 24 hour nursing care.

33. We agree with the clinical reviewer that appropriate adjustments were made to ensure that the man was located appropriately after he was discharged back to prison.

34. The man's wife asked whether his fall from bed shortly before he died contributed to his death. The nurse on duty on the evening of his death made him comfortable in bed shortly after 8.00pm. He was found on the floor beside his bed at 8.45pm. A nurse examined him, found no injuries and settled him back into bed. He was checked 15 minutes later and found not to be breathing. No attempts were made to revive him, in line with his wishes. He was pronounced dead at 11.30pm.

35. The man's wife asked why he did not have a bed rail to prevent falling. We understand that the pressure-relieving mattress was too large to allow bed rails to be fitted.

36. The clinical reviewer considered the fall did not materially contribute to or hasten the man's expected death.

Palliative care plans

37. When the nursing sister visited the hospital on 2 September, she determined the man's palliative care needs. After her visit, she arranged for a special pressure-relieving mattress and oxygen equipment to be available in the healthcare centre before he was discharged from the hospital. He returned to the prison on 5 September and the Clinical Manager spoke to him about his needs the next day. She then set up a multidisciplinary meeting to discuss his palliative care plan.

38. On 7 September, a palliative care specialist attended the multidisciplinary meeting that initiated the Liverpool Care Pathway.

39. She recorded in the medical notes that it was "important to acknowledge the man's acceptance of his impending death, and allow him to explore the implications of this". She also advised that he would require "reassurance of companionship at time of death, provision of palliative care intended to maintain comfort and quality of life, but not prolong or hasten death".

40. The clinical reviewer reflects "throughout his hospital stay, [prison] medical staff liaised fully with the hospital staff in order to provide the standards of medical and palliative care on his discharge". We agree with the clinical reviewer that staff at Peterborough, supported by palliative care specialist services, delivered care equivalent to that he could have expected to receive in the community.

The man's pain relief and medication

41. In November 2010, the man was diagnosed as having a kidney stone, which caused him severe pain. He was prescribed pethidine (a strong opiate-based pain relief), among other pain relief medication.

42. After his discharge from hospital in September 2011, the man suffered occasional breakthrough pain. On 8 September, a nurse recorded that midazolam was very effective in managing his pain. On 9 September, a doctor prescribed morphine sulphate (a strong painkiller) and recorded that he was pain-free as a result.

43. The clinical reviewer writes that, on the last day of his life the man:

> "was unable to manage to take his medicines as his fluid intake become very low. A decision was taken to administer the medicines under the skin via a syringe driver to ensure that full benefit was gained. Despite the absence of such a specialised piece of equipment and the security problems posed to get it into the prison the equipment was sourced and set up within a very few hours on a Saturday."

44. We agree with the clinical reviewer that the pain relief was appropriate for his needs.

Liaison with the man's family

45. The man's wife was informed by the prison of his admission to hospital on 29 July. She visited him frequently in hospital.

46. A family liaison officer had met the man's wife during hospital visits, and was formally appointed as the prison's family liaison officer on 11 August, when a hospital doctor told the prison that his condition was deteriorating. He maintained contact with her throughout his illness and arranged for taxis so that she could visit her husband. When she was unable to visit, he contacted her with an update on her husband's condition. When the man was back in prison his wife was allowed to visit him every day in the healthcare centre.

47. The family liaison officer had previously agreed with the man's wife about how she wanted the news of his death broken to her. Due to the late hour, as agreed, he telephoned her to tell her he had died. He visited her at her home the next day. We consider that good efforts were made to establish and follow her wishes about how she would be informed of his death.

48. The man's wife was offered financial assistance towards her husband's funeral costs as well as support from the chaplain. She was very positive about the help and support she received from the family liaison officer. We consider that Peterborough provided a good standard of family liaison.

Compassionate release

49. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 1600 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

50. On 16 August, the prison's clinical team leader and an officer from the Safer Custody team went to hospital to ask the consultant to consider whether the man's life expectancy was such as to make him eligible for release on compassionate grounds. On 23 August, the clinical team leader spoke to a consultant at the hospital who told her that he had a very tired heart but he would live for more than three months.

51. This discussion was noted in the man's medical record but the application for compassionate release was not started and was never revisited. We accept that it would have been difficult for him to meet the criteria in light of the consultant's opinion. Although his condition was terminal, his life expectancy was not clear.

Restraints, security and bed watch

52. 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 and which also takes into account factors such as the prisoner's health and mobility. 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. It deemed that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

53. When the man was taken to hospital on 29 July 2011 he was assessed as a medium risk to the public, but a low risk of escape or hostage taking. The medical part of the assessment indicated that medical issues needed to be taken into account, but no details were recorded. The first risk assessment,

signed by the Head of Security, concluded that he should be restrained using double cuffs and two escort officers, at least one of whom should be male.

54. Double cuffing entails the prisoner having his wrists cuffed together in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs. This is usually required for moving Category A or Category B prisoners in good health. When, exceptionally, double cuffs are used for a Category C prisoner there is a requirement that the reasons should be recorded in writing. The man was a Category C prisoner and there is no evidence to support the decision to use double cuffs and we can see no reason how it could have been justified.

55. The risk assessment was reviewed on 2 August, after the man's heart attack, and it still indicated that double cuffs should be used with an escort chain during treatment or when using the toilet. It was not until 4 August, that restraints were reduced to an escort chain after medical advice that he was not fit or mobile. A new risk assessment was completed on 11 August, and his risk remained low for escape and hostage taking, but he was still considered a medium risk to the public. Restraints were removed because of his failing health and two officers were to remain with him.

56. Although the man's medical condition was recorded, there is no evidence that it affected the assessment of his level of risk, which remained the same throughout his illness. He was an enhanced regime level Category C prisoner, with no recorded security issues. (Category C prisoners are assessed as not to be trusted in open conditions but a low risk of escape.) Although the prison reviewed the level of his restraints, insufficient weight was given to his rapidly deteriorating medical condition.

57. We do not believe the risk assessment fully took into account the individual circumstances in this case and consider that the use of restraints was not justified by the man's actual risk.

The Director should ensure that risk assessments for prisoners taken to hospital are consistent with the prisoner's security category and medical condition.

RECOMMENDATIONS

1. The Director should ensure that risk assessments for prisoners taken to hospital are consistent with the prisoner's security category and medical condition.

   Accepted.

   The prison responded as follows:

   There were some concerns by the prison about the nature of the offence of the man that did affect the thinking behind the restraint process.

   This said, given his security category, the use of single cuffs or escort chain would have been seen as more appropriate. Reviews of escorts where the situation is life threatening will be scrutinised to ensure compliance with this standard.