

**Investigation into the circumstances surrounding the
death of a man in November 2007 at
Peterborough General Hospital whilst in the custody of
HMP Peterborough**

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

October 2008

This is the report of an investigation into the circumstances surrounding the death of a prisoner at HMP Peterborough. The man died on 8 November 2007 at Peterborough General Hospital.

The loss of any family member is distressing, but especially so whilst they are in custody. I offer my sincere condolences to the man's family and friends.

The investigation was undertaken by my colleagues. We would like to extend our thanks to the Director of Peterborough and his staff for their cooperation. Particular thanks go to the Head of Male Health for gathering additional relevant documentation and for liaising with my office.

A representative from Peterborough Primary Care Trust carried out a clinical review into the care and treatment the man received whilst at Peterborough. I extend my thanks to the clinical reviewer for completing the review and I include it as an annex to this report. I am also grateful to the Detective Superintendent from Cambridgeshire Police Headquarters for sight of the police investigation interviews following the man's death.

As the report shows, the man had a history of hypertension and had previously suffered a stroke. At lunchtime on 30 October 2007, he pressed his cell bell and asked for medical attention. When a doctor saw him later that afternoon, he diagnosed that the man had had a second stroke. He was taken to hospital by ambulance where he remained for nine days until he died, aged 61. I judge that the man was managed sensitively and compassionately by the prison custody officers who supervised him, and by the management team at Peterborough.

I have relied heavily on the clinical reviewer's findings for this report. The main focus of my investigation was Peterborough's management of the man's deteriorating health and their actions after he was admitted to hospital. I have also focussed on events following his death. I make three recommendations for improvements to continuity of clinical care and record keeping.

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Prisons and Probation Ombudsman

October 2008

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SUMMARY

The man was remanded in custody on 23 April 2007, charged with a serious offence. He went straight to HMP Bedford where his extensive list of medications and high blood pressure was recorded. The doctor who first saw the man after his reception healthscreen asked healthcare staff to order his medication, to check his blood pressure weekly and to review his health every four weeks.

On 30 April, the man went to court from where he was transferred to HMP Peterborough. His healthcare screening at Peterborough noted that he had previously suffered a stroke, and the nurse who assessed him referred him to a doctor. When the man saw the doctor the following day, his blood pressure was recorded as high. The doctor prescribed naproxen (for the relief of joint pain and swelling associated with arthritis).

For the next few months, the man was located in a cell in the main prison but had two spells in the healthcare centre for respite care. Throughout this time, he complained of nausea, headaches and photophobia (light sensitivity).

The man's symptoms continued. In June 2007, he complained of migraine and a cramping sensation in his right leg. He spent 24 hours in healthcare for respite and then returned to his wing. The man rarely left his cell. By the end of that month, he presented healthcare staff with symptoms synonymous with a stomach upset and was medicated to control his nausea and sickness.

Approximately six weeks later, the man's personal officer on his wing noticed that he had been feeling unwell again. The officer also noticed that he did not participate in wing life and only came out of his cell for meals and medication. The man was not seen by staff from the healthcare unit during the month.

On 31 August 2007, the man was sentenced at Peterborough Crown Court to eight years imprisonment. Around three weeks later, on 24 September, he saw the prison doctor in his cell. The doctor made a note of his arthritis, checked his blood pressure and found that the man had missed a dose of his blood pressure medication.

The man moved cell and was placed on the enhanced regime in October. This meant that he qualified for certain privileges that the standard regime did not allow. A few days after his move, he failed to attend both a nurse clinic appointment and what was recorded as a secondary healthcare appointment. The man was assessed by a prison doctor three days after his second missed appointment and his blood was tested.

On 24 October, the man complained in writing to the Head of Healthcare about his experience of care and treatment at Peterborough. The man explained that he was partially paralysed from his previous stroke and was disabled. He criticised the disabled facilities on his wing, and said that his medication had been confiscated in reception which left him with an insufficient amount. The man also complained about his access to healthcare on 24 September. His letter said that, had it not been for the persistence of another prisoner on his wing, he would have been left waiting a long time to see the doctor.

Six days later, on 30 October, the man was produced at Thorpe Wood Police Station for further questioning in relation to a number of other offences. He was taken ill in his police cell, and following an examination by the Forensic Paramedic, was assessed as unfit for questioning. He was escorted back to Peterborough at around 11.15am, and was due to be admitted to the healthcare unit. Instead, the man went back to his wing. Within an hour, he pressed his cell bell for medical attention. Following an examination by the prison doctor, the man was admitted to hospital by ambulance. A series of tests confirmed that the man had suffered another stroke and a brain haemorrhage. He remained in hospital, under bedwatch escort, for nine days and died in hospital on 8 November 2007.

THE INVESTIGATION PROCESS

1. On 13 November 2007, my investigator opened the investigation and was briefed about the circumstances leading to the man's death. My investigator requested all prison and medical files and began the process of identifying the key issues and the staff who had interacted with the man during his time at Peterborough. My investigator received the man's electronic medical record. The man's paper medical record was not forwarded to my office and, despite efforts to locate the document, it has not been found.
2. My investigator discussed the events following the man's death by telephone with the Duty Governor. Following notices informing staff and prisoners about the investigation, one prisoner wrote to my investigator and received a reply on 12 March 2008. On 29 April, my investigator conducted two interviews with healthcare staff over the telephone. Another of my investigators visited Peterborough on 29 and 30 April and conducted three additional interviews with healthcare and prison staff.
3. A review was conducted of the clinical care the man received whilst at Peterborough. His review and recommendations are attached as an annex to this report.
4. The HM Coroner of the area was informed of the Ombudsman's investigation. The Coroner kindly forwarded a copy of the final post mortem report to my office on 16 July 2008. The post mortem concluded that the man's cause of death was as follows:
 - 1a. Bronchopneumonia
 - 1b. Intracerebral haemorrhage

I am grateful to the Coroner for sharing this information with my office. The Coroner will receive a copy of this report when it is completed to assist him with his enquiries.

5. One of my Family Liaison Officers (FLOs) contacted the man's next of kin shortly after the investigation was opened. The family liaison officer explained her role and that of my office, and provided information about the investigation process. The family liaison officer also offered the man's family the opportunity to meet her and my investigator to discuss any issues or concerns. The man's family will receive a copy of this report.
6. My investigator met with a Detective Superintendent, Head of Victim Centred Investigations, at Cambridgeshire Police Headquarters on 21 May 2008. The Detective Superintendent kindly shared police witness statements and his own findings from the police investigation with my investigator. I am very grateful for sight of these documents.

HMP PETERBOROUGH

7. HMP Peterborough is a modern local prison for both men and women, with an overall operational capacity of 948 (576 male prisoners). It is a contracted private prison and one of the newest in England and Wales. It was opened in 2005 under a long term contract. Healthcare and other services are sub-contracted to the operator, Kalyx.
8. The prison is the only 'dual gender' prison in England and Wales and serves the East of England region. The male side of the prison is completely separate to the female prison, and has two houseblocks, consisting of four self contained wings. Cells are mostly single occupancy but there are purpose built double cells on each wing. In cell television is provided for all prisoners on enhanced and standard regime levels which form part of the incentives and earned privileges scheme (IEP). Prisoners also have access to their own laundry services. Each wing provides locked boxes for prisoners wishing to complain or make requests.
9. HM Chief Inspector of Prisons, Ms Anne Owers, inspected the male prison in October 2006 (a follow up inspection was conducted in August 2008, but the report was not available at the time of writing). Her report (published in February 2007) was Peterborough's first inspection report. Against a backdrop of relatively new buildings and services, Ms Owers expressed concern that the prison was being asked to increase its population and take on additional challenges when it had not performed sufficiently well in its first 18 months.
10. Ms Owers focused on the difficulty of running both a local male and female establishment, and said that Peterborough faced overcrowding pressures, similar to other local prisons. More generally, her report revealed fundamental problems and shortfalls at contractual management and frontline service levels, which left prisoners and managers exposed.

Healthcare

11. Peterborough has a type three healthcare facility, which means health service provision is clinic based (akin to a doctor's surgery in the community). The prison also has an inpatient facility. In the spring of 2005, Kalyx (then UKDS), commissioned the nursing and overall management of all healthcare from Peterborough PCT.
12. The SystemOne clinical information system has replaced hand written medical records at Peterborough. It is only compatible with the same system in other prisons but, where two prisons use the same IT, staff at the receiving prison are able to look at a patient's medical history and provide a continuous care record.
13. In her inspection report, Ms Owers commented negatively on the delivery of healthcare services, and wrote that urgent remedial action was needed to meet expectations. Ms Owers pointed to a number of areas covering clinical

governance, primary and inpatient care, and pharmacy services which all needed improvement to bring them in line with NHS standards. In total, 31 recommendations were made. An action plan, responding to each recommendation, was drawn up in August 2007. A follow up progress report was due in August 2008

Personal Officer Scheme

14. Peterborough introduced the personal officer scheme in July 2006. The local policy covers general information about personal officer duties; of most importance is the provision of an introductory interview with prisoners, weekly contact between officers and prisoners, and the weekly recording of significant events and outcomes. In her 2006 inspection, Ms Owers looked at a sample of wing history records and surveyed the prison population. In her report, Ms Owers said that the personal officer scheme, in its infancy at the time of the inspection, was not effective. Her report made three recommendations to improve its effectiveness. The recommendations encouraged personal officers to build up a good relationship with prisoners, and to record accurate chronological histories of prisoners' time on the wings. The report also recommended that wing managers make regular quality and quantity checks of entries. With regard to prisoners with specific care needs, Ms Owers recommended the introduction of regular monitored care plans as part of prisoners' wing histories.

Independent Monitoring Board

15. The most recent Independent Monitoring Board (IMB) Annual Report at Peterborough covered the reporting period from 1 April 2006 to 31 March 2007. The report echoed the findings of HM Chief Inspector in relation to healthcare provision, most notably the failure to provide a safe and effective service. The IMB also stressed that, since Ms Owers' report, a major action plan had been put in place to remedy the deficiencies identified. One of the major areas of concern, not specifically identified in Ms Owers' report, was the use of Healthcare Assistants (HCAs) to carry out first reception healthscreens.
16. With regard to the personal officer scheme, the IMB again echoed the findings of the Chief Inspector and criticised Peterborough for the delays experienced by prisoners in being allocated personal officers. The IMB added that this could lead to further delays for new prisoners accessing services within the prison.

Elderly Prisoners

17. Prisons are not principally designed for the elderly, and it is difficult for an individual establishment to accommodate an aged population. A thematic review by HM Chief Inspector of Prisons in 2003 found that, although older prisoners (60 years and over) make up a small percentage of the overall prison population, the number of elderly prisoners had trebled between 1992 and 2002 and was continuing to grow. The study also said that there was no

overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.

18. The thematic review found that some elderly prisoners will inevitably spend the rest of their lives in prison. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria and the Chief Inspector stressed that the prison environment must be geared towards meeting the specific needs of its ageing population. Since the review, the elderly male prisoner population has seen a year on year increase. The most recent figures, taken from the Ministry of Justice, Offender Management Caseload Statistics, show that in the last four years (2002-2006), the population has increased by another 26 per cent from 1,365 to 1,725.
19. A report, *Growing Old in Prison*, published by the Prison Reform Trust in 2003 quoted a Department of Health study that focused on older prisoners. The study said that, out of 203 prisoners aged 60 and over, 85 per cent had one or more major illnesses reported in their medical records. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory.
20. With the exception of a small number of establishments, prisons do not provide a separate regime for elderly prisoners. The man's experience at Peterborough was no exception.

KEY FINDINGS

21. The man was remanded in custody at HMP Bedford on 24 April 2007, charged with a serious offence. It was his first time in prison. He was seen by a healthcare reception nurse and his medication was recorded. The man saw a prison doctor the following day. The doctor instructed healthcare staff to continue The man's medication and to arrange for weekly blood pressure checks and four weekly reviews,
22. The man appeared in court on 30 April and was remanded into the custody of Peterborough. On arrival, the healthcare assistant (HCA) conducted the man's first reception healthscreen and recorded this on Peterborough's electronic medical record, SystemOne. The healthcare assistant noted that the man came from court and had with him a prescription drugs chart. She made an appointment for him to see a prison doctor the following day. The healthcare assistant also established that the man had suffered a stroke and lost the use of his right arm. The date of his stroke was incorrectly recorded as October 2007.
23. Whilst in reception, the healthcare assistant asked the man for consent to obtain his medical records from his own doctor's surgery. The man signed the consent form and the healthcare assistant made a further entry in his electronic medical record which set out his doctor's name and contact details. The man was then located to cell 11 on wing W1 and began his induction into the prison.
24. On the morning of 1 May 2007, the prison doctor saw the man as arranged and recorded the correct date of his stroke on SystemOne as October 2006. The doctor described him as having high blood pressure, a severe disability, arthritis and a slipped disc. He recorded an extensive list of medication which the man was prescribed for his conditions. The in-possession medication included naproxen, a non-steroid anti-inflammatory drug used to treat arthritic and other inflammatory conditions, tramadol (an over the counter analgesic used for pain relief), ramipril and bendroflumethiazide for hypertension, and simvastatin and aspirin for the prevention of blood clotting.
25. Just under a week later, on 7 May, the man complained of a headache, nausea symptoms and photophobia. He saw a senior sister and was admitted to the healthcare unit for observation. His blood pressure was taken which showed no significant change. The man went back to his cell the following day after being assessed as fit for normal location.
26. During the first week of June, the man saw members of the healthcare team on four different occasions. On 1 June, he presented the prison doctor with symptoms of migraine and was prescribed imigran tablets, used to treat headache, nausea and light sensitivity. Three days later, the man complained that he had not felt well whilst working and had experienced mild abdominal pain. The prison doctor admitted him to healthcare for observation for a second time. The man's blood pressure was taken the following day and, on 6 June, a nurse observed that he had cramp-like sensations in his right leg.

The man was then scheduled to see the prison doctor during the doctor's rounds.

27. The following day, the man moved to Wing XI. For the next three weeks he settled onto the wing and kept himself to himself. His personal officer introduced himself. In the man's wing history record, the man's personal officer described him as a compliant and polite prisoner who rarely came out of his cell except to collect his meals.
28. On 29 June, the man complained of headache symptoms again. He was seen by a nurse on the wing and was given paracetamol (1g) and ibuprofen (200mg) for the pain. The man was also advised to take his naproxen, prescribed as an in-possession medication. The next day the man felt nauseous again and complained of abdominal pain and diarrhoea. A second nurse went to see him on the wing and noticed that he looked pale. The nurse advised him to drink plenty of fluids and he was prescribed prochlorperazine to treat the symptoms of his sickness. The second nurse checked the man again during the early evening and recorded in his medical record that he seemed much better.
29. The man was assessed as fit for court by healthcare staff on 12 July. The following day, he was convicted at Peterborough Crown Court and ordered to reappear on 31 August for sentencing. For the rest of the month, he remained settled on his wing. The man's personal officer made weekly personal officer entries which indicated that the man continued to present as a quiet man who just wanted to keep to himself. On 3 August, the man moved to another cell and was introduced to his new personal officer. The new personal officer's first entry in the man's medical record said that the only cause for concern was his health, "as it is easily upset". A week later, the new personal officer noticed that the man had been feeling unwell and that the man thought this might have been as a result of his blood pressure medication.
30. On 31 August, the man was sentenced to eight years in prison. In the days leading up to his court appearance, he had become unsettled and had asked for a different cell mate. The man moved wings instead, and on 1 September, was located in cell 44 on Wing WI as a sentenced prisoner. He began to mix well with other prisoners but was not given a personal officer introduction until 15 September.
31. Two days later, the man saw the prison doctor. In his medical record, the doctor made a note to remind healthcare staff that the man's blood pressure needed checking and that a blood sample should be taken. The prison doctor also said that he would re-book an appointment with a post-stroke consultant. On 21 September, the man underwent a full observations check with a nurse. His blood was also taken and sent to the local pathology department.
32. A second prison doctor carried out a review of the man's medication on 23 September. The doctor listed the medication on SystemOne and omitted naproxen. The following afternoon (24 September), the first prison doctor

visited the man in his cell and added paracetamol to the man's medication to help relief the arthritic pain in his shoulder and neck. The first prison doctor also noted that his blood pressure was above normal and that the man had mentioned that he missed one dose of the medication to treat his hypertension.

33. On 25 September, the man wrote a letter of complaint to the Director. The man explained that he had been registered disabled for 28 years due to a progressive deterioration of his spine, and that he was partially paralysed as a result of the stroke suffered prior to coming into prison. The man's main complaint focused on healthcare provision at Peterborough, the lack of disabled facilities at the prison and his medication. His letter explained that he rarely had access to all of his medication, and that a ten day supply had been stolen from his cell (this had been reported but the medication was not replaced). The man also complained that, when he woke up on the morning of 24 September, he could not get out of bed and a nurse came to see him around two hours later. According to the man, the nurse made a doctor's appointment for him for that day, and at 1.00pm one of the officer's on his wing told him that he would be going to the healthcare unit in a wheelchair. The man's letter then said that, at 3.00pm, his cell mate spoke to a custody officer and asked him to "kickstart healthcare". The man concluded by saying that the custody officer had been "enormously helpful", but that after he saw the first prison doctor (and was prescribed something for his pain) he was still waiting for pain relief at the time of writing the letter.
34. The man moved cells again on 5 October and, following an Incentives and Earned Privileges Review four days later, he was upgraded to an enhanced level regime. It is not clear from the man's wing history who his new personal officer was on W2.
35. On 15 October, the man had an appointment with one of the nurses in the Male Nurse Clinic. He did not keep the appointment and the prison doctor recorded this in his medical record. The man's wing history did not have an entry for that date. Four days later (19 October), the man missed another appointment, this time with a second nurse. Again, the man's failure to attend was recorded appropriately and the entry said, "did not attend for SECONDARY HEALTHCARE [sic] appointment..." The man's wing history made no mention as to why these appointments were missed. There is no evidence to suggest that they were followed up.
36. The prison doctor saw the man in the surgery on 22 October and requested a blood test. Two days later, a healthcare worker received the man's letter of complaint and recorded receipt of his letter in his medical record. The healthcare worker replied the same day. She apologised for the loss of medication but explained that nothing could be done about it at this stage. The healthcare worker also explained that it was standard procedure for prescription drugs to be taken away from prisoners on arrival. In answer to the man's general healthcare complaint, the healthcare worker suggested that they meet during the first week of November to discuss the issues in more detail. The healthcare worker ended her letter by telling the man that she had

referred him to the Disability Liaison Officer who would assess his needs as a disabled person.

37. The man had his blood taken in the nurse-led clinic on 25 October. Later that day, the prison doctor made an extensive entry in the man's medical record which listed the results of the tests. At the foot of the list was the following:

"Notes patient [sic] in intensive care, awaiting information regarding his situation. message [sic] left. "

Events of 30 October

38. At 8.45am, the man was escorted by police officers to Thorpe Wood Police Station for police presentation. This was by prior arrangement for further questioning in relation to other offences. The man arrived at the station at 9.00am. Around one and half hours later, a detective constable made her way to the cell area to collect the man. She looked through the observation hole in the cell door and first thought that the man was sleeping. When the detective constable went in, the man complained that he was not feeling very well. The detective constable also noticed that he was holding his head. She asked if he wanted to see a doctor and the man said yes.
39. A forensically trained paramedic came to the police station to assess the man. The paramedic arrived at 10.45am and, following an assessment, concluded that the man was not fit for questioning at that time. The paramedic then rang HMP Peterborough but could not get through to the male side of the prison. In his statement to the police, the paramedic said that he did get through to the female side, and spoke to a female member of staff. He explained that the man would be returned to the male side of the prison, and that he should see a doctor.
40. A registered general nurse, confirmed during her interview with my investigator that she received a telephone call from the police at around 11.00am, and was told that the man had been taken ill. The registered general nurse did not know the name of the person who rang. The registered general nurse said that she told the prison doctor and then spoke to the senior sister, but she could not remember whether she or the sister made a telephone call to reception staff to say that the man should be admitted to healthcare on his return. In contrast, the sister's recollection was that she did not receive a telephone call from reception or have prior contact with the registered general nurse. The registered general nurse said that she tried to book the man in but there was no space to make an appointment. Instead, she planned to make space once he arrived.
41. The man was escorted back to Peterborough at approximately 11.40am. About ten minutes after he arrived in reception, he was taken back to his cell on W2. It is not clear who escorted him back. The man's health deteriorated, and at 12.04pm he pressed his cell bell. The sister received a telephone call from wing staff and went to see him at approximately 12.20pm. Both the sister and the prison doctor went over to the wing together and found that the

man could not speak properly. They also noticed that the right hand side of his face had drooped slightly. The sister later told the police that her concern was that the man had suffered another stroke. The prison doctor decided to admit him to hospital and requested an ambulance. The senior sister returned to the healthcare unit and collected the man's medical and prescription record ready for when the paramedics arrived.

42. At 1.05pm, the senior sister went back to the man's cell and noticed that he had deteriorated. She told both the police and my investigator that she considered taking him back to the healthcare unit whilst waiting for an ambulance but, seeing that his mobility was affected, she decided to remain in the cell with him instead. The ambulance arrived at approximately 1.30pm and the paramedics then took over from prison staff.
43. A risk assessment for the man's escort to hospital was carried out by an officer which placed him in double cuff restraints for the journey. The duty manager (Victor 2) altered the level of restraints before authorising the risk assessment. The duty manager reduced the man's restraints to a single cuff attached to one officer on the left hand side of his body. The duty manager authorised the assessment at 1.45pm, and wrote the following guidance for escort officers:

"... V2 to be informed at regular intervals at hospital and placed on double cuff as soon as possible."
44. According to the man's Prisoner Escort Record (PER), he left Peterborough at 1.50pm, escorted by two PCOs, and arrived at Peterborough General Hospital at 2.10pm. On arrival, the second custody officer contacted the duty manager (Victor 2) and asked for authorisation to apply an escort chain but this was denied. Around 20 minutes later, the second custody officer asked for use of the escort chain again, and explained that the request had come from the doctor on duty in the Accident and Emergency Department. The request was then authorised by the duty manager and the third custody officer changed the restraints.
45. At 3.40pm, the doctor told the second custody officer to contact the man's next of kin as his condition was deteriorating. Five minutes later, the doctor asked for the escort chain to be removed in case the man needed emergency defibrillation. The second custody officer contacted Peterborough and the request was authorised by the director. The man's restraints were never re-applied. The man then had a CT scan, and the result led the doctor to believe that his prognosis was poor. The duty manager telephoned the man's wife and explained that he had been taken by emergency ambulance to hospital following a suspected stroke. She also said that the man might transfer to an intensive care unit at another hospital, and left her contact details.
46. For the remainder of the day, escorting staff kept Peterborough's communications staff up to date over the man's condition. At 6.15pm, the man was moved to the intensive care unit (ICU). It was first thought that he would be transferred to Addenbrooke's Hospital, but at approximately 7.00pm

one of the handover bedwatch officers confirmed that the transfer would not go ahead due to lack of bed space.

The man's stay in hospital

47. The man's family arrived at the hospital about half an hour later. When they left, the bedwatch officer contacted Peterborough again to tell communications staff that the hospital would endeavour to find a bed for the man at either Addenbrooke's or Nottingham, but that the man would remain at Peterborough General Hospital for the time being.
48. On 1 November, the man had another scan. At around 6.30pm that evening, he was placed on a life support machine and a review of his risk assessment reduced the escort from two officers to a singleton officer. The man was sedated and his condition remained unchanged.
49. For the next few days, his family came to visit him regularly in the ICU. The man remained unconscious and the PCOs on bedwatch duty kept Peterborough's staff up to date with any changes to his condition. The man's ability to respond to pain stimuli deteriorated, and the doctor in the ICU reduced his sedation to determine the extent of his breathing capabilities.
50. The man moved out of the ICU on 3 November and was placed in a private room on a ward, referred to by hospital staff as the TLC ward. The PCO on bedwatch duty that evening was told that, if the man's heart stopped, nursing staff would not try to resuscitate him. At 5.00pm, the duty manager arrived at the hospital to complete a management check of the bedwatch arrangements and spoke at length with the man's family. The duty manager reminded them of the contact details for the prison and offered her support. The man's family said that they were pleased with the contact and were simply finding things difficult at the moment.
51. The man's family continued to visit him on a regular basis and the prison was kept informed of any developments. At 3.13am on 8 November 2007, a bedwatch officer made an entry in the man's bedwatch log which said that hospital staff had contacted his family. The officer was told that the man was very poorly. His family arrived at the hospital and found that the man had deteriorated further. At 2.10pm, his breathing became faint and a nurse confirmed that this pulse had weakened. A few minutes later, the man died. He was pronounced dead at 2.36pm.

Events following the man's death

52. At around 3.45pm, a member of the care team at Peterborough went to the hospital to speak to the bedwatch officer. Whilst there, the care team member met the man's family and gave them the director's contact details. The man's family were also advised how best to contact the duty managers at Peterborough.
53. At the prison, contingency plans following a death in custody were followed without any problems. On 12 November, the director made attempts to contact the man's family personally and asked the duty manager to take over the Family Liaison Officer responsibilities. Later that same day, the duty

manager spoke to the man's wife and offered her support and assistance. The duty manager contacted the Coroner's Office on the man's wife's behalf and was told that funeral arrangements could begin. The duty manager then contacted the man's wife and discussed how best the prison could support his family over the next few days. They met at Peterborough the following day and discussed a number of arrangements.

54. The man's funeral took place on 27 November 2007 with his family present.

ISSUES

55. The clinical review conducted has looked at the care and treatment the man received whilst at Peterborough. Of particular concern to the clinical reviewer was the administration of the man's medication, the management of his hypertension and the electronic record keeping. I deal with the issues raised by the clinical reviewer and include a summary of his comments below.
56. My main focus has been on how Peterborough managed the man's failing health from an operational point of view, both at the prison and once he was admitted to hospital. The man came into prison several months after having suffered a mild stroke. He had a long term history of high blood pressure and had also developed symptoms of arthritis. In the seven months that he was in custody, the man appeared to settle, but he was never a well man. Once the prison doctor suspected a second and more serious stroke, the man's admission to hospital was both timely and appropriate. His subsequent stay at Peterborough General Hospital was also managed in a compassionate and sensitive way.
57. None of the findings from this report would have changed the outcome for the man. That said, I have observed a number of areas where improvement to procedures could be made in order for staff at Peterborough to better meet the needs of its population. However, I am mindful that some of these areas cross over with those uncovered in the most recent report from HM Chief Inspector of Prisons, and were responded to in an action plan to Ms Owers' office in August 2007. (The Office for Contracted Prisons was due to issue a further report on the progress made in August 2008.) For that reason, I will not repeat recommendations that have already been made, have been accepted by Peterborough, and in some areas, have been acted upon. Nevertheless, it is important to monitor the impact of the changes being made and to ensure that they continue. I have made an all encompassing recommendation to this effect below.

Reception healthcare screening and needs assessments

58. The man was sent to two different prisons within the same week. That meant that he should have had two full healthcare screenings, one at Bedford and, following his court appearance, another at Peterborough. The healthcare officer completed his first screening on 30 April but the record on SystemOne showed that it was not a full screening. The following day, the man was seen by the prison doctor and a more detailed examination of his medication and well being took place. When asked about the healthscreen process, the healthcare assistant confirmed to my investigator that current practice was to carry out a full healthcare screening where a prisoner had been transferred to Peterborough directly from court. Where a prisoner was returning to Peterborough or had been transferred in from another establishment, the healthcare assistant said that HCAs only needed to establish a prisoner's immediate health concerns and medication.

59. My investigator raised the issue of first reception healthscreens with one of the healthcare managers. The manager, who was newly appointed, confirmed that she had since sent a memo to healthcare staff, reminding them of their “legal duty to carry out full healthcare screenings” within two hours of a prisoner’s arrival (with the possible exception of prisoners already serving their sentence at Peterborough). The memo refers to the continued use of HCAs to carry out healthscreens, but says that it is not acceptable to rely on healthcare screenings from other establishments. The healthcare assistant may have assumed that, as the man had arrived from Bedford via court, she only needed to carry out an immediate healthcare needs assessment. The manager provided my investigator with a copy of the memo, dated 10 April 2008. I am grateful to her for circulating her reminder to staff, and for this reason I make no formal recommendation.
60. More positively, and in accordance with Prison Service Order 3050 ‘Continuity of healthcare for prisoners’, The healthcare assistant did ensure that sufficient background medical information could be obtained from the man’s own doctor by gaining the man’s consent. The healthcare assistant also referred the man for a doctor’s appointment within 24 hours of his arrival at Peterborough.
61. Prisoners are usually followed up a few days after their arrival with a secondary healthscreen. In some of my recent investigations, I have discovered that prisoners of the man’s age and over also undergo an elderly healthcare screening, which draws down on the specific healthcare needs of older prisoners. In the absence of the man’s paper medical record, it is not entirely clear whether he had a secondary healthcare screening (akin to a general medical assessment when an individual registers with his or her own doctor). However, it is clear that the prison doctor effectively carried out a brief follow up screening during his consultation with the man on 1 May.
62. All Department of Health and National Health Service policies are applicable to the prison setting. Unfortunately, Peterborough does not routinely assess the specific healthcare needs of its elderly prison population. The senior sister told my investigator that she did not know of a protocol designed to record the specific needs of older prisoners, but that most prisoners over 60 years old did see the doctor. Statistically, the man formed part of the older prisoner population and might have benefited from undergoing a local elderly healthcare assessment which mirrors the NHS National Framework for Elder Care in the community.
63. The man defined himself as disabled when he arrived at Peterborough and he could not use his right arm. Both the healthcare assistant and the prison doctor recorded his disability on SystemOne but the man was not referred to a Disability Liaison Officer until 24 October. This was around six months after he arrived at the prison. The man’s referral was prompted by his letter of complaint to the director, rather than by any pre-existing local protocols for assessing the needs of prisoners with specific needs. The senior sister told my investigator that a disability questionnaire was available in reception for prisoners to complete. Referrals to the Disability Liaison Officer would then follow depending on the answers that individual prisoners gave. When asked

about its implementation, the senior sister said that she could not remember whether the questionnaire was introduced before or after the man arrived at Peterborough.

64. Having effective assessment procedures in place for prisoners with specific physical and mental disabilities has obvious benefits for an individual's well being and continuity of care. The lack of appropriate healthcare assessments for prisoners with specific needs formed part of HM Chief Inspector's larger concern over healthcare services at Peterborough at the time of her inspection. Ms Owers made three recommendations to address these concerns. It is clear from speaking to the senior sister that disability assessment and referral is now in place for the reception process. Two other recommendations, namely to draw up care plans for older prisoners and/or those with disabilities, and for those plans to be included in prisoners' wing histories, were accepted in the action plan with a target date for implementation set for December 2007. Although too late for the man, I am reassured that the recommendations were included in the new Disability Local Operating Procedures at Peterborough. I make no recommendations of my own but echo those made by Ms Owers. I also look forward to learning of the progress made in Peterborough's imminent follow up report to the Chief Inspector.

The man's in-possession medication

65. The man was receiving medication for hypertension before he was remanded in custody. He also received prescriptions following his first stroke in October 2006 to prevent further thrombo-embolic conditions. In his clinical review, the clinical reviewer describes these as strokes or heart attacks caused by blood clotting. The man's medication was continued in prison and also included painkillers and anti-inflammatory drugs. He was permitted to have his medication in his possession, which meant that he could keep it in his cell, and was trusted to take it without being monitored. Unfortunately, I did not have sight of any risk assessment to evidence why the man qualified for in-possession medication. The clinical reviewer also raises this issue and makes a recommendation which is included in the attached clinical review. It may be that the risk assessment was filed in the man's paper medical record. With this in mind, I refrain from endorsing the recommendation but urge the Head of Healthcare to take specific note of the clinical reviewer's concern.
66. The clinical reviewer has reviewed the medication that the man received and questions the effects of prescribing a combination of non-steroidal anti-inflammatory drugs (NSAIDs) together with blood pressure tablets. In his clinical review, the clinical reviewer explains that NSAIDs work against drugs like ramipril, used to treat patients with hypertension, and can cause gastric problems. The man complained of abdominal pain and sickness on 30 June, the day after he was seen by a nurse on the wing and was prescribed paracetamol and the one dose of the NSAID, ibuprofen. The clinical reviewer suggests that the addition of ibuprofen to the man's other anti-inflammatory drugs might have caused his abdominal pain, and would not normally be recommended.

67. With regard to the man's prescription charts, the clinical reviewer is critical of their presentation. The man was medicated weekly, fortnightly and monthly. However, from the drugs charts he reviewed, the clinical reviewer says that drug issue dates were incomplete between April and October 2007. When the man refused medication on 30 September, no explanation was given as to why. Furthermore, the clinical reviewer feels that the man's self medication status gives rise to concern over the potential to 'stockpile' medication. The clinical reviewer says:

"I have concerns that a depressed man, anticipating humiliation of conviction followed by a long custodial sentence may stockpile medication, or decline to take the medication as prescribed with the direct or indirect intent to harm himself."

The clinical reviewer has formed his opinion in the absence of the man's paper medical record. He comments that patients such as the man:

"... may fare better if one or two clinicians take an overview of their situation, and consider previous medical histories, ongoing blood pressure, prescribed medication as a whole, and make adjustments at an earlier time, while implementing regular reviews of the above."

I am mindful that sight of the paper record may fill in some of the gaps that The clinical reviewer and I have identified elsewhere in this report.

The healthcare manager should consider how best to ensure that continuity of care is provided for all prisoners.

Personal Officer

68. As a remand prisoner, the man was allocated personal officers in a timely way, and weekly entries were made in his wing history albeit they were not always informative. However, after being sentenced, the man's experience of the personal officer scheme seems to have been more irregular. Of most concern is the failure to allocate the man a personal officer until 15 September, approximately 16 days after he was sentenced. The days following sentence are a vulnerable time for prisoners, especially long sentenced prisoners like the man. The personal officer scheme is designed to build good relations between staff and prisoners and to enable officers to record an accurate history of a prisoner's time on an individual wing. I mention earlier in this report the recommendations made by HM Chief Inspector of Prisons to improve the efficiency and effectiveness of the personal officer scheme. These too were accepted in the action plan that followed the inspection, and further training for officers began in December 2007.

The man's missed healthcare appointments

69. On 15 and 19 October 2007, the man's medical record showed that he missed two appointments, one at the male clinic and one for a secondary healthcare screening. Whilst these were recorded appropriately, they were not accompanied by an explanation as to why the man did not attend. My investigators raised the issue with both the prison doctor and the senior sister. During a discussion with the senior sister, the investigator was told that the record was misleading, and that the man had in fact only missed one appointment on 15 October. The senior sister explained that the appointment on 19 October was a re-booking of the original appointment that he missed. My investigator asked the senior sister what she would normally do when a prisoner failed to attend. The senior sister said that there were a number of possible reasons: one of which was the shortage of staff to escort prisoners to healthcare, healthcare staff not being permitted to escort prisoners alone. The senior sister added that, due to the busy nature of the healthcare unit, she did not always have the opportunity to follow up missed appointments. However, if one was missed without an explanation, another appointment was re-booked.
70. Access to the man's paper medical record might have provided the reasons why he did not keep both his original appointment and the re-scheduled appointment four days later. However, I agree with the Chief Inspector that prisoners who do not attend appointments should be routinely followed up. Peterborough accepted a recommendation made to this effect, and said that by December 2007 lead clinicians would be responsible for both following up and recording the reasons why prisoners did not attend. I make no recommendation of my own but I do urge the Head of Healthcare to ensure that this routine continues.

Blood Pressure Monitoring

71. When the man first entered custody at Bedford, he was placed on weekly blood pressure (BP) checks. Had he stayed at Bedford, the man expected to be reviewed four weeks later. At Peterborough, the man's BP was first taken by the prison doctor the day after he arrived (1 May) but there is no record of a similar BP monitoring plan thereafter (or, if considered unnecessary, a record of why the man would be monitored differently). I must stress that there was no specific request made by the doctor at Bedford for the same plan to be continued at Peterborough. The prison doctor did confirm, when interviewed, that if a doctor at another establishment was monitoring a prisoner's blood pressure weekly, then he would be likely to do the same. When asked about the recording of weekly BP readings, the prison doctor agreed that each reading should be recorded in a prisoner's medical record, but that he did remember checking the man's BP and not recording it. Asked how significant non-recording was, the prison doctor said that in retrospect it was significant. He stressed that he and his staff were very busy, and on a few occasions BP measurements are not recorded. The prison doctor stressed that he would not necessarily record acceptable readings but would always record those which were higher or lower than normal.

72. Between 12 July and 17 September, there were no entries in the man's electronic medical record. It is not entirely clear whether he was supposed to have or did have his BP checked regularly during this time, but it is certain that his BP was not recorded until 24 September. Although the prison doctor could not explain the reason for the gap, when he was asked about his request for the man's BP to be taken on 17 September the prison doctor said that it was likely that he told the man to have it checked by a nurse on the wing during the medication round. The prison doctor explained that, as patients could not attend the healthcare unit to have their BP checked without an appointment slip, this made it more difficult to facilitate. The prison doctor added that it was much easier for patients to be monitored on the wing.
73. In his clinical review, the clinical reviewer raises the issue of BP monitoring and the importance of keeping blood pressure under control to reduce the risk of stroke in a patient. The clinical reviewer also notes that the man's BP care plan was not carried over between the two prisons. That said, his review stresses that the man was being medicated for hypertension. Commenting on the gap in recording his BP, The clinical reviewer says:
- “There is a fifteen week period (110 days) in which the man's blood pressure is not recorded ...This includes the time when he consulted with a headache on 29/06/07, and nausea and vomiting the following day.”
74. In the absence of the man's paper record, the clinical reviewer has not been able to comment further on the frequency of the man's blood pressure monitoring. That said, duplication of medical checks in both paper and electronic medical records should have occurred to provide a true reflection of the care the man received. This is especially significant now that SystemOne has been introduced and is compatible and can be shared easily with other establishments and medical professionals. I make no recommendation but I urge the Head of Healthcare to remind staff to record medical interventions as soon as possible in the appropriate records.

The man's transfer from Thorpe Wood Police Station to Peterborough

75. It is clear from both the documentation and from interviews with staff that the intention was for the man to go straight to the healthcare unit on his return from the police station on 30 October 2007. The paramedic who assessed The man in the police station confirmed in his statement to the police that he made contact with an administrator in the female side of the prison (as he could not get in touch with anyone on the male site). The registered general nurse said that she remembered speaking to the police over the telephone, and then spoke to the senior sister and the prison doctor before continuing her rounds on the wing.
76. The prison doctor said that he had no recollection of being told about the arrangement before the man returned to the prison. However, in his police statement, the doctor did recall that when he walked over to the man's wing

with the senior sister she gave him a brief history of what had happened to the man. The prison doctor said:

“She told me that [sic] had been told he was out of the prison at the police station and had been taken ill. She was under the impression that he was being brought back directly to the Healthcare unit and was concerned that he had actually been taken back to the wing instead.”

77. The senior sister said during her interview that she was unaware of the arrangement to admit the man to healthcare, and found it surprising as she was the senior nurse in charge that day. It appears that neither member of the healthcare team knew that the man had even returned to Peterborough until his health deteriorated and he pressed his cell bell later that afternoon.
78. A senior custody officer was on duty in reception that morning. When interviewed by the police, the senior custody officer said that, when the man arrived back in reception at around 11.45am he told him that he did not feel well. He asked the man if he wanted to see a nurse, to which the man said no. The senior custody officer added that he was not made personally aware of the wishes of healthcare, but that four or five other officers could have taken a telephone call that morning. As I have already mentioned, it is not clear whether a telephone call was made, and if so, who made it.
79. I have been unable to establish exactly what happened in preparation for the man's return to Peterborough or when he was in reception. I must also stress that, according to the witness statement of the doctor (the medical opinion sought by the detective superintendent as part of his own enquiries), the man's transfer to his wing did not impact any more negatively on his physical health. Having considered the recollections of the staff on duty that morning, I can only assume that what did happen was demonstrative of a breakdown in communication between the healthcare unit and the reception area. I do not know whether the man's case illustrates a broader communication problem between the operational and healthcare sides of the prison, and I make no formal recommendation. That said, I do urge the Head of Healthcare to consider raising this issue at the appropriate management meeting, and to invite discussion on strengthening communication channels in future.

Record Keeping

80. The standard of record keeping from wing staff at Peterborough was generally acceptable, although some of the documents were not as legible as they could be. In addition to the comments I have made above concerning personal officer entries, it was difficult to decipher the names of the members of staff who documented the man's wing history at times. This is an issue that I frequently raise in my reports. I make the following recommendation:

The Director should remind operational staff of the importance of maintaining legible records which meet the required Prison Service standard for auditing purposes.

81. The healthcare records made available to my investigator were in electronic format. Whilst this made them easier to analyse, it did leave my investigator and the clinical reviewer confused about some of the entries. As I have already mentioned, I am concerned that if medical interventions, like blood pressure readings, were taking place elsewhere in the prison, entries duplicating this information should have been made on the electronic record. The clinical reviewer comments as follows:

“Clear record keeping is of great value in planning and implementing safe and effective clinical care in all medical fields and institutions. Care needs to be taken to keep the hand written prescription charts up to date and aligned with the computer records.”

The healthcare manager should remind healthcare staff of the importance maintaining accurate prescription charts.

82. Both the clinical reviewer and my investigator were concerned about a specific entry in the man's electronic medical record made on 25 October. On the surface, it appeared that the prison doctor made a retrospective entry which said that the man had been admitted to ICU. The content of the entry under the field 'Notes' relates to what happened to the man five days later. (I have quoted the SystemOne entry from that day earlier in this report, and will not repeat it here.) My investigator explored the issue with the prison doctor during his interview. The prison doctor explained that the entry might have been computer generated from the hospital to the prison's computer system. This would explain the appearance of test results but not the 'Notes' field entry which said that the man was in intensive care. I have not been able to establish exactly how the entry could have appeared five days prior to the man's admission to hospital. My investigator also spoke to the manager who confirmed that SystemOne does not allow a user to return to a date and enter data retrospectively. However, neither the manager nor the prison doctor could offer a further explanation as to how the 'Notes' entry could have been made. The entry remains a mystery, and I must assume that there was indeed an IT problem with the system at the time. The Head of Healthcare should raise the example in the man's medical record with an appropriate IT systems support team at the earliest opportunity.

Use of Restraints

83. I have commented in many of my reports on the use of restraints, and the difficult balance that prisons have to strike between the potential risk to the public and the compassionate management of an individual who is very ill. The initial risk assessment for the man's escort to hospital was undertaken by a Senior Prison Custody Officer who circled the double cuff option on page 2 of the form. The duty manager on 30 October reduced the man's level of restraint to a single cuff (whereby the man was then attached to one officer), before authorising his risk assessment and escort.
84. However, it is not entirely clear why the first request by the second custody officer to replace the man's single cuff with an escort chain was refused. That

said, as soon as the doctor specifically asked for an escort chain, the duty manager gave her authorisation. Additionally, minutes later when the doctor asked for all restraints to be removed, the director granted permission quickly and appropriately. Furthermore, when the man was transferred to a ward and placed on constant supervision, bedwatch officers kept good quality logs and remained sensitive to the man's privacy when attended to by nursing staff. The man's level of security was then reduced to one officer for the last few days of his life. I am pleased to report that Peterborough's risk assessment process and escort and bedwatch operating procedures were applied well, and were further tailored to the man's circumstances as he deteriorated.

Conclusion

85. My investigation has indicated some ways in which HMP Peterborough can learn from the circumstances of the man's death. However, in general, I judge that he was treated appropriately in custody and that his time in hospital was managed well. The man's family were contacted (at the hospital's instruction) on the same day that he was admitted, and arrangements for them to visit him were facilitated effectively.
86. I do not believe that the man's death was related to the fact that he was in custody

RECOMMENDATIONS

To Kaylx Healthcare Services

1. The healthcare manager should consider how best to ensure that continuity of care is provided for all prisoners.

Accepted - a review to be conducted regarding continuity of care. This will be addressed as part of the Health Needs Assessment and form part of the Health Delivery Plan. Target date for completion - January 2009

2. The healthcare manager should remind healthcare staff of the importance maintaining accurate prescription charts.

Accepted - a Notice to Staff is to be issued regarding this. A review of pharmacy and System One use is underway to ensure records are maintained and easily accessible to all. Target date for completion - December 2008

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To the Director, HMP Peterborough

3. The Director should remind operational staff of the importance of maintaining legible records which meet the required Prison Service standard for auditing purposes.

Accepted - a notice to all staff will be issued as a reminder about the importance of maintaining legible records for the purpose of Prison Service standards. Monthly management quality checks of wing files will highlight any shortfalls. The issue will be raised on staff briefings. Target date for completion – end of October 2008