

**INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING
THE DEATH OF A MAN IN HOSPITAL IN DECEMBER 2005
WHILST IN THE CUSTODY OF HMP PETERBOROUGH**

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

April 2006

This is the report of an investigation into the death of a man in hospital in December 2005. The man was on the second day of his remand at HM Prison Peterborough. The preliminary cause of death was given as a significant bleed into the abdominal cavity (retroperitoneal haemorrhage due to ruptured right common iliac artery aneurism.)

One of my Investigators conducted this investigation. Greater Peterborough Primary Care Partnership was commissioned to conduct a clinical review into the man's care and treatment whilst at Peterborough.

I would like to extend my condolences to the man's family for their loss. I would like to thank the Director in charge of HMP Peterborough and his staff for their help and co-operation during this investigation.

I make recommendations in this report relating to the care and support of prisoners in healthcare, in particular, to the basic standard of cleanliness that protect an individual's dignity. I also draw attention to the prison's response to deaths in custody.

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CONTENTS

Summary

The investigation process

HMP Peterborough

Events prior to the man's death

Events after the man's death

Clinical review and post mortem

Findings and conclusions

Recommendations

Summary

In December 2005, the man died in hospital. After being charged with shoplifting in December 2005, he was remanded in custody at HMP Peterborough. The man was a long term drug user, who was estranged from his family and who had chosen to live an itinerant lifestyle. Although he entered prison with some health issues he was not considered to be duly unwell but was suspected of carrying MRSA. He had also tested positive for drugs and was placed on the detoxification regime. He was located in a shared cell in the male healthcare unit with another prisoner.

On the second night of his remand at Peterborough at about 3.30am, the man became incontinent and confused to the extent that his cellmate demanded to be moved to another cell. Whilst his cellmate was moved in the early hours of the morning, the man remained in the cell. He was not considered to be in any particular distress despite the foul condition of his cell. Due to the reduced numbers of staff on duty at this time of day a decision was made not to assess him or clean his cell until later on in the morning when there was more staff on duty. Staff reported to have seen him sitting up on his bed at 5am and at 7.10am.

At about 7.15am, day healthcare staff went to the man's cell in order to clean him up and to assess his needs. He was discovered to be lying on his quilt on the floor, semi-conscious and breathing erratically. The nurse attending his cell was concerned about his condition and requested that a 999 ambulance be called. The ambulance arrived within five minutes and attended to the man who was semi-conscious. He was taken to hospital at around 8.12am, under escort. However, his condition continued to deteriorate and despite the efforts of medical staff he was pronounced dead soon after. The preliminary cause of death was given as a significant bleed into the abdominal cavity (retroperitoneal haemorrhage due to ruptured right common iliac artery aneurism.)

The man's death is the first death at Peterborough, since it opened in Spring of 2005. The clinical review into the man's care and treatment has established that his behaviour and presentation would not have naturally led healthcare staff to believe that something was wrong. However, the review does state that given the change in his condition from the previous night it would have been prudent to have observed him more closely and regularly, and to have recorded the findings. I have also drawn attention to the need to address prisoner's basic hygiene needs. In general, the clinical review has highlighted a number of issues that the Director in conjunction with his Healthcare Manager will want to consider which will assist in establishing an equitable level of healthcare to that which can be found in the wider community.

The investigation process

1. One of my investigators visited HMP Peterborough on 13 December 2005, to open the investigation into the death of the man who is the subject of this report. Notices were issued to staff and prisoners informing them about the investigation and giving them the opportunity to speak with my investigator. One response which was not specific to the death of the man was received.
2. The Director and his staff produced the man's core record, his Medical Record and a number of other documents for examination. Various members of staff at Peterborough were interviewed.
3. My investigator also interviewed an agency nurse who no longer works at Peterborough at her home address in order to obtain her version of the events leading up to the man's death. One member of discipline staff who my investigator would liked to have spoken to has not been able to be contacted and at the time of compiling this draft the prison was not aware of his whereabouts.
4. The Head of Nursing from the Greater Peterborough Primary Care Partnership was contacted so that she could conduct a clinical review into the care and treatment that the man received in prison.
5. One of my family liaison officers contacted the man's next of kin, his brother, by telephone offering the family an opportunity to meet with him and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that the family would like explored and addressed. On 29 December, the family liaison officer and my investigator visited the man's brother and his step-father in Lancashire and noted their concerns.
6. My investigator contacted Her Majesty's Coroner to inform him of the nature and the scope of my investigation and to request a copy of the post mortem report. Upon completion, the final report will be sent to the Coroner to assist him. At the time of completion of the draft report a full post mortem report was not available.

HMP Peterborough

7. Peterborough is a private prison run by United Kingdom Detention Services (UKDS). It opened in Spring 2005 and is the first purpose built Category B prison to house both men and women.
8. Healthcare is provided by the Peterborough Primary Care Partnership and there are separate healthcare facilities for male and female prisoners. For the male side there is capacity for 13 inpatients.
9. As the establishment has only been operating for less than one year it has not been subject to any visits by Her Majesty's Inspector of Prisons (HMIP).
10. This is the first death in custody at Peterborough.

Events prior to the man's death

The man appeared before Magistrates Court in December 2005, charged with shoplifting. He was remanded in custody to Peterborough and was due to reappear in court two days later.

11. On reception at Peterborough from the magistrates court, the Prisoner Escort Form (PER) indicated that the man had a leg injury. The form also indicated that he could be violent. He was seen by a healthcare assistant and was asked a series of questions as part of an initial health screen the purpose of which is to ascertain a prisoner's health care needs. The man stated that he was of no fixed abode and that he was not registered with a doctor and was not in receipt of any prescribed medication. The man also indicated that he had no particular concerns about his physical or mental health although it was noted that he had 'Trenchfoot' an infection of the right foot caused by cold, wet and unsanitary conditions. The initial health screen, also records that whilst in police custody he had tested positive for heroin and benzodiazepines. The man also stated that he had been diagnosed with the MRSA virus. Although he had told his brother that he had been diagnosed with hepatitis, he did not disclose this during his reception at Peterborough.
12. The day senior nurse has stated that on arrival at Peterborough, the man was coherent and did not appear unduly unwell. The clinical review established that following a risk assessment, the man was assessed as being capable of being in possession of his own medication in his cell and was administering his own antibiotics. He was also able to walk about with the aid of crutches.
13. Because the man had tested positive for drugs he was placed on the First Night Protocol. The Protocol ensures that all new prisoners with a history of substance misuse and who test positive for drugs are seen by the prison doctor within 24 hours and receive the appropriate medication for withdrawal from drugs. In light of this and due to his foot infection he was located in a shared cell in the male healthcare unit with another prisoner who was also a remand prisoner and an MRSA sufferer. The man's cellmate stated to my investigator that the man's foot was in a very bad way in that it looked very scabby and had been bleeding. The man found it difficult to walk although he had the use of crutches. He told his cellmate that he was a heroin user and the cellmate stated that when he first met him he was 'clucking'. This term is used to describe someone who is withdrawing from drugs and in an agitated state. Otherwise, there were no concerns in respect of the man on the first night that he was in prison custody.
14. On 11 December, the man was seen by the prison doctor and was prescribed antibiotics and cream for his foot as well as Methadone and Diazepam. He was also given Immodium for diarrhoea. During the course of the day nothing untoward was recorded and the duty manager for the weekend stated that there were no issues that were brought to her

attention that weekend, although she was aware that there were two prisoners with MRSA sharing a cell. However, according to the man's cellmate, after the man had seen the prison doctor around 11am, to receive his Methadone, he seemed to act in a bizarre manner constantly talking to himself and trying to walk around the cell. The cellmate said that he tried to reassure him and calm him down. My investigator established that all prisoners in the healthcare wing are checked at least once an hour by staff, irrespective of whether they are subject to the self-harm prevention regime. This usually entails a cursory look by a member of staff through the flap of the cell door.

15. At about 7pm, the senior nurse reported for duty and received what she described as a brief and inadequate handover from the day staff and that she had to refer to the notice board for information. She was told that the man and his cellmate were sharing a cell and that both had MRSA, although she was unaware of his foot infection. At interview the senior nurse and the healthcare assistant told my investigator that there was some misperceptions of MRSA among staff and that it was natural for some staff to be wary of dealing with prisoners who have it, although there is some documented guidance that is available.
16. The senior nurse recalled that the unit was very noisy that night, with some prisoners banging on their cell doors and shouting which caused some disruption to the rest of the unit. She recalled that she and the night duty healthcare assistant were busy and rushed off their feet. However, neither the man nor his cellmate came to her attention, save to complain about the noise on the wing. No medical issues were raised at this point.
17. At 1.10am on 12 December, the observation log for the male healthcare unit records that the man's cellmate told night duty staff that the man was harassing him and acting in a very strange way and that he could not sleep. At 2.50am, the cellmate told staff that the man had soiled himself and had thrown his soiled jogging bottoms into the middle of the cell floor. He was lying on the floor trying to set fire to himself. The man was told by the night duty prison custody officer (PCO) to get back on his bed and not to disturb the others. Unfortunately, my investigator was unable to speak to the PCO who has been registered sick for some time. The PCO has not kept in contact with the prison and despite their efforts to locate him, his whereabouts are presently unknown. It was also unfortunate that following the man's death, the PCO did not provide a statement. This would have assisted in establishing his level of involvement with the man.
18. The man's cellmate told my investigator that in the early hours of the morning, the man was talking 'gibberish' and kept trying to get up from his bed as if he wanted to go somewhere. He recounted that the man kept saying "I am off to Lion Walk" and that he would try to get up and walk around the cell without the use of his crutch and then collapse on the cell floor. He was also very incontinent and was unable to make the toilet on several occasions, messing the floor.

19. At about 3.30am, the senior nurse, was aware that the man's cellmate had alerted staff by shouting and had threatened to kill the man if he was not moved to another cell. The cellmate told my investigator that the cell was in a deplorable state, with faecal matter all over the floor and that he could not stand it any longer. The man seemed oblivious to his condition and his surroundings.
20. At about 3.45am, the PCO responded to the cellmate's calls from the cell door and contacted the senior officer on night duty by radio requesting assistance for the removal of the cellmate from the cell. To unlock a prisoner's cell at that time of the night would have required the senior officer to be present with additional assistance from discipline staff. This is in compliance with the prison's security operating procedures. The duty SO stated that the PCO said that the man's cellmate had threatened to kill the man unless he was moved. The SO thought at the time that the two prisoners had just fallen out.
21. At approximately 4.30am, The man's cell was unlocked and his cellmate was moved to an unoccupied four bedded dormitory in the Healthcare unit. In view of the fact that both prisoners had MRSA and the risk of cross infection, staff entering the cell wore disposable gloves and gowns. The cellmate told my investigator that when he left the cell, the man was lying on the floor near to the toilet, wearing a pair of trainers and a tee shirt. However, the duty SO who supervised the unlocking of the cell stated that the man was sitting on the toilet and that when asked if he was okay, he replied that he was alright. The SO told my investigator that he had attributed the smell of the cell to the man's use of the toilet.
22. The senior nurse recorded in a statement following the man's death that whilst she recommended that the man be showered an officer reminded her that such a task could compromise the safety of others if there was another incident that required medical assistance elsewhere in the prison. There are conflicting accounts as to how a decision was reached but the senior nurse acknowledged that the man had gone back to bed, appeared settled and was not showing any obvious signs of distress. She told my investigator that in light of the man's presentation, a collective decision was taken to leave him until later when day staff reported for duty so that the task of cleaning him and his cell and assessing his needs could be completed safely. The senior nurse told my investigator she felt that this was a reasonable decision to take. My investigator found that whilst the cellmate could be moved, there was no other cell in which to place the man as the unit was full to capacity. The duty manager has confirmed to my investigator that in her opinion that at 4.30am there were enough staff on duty to assess and deal with the man's needs, although the task of assessing him and cleaning him up needed to be taken in context of perceived events that could happen elsewhere in the prison that needed to be dealt with as priority.
23. The night duty SO also confirmed that at the time of the cell being opened, the man told staff that he felt alright. In his opinion, the man was fully

conscious, aware of his surroundings and settled and his presentation gave him no cause for concern. At about 4.45am, when the SO left the unit to attend to his normal duties, he recalled looking through the window of the cell and receiving an acknowledgement in the form of a wave from the man. It was also reported to the SO that at about 5.30am, he had asked the PCO for a cigarette which he felt showed that he was not in any obvious sign of distress.

24. At 5am, the senior nurse was told by the PCO that the man was sat up in his bed. However, in light of his physical condition during the night she deemed him unfit to attend court that day and noted this in the medical record.
25. At about 6.45am, the senior nurse handed over to her day duty colleagues, the day senior nurse and the healthcare assistant. She gave them a printed handover sheet and a brief report on the key events of the night. The senior nurse indicated to her colleagues that the man would need to be cleaned and clinically assessed as he had been incontinent, confused and disorientated during the night. The senior nurse then left the unit at about 7.10am, having completed her handover. As she was being escorted off of the unit, she noted that the man was sitting upright on his bed. At around the same time, the day PCO came on duty, taking over from the night PCO. The day PCO told my investigator that at about 6.50am, he glanced through the flap of the cell door and saw the man wrapped in a blanket. The man looked up at him and nodded in acknowledgement. The PCO described the cell as messy and smelly but the man gave him no cause for concern.
26. At around 6.45am, the duty manager reported for duty and spoke briefly to the duty SO, who had finished his night duty. He told her that the man's cellmate had to be moved in the early hours of the morning because the man had become incontinent and confused but the man had remained in the cell which was in a foul state. The man and the cell required cleaning.
27. At 7am, the duty manager visited the male healthcare unit in order to assess the situation for herself. She was aware that there were two prisoners on remand who had MRSA who were due to attend court that day and enquired with nursing staff whether it was acceptable that they should appear in court with the condition. The day senior nurse confirmed that it was acceptable in the cellmate's case, although the man had not been deemed fit to attend. The duty manager requested that the man should be cleaned up and then arrangements made to clean up his cell.
28. At about 7.15am, the day senior nurse, the healthcare assistant and the day PCO attended the man's cell to unlock him, clean him up and assess his needs. When the nurses entered the cell they noticed that the man was laying half on and half off his duvet on the floor, not wearing any trousers. The duvet and the cell floor were covered in faecal matter and the senior nurse told my investigator that she was surprised at the state of the cell. The man did not respond to her questions. She then checked his

vital responses. She said he was pale, clammy, short of breath and he was semi conscious. The healthcare assistant began to clean up the man in order to give him some dignity and comfort. In the meantime, the day senior nurse became very concerned at the man's presentation and shouted to the PCO who was standing at the doorway to call for an ambulance. The PCO immediately informed the duty manager who was in a nearby office to telephone the control room for an emergency ambulance. She did this immediately. Having ensured that an ambulance was on its way, the duty manager returned to the cell to see if she could be of any assistance.

29. The senior nurse left the man's cell to get some oxygen, whilst the healthcare assistant continued to clean the man the paramedic team arrived. The man remained semi-conscious and was breathing erratically.
30. At about 7.20am, paramedics arrived in the man's cell. Due to their extremely rapid response the senior nurse did not even have time to administer oxygen before the paramedics arrived. The PCO was called away to attend to other functions in the healthcare unit. The man was taken by stretcher to the back of the ambulance where the paramedics assessed his condition. A venflon tube was used to assist him with his breathing. The paramedic staff decided that the man needed to be taken to hospital.
31. At 8.12am, the ambulance left Peterborough with two escorting officers to go to hospital. In light of the man's grave and deteriorating condition he was not handcuffed. During the journey escort staff called the prison, to say that the man's condition was giving paramedics extreme cause for concern. Following this, the duty manager informed the Director of Peterborough of the situation. At about 9.30am, the prison was told that the man had died in hospital.

Events after the man's death

32. Following news of the man's death, Peterborough implemented its contingency plan for a death in custody. The plan included arrangements to inform the Police, the Prison's National Operations Unit, The Independent Monitoring Board as well as the man's next of kin.
33. Because the man's family live in Lancashire, the prison asked Lancashire Police to contact the family on their behalf, through Cambridgeshire Constabulary. At about 6pm on 13 December, Lancashire Police broke the news of the man's death to his brother. Lancashire police did not know of the particular circumstances surrounding the death but gave contact details and a reference number for the family to contact Cambridgeshire Constabulary. Then the man's brother contacted them. They were also not aware of the circumstances of the death but referred him to the prison. The brother contacted Peterborough and spoke to the prison's nominated family liaison officer. He confirmed that the man had died in hospital at about 9.30am. giving brief details of the circumstances of his death including the fact that the Prisons and Probation Ombudsman would be carrying out an investigation.
34. My investigator contacted Cambridgeshire Constabulary in respect of the death of this man. Their enquiries have concluded that his death is not suspicious or the subject of any criminal investigation.
35. The man's funeral took place on 21 December. The family stated that people who knew him from the night shelter and the street attended. The prison did not send a representative but did send flowers. The family told my family liaison officer that initially there was no offer of financial support towards the funeral expenses. However, I understand that following the funeral, an offer of financial support towards the funeral was made by the Director of Peterborough. The family have had little contact with Peterborough since the man's death. Although they have no wish to visit the establishment they were aware that the man owned a mobile phone when he went to prison and asked for this and any other personal property to be returned to them as soon as possible. To date, the man's property has not been returned to his family despite several requests.
36. When my family liaison officer and the investigator met with the man's family on 29 December, it was established that the man had become estranged from his family some years ago, although some contact was maintained by telephone calls, particularly in the last 12 months. The family were aware of his lifestyle. In light of the circumstances surrounding his death the family's main concern focused on his physical state in the early hours of 12 December, and whether an earlier referral to hospital or medical intervention on site might have saved his life. Following disclosure of the man's preliminary cause of death, the clinical reviewer of the Greater Peterborough Primary Care Partnership stated that the confusion and incontinence experienced by the man earlier would not have naturally led healthcare staff to suspect that something was wrong.

However, it would have been prudent to have implemented regular, routine observation that should have been recorded. The preliminary cause of death was an acute and sudden event that could not be foreseen or prevented and therefore it was reasonable for them not to have hospitalised him earlier.

37. This was Peterborough's first death in custody and whilst most staff have told my investigator that they were offered appropriate support by the Care Team following the man's death, other staff were not aware of the support mechanisms in place. My investigator established that a staff debrief for those involved in the man's care had not taken place. Staff considered that this would have been useful as a means of supporting them and offering reassurance.

Clinical review and Post Mortem

38. The preliminary cause of death for the man stated that he died as a result of a significant bleed into the abdominal cavity (retroperitoneal haemorrhage due to a ruptured common iliac artery aneurism). The post mortem report was not available at the time of completion of this draft report.
39. Following disclosure of the man's preliminary cause of death, the clinical reviewer from the Peterborough Primary Care Partnership was asked whether his death could have been prevented by earlier referral to hospital. She stated that his illness was an acute sudden event. The behaviour displayed by him would not have naturally led healthcare staff to suspect that something was wrong. Staff had also seen him showing no noticeable sign of distress just before he was found collapsed and this indicates how quickly his deterioration occurred. She states that it could not have been foreseen or prevented. However, the clinical review has highlighted other healthcare issues with regard to the man's care and treatment of him in particular as well as his general healthcare.
40. The clinical review into the man's care and treatment – has highlighted that when the opportunity arose, the man's clinical needs were not assessed or recorded appropriately, especially in light of his earlier lucid and rational behaviour. The clinical review is also highly critical of the fact that, notwithstanding security and staffing levels during the night state, the man's basic hygiene needs were not addressed in any professional or dignified manner until the arrival of day duty staff. The review concludes that in this instance, the man did not receive an equitable level of treatment or care to that which he would have received in an outside hospital in the wider community. However, the review establishes that overall, the man's care and treatment was appropriate.
41. Although some work has been carried out at Peterborough in respect of informing staff about MRSA, the clinical review suggested that efforts need to continue in this area, in order to improve the awareness and understanding of all staff that may have to deal with a prisoner who has MRSA. On interviewing the day senior nurse and the healthcare assistant it was stated that there were some misperceptions of MRSA in which staff were naturally wary of dealing with prisoners who had the virus. However, this did not affect the care and treatment afforded to the man who died.
42. The clinical review also identified the need for a formalised handover between staff in male healthcare. This should include both healthcare and discipline staff who are, after all dealing with the same patients. The clinical review also established that following the man's death there was no formal debrief of staff who had dealt with the deceased that day. This may have helped staff to reflect on and identify any issues as well as support staff who had dealt with the man.

43. Finally, the clinical review has emphasised the need for staff to record all observations appropriately, as the level of activity that appeared to have taken place on 12 December, was not adequately reflected in the man's medical notes.

Findings and conclusions

44. When the man entered Peterborough, it was established on reception that he had an infected right foot that required attention and appropriate treatment with antibiotics. He had also tested positive for drugs and was placed on the appropriate drug detoxification regime. The man had also stated during his reception that he was diagnosed as an MRSA sufferer and as such he was placed in a shared cell with another prisoner suffering from MRSA in the male healthcare unit. The man was not unduly unwell when he went into prison on 10 December, and was described as coherent and lucid.
45. The investigation highlighted that there was no formalised handover procedure in the male healthcare unit and that the existing level of handover between nursing staff was variable and did not always include discipline staff. The clinical review suggested that handovers should be reviewed.
46. It was established during the investigation on talking to healthcare staff that despite guidance and advice that is available to staff in regard to dealing with prisoners who have MRSA that there still remains a degree of ignorance and reluctance to deal with such prisoners, the onus being on healthcare staff to deal with them. Although there is no evidence to suggest that this had an impact on the man's death, the clinical review has highlighted that there needs to be an improved awareness of MRSA by staff. This may dispel any myths about the condition and instil greater confidence in staff dealing with prisoners who have this condition.
47. There were no issues brought to the attention of the duty manager over the weekend in regard to the man. However, during the course of the night of the 11 December, the man became confused, disorientated and incontinent which was interpreted by his cellmate as bizarre behaviour.
48. At 1.30am on 12 December, the man had soiled himself and had discarded his jogging bottoms on the cell floor. He appeared over the next few hours to become more incontinent and incoherent. Due to the state of the cell and the man's behaviour his cellmate alerted staff and demanded that he wanted to be moved to another cell.
49. At 4.30am, the cellmate was transferred to another cell. Because there were no other suitable cells in the healthcare unit, the man was left in his cell. According to staff, he was conscious, not in any apparent state of distress and it was felt that he could wait to be cleaned up later on in the day, when there were more staff on duty to attend to his needs. The man also responded to staff that he was okay.
50. Whilst the man's cellmate was transferred to another cell at his own request, this could have been considered an ideal opportunity in which to assess the man and ascertain the reasons for his incontinence and confused state. It would also have been the opportunity to clean his cell.

This was discussed by staff and there are a number of conflicting accounts on how this decision was reached. Although the senior nurse wanted to do this she was advised that staffing levels at that time of the morning limited this option because of the need to deal with any other incidents in the establishment should they arise. However, she concluded that it was a reasonable decision to have reached. The clinical review established that given the change in the man's condition from the previous evening, consideration should have been given to taking some baseline observations. It would have been prudent to have observed him more closely and on a regular basis, and to record the findings for the duration of the night following the cellmate's removal from the cell at 4.30am. At the very least this would have allowed an opportunity for the man's hygiene needs to be addressed and his dignity maintained. However, they were not because of a perception of shortages of staff at night time.

51. The clinical review also determined that the man did not receive equitable treatment compared to an outside hospital. Although there are reduced staff on duty at night time, this should not have impeded healthcare staff in accessing his cell in order to assess or clean him up. Notwithstanding the prevailing security conditions and manpower limitations at that time of the day, the clinical review suggested that some effort could have been made to attend to the man's basic hygiene needs and dignity. However, following disclosure of the preliminary cause of death, the clinical reviewer from the Greater Peterborough Primary Care Partnership has confirmed that the man's death was an acute and sudden event that could not have been foreseen or prevented. His presentation in the earlier hours of the morning would not naturally have led healthcare staff to suspect that something was wrong.
52. The man was seen at about 4.45am and 5am by members of the discipline staff, sitting upright on his bed which confirmed that he was conscious. Whilst the night duty SO was able to confirm that he had seen the man, my investigator has not been able to contact or confirm this with the night duty PCO. The man was also seen by the senior nurse going off duty at about 7.10am sitting upright on his bed. The clinical review has established that although there seems to have been a lot of activity in regard to sightings of the man, these were not documented. It was also unfortunate that following his death, no statements were taken from the night duty discipline staff that would have assisted in obtaining an accurate picture of the events leading up to his death. At the time of writing this draft all efforts to contact one discipline officer have been unsuccessful.
53. At 7.15am, the day duty healthcare team were made aware that the man had been incontinent with faeces during the night and that his cellmate had been moved. In light of the man's condition he was not fitted for court that day. His cell was entered by the nurse and healthcare assistant in order to clean him up and to assess his needs. There they found him to be lying on the cell floor on his duvet in a semi conscious state with no clothes. He was pale and clammy and was unresponsive to questioning. His breathing and vital signs were considered to be erratic and of concern

to the nurse who requested that a 999 ambulance be called. As the man was semi-conscious cardio-pulmonary resuscitation (CPR) was not considered by healthcare staff. Within five minutes of being called the paramedic team arrived in his cell and took over from healthcare staff. He was taken to the back of the ambulance on a stretcher and assessed. A venflon tube was inserted to assist with his breathing.

54. At about 8.12am, the man was taken by ambulance to hospital. As a prisoner he was escorted by two members of the discipline staff in accordance with the prison's security and operating procedures. However, because of his poor condition and the fact that paramedics needed to administer treatment he was not handcuffed. During the transfer to hospital, one of the escort staff reported that his condition was considered by the paramedic staff to be grave. He died in hospital at 9.10am.
55. Whilst most staff were offered care and support following the man's death, others felt that a formal debrief of the events leading up to his death would have been useful and reassuring. The clinical review has also highlighted the need to provide adequate debriefing to staff following a death in custody in line with Prison Service Order 2710 which deals with a prison's follow up to a death in custody.
56. The man's next of kin was informed during the early evening of 13 December, by Lancashire Police who had been notified by Cambridgeshire Constabulary. The man had not disclosed details of his next of kin to the prison and in view of his itinerant lifestyle, it had taken some time to trace his family and inform them of his death. This lapse in time was unfortunate but unavoidable given the circumstances. However, consideration could have been given to ensuring that Lancashire Police gave direct contact details for the prison to the family.

Recommendations

1. The Clinical review by the Greater Peterborough Primary Care Partnership highlighted the need for an improved awareness of MRSA by staff. This may dispel any myths about the condition and instil greater confidence to staff in dealing with prisoners who have this condition.

Recommendation

That the Healthcare Manager at Peterborough in conjunction with the Greater Peterborough Primary Care Partnership raises awareness of MRSA so that all staff feel confident and comfortable, in dealing effectively with prisoners who have or are suspected of having MRSA.

2. Given the change in the man's condition from the previous evening, consideration should have been given to taking some baseline observations and it would have been prudent to have observed him more closely and on a regular basis, and to record the findings for the duration of the night following his cellmate's removal from the cell at 4.30am. Staff were concerned about a perceived shortage of manpower and the risk of intervention preventing them from attending another potential incident at that time. I do not consider that the potential for a further incident to occur is sufficient reason to prevent staff attending to a prisoner's basic hygiene needs. The duty manager also confirmed that there were enough staff on duty that night not to compromise the man's basic hygiene needs. Ultimately it should be within healthcare staff's command to make a decision about whether to do that and for others to comply.

Recommendation

That the Director and Primary Care Partnership agree protocols for the basic standards of hygiene needs offered to all prisoners to be maintained, to include ensuring that soiled clothing and bedding is replaced as quickly as possible.

3. Staff were concerned about a perceived shortage of manpower and the risk of intervention preventing them from attending another potential incident at that time. I do not consider that the potential for a further incident to occur is sufficient reason to prevent staff attending to a prisoner's basic hygiene needs. The duty manager also confirmed that there were enough staff on duty that night not to compromise the man's basic hygiene needs. Ultimately it should be within healthcare staff's command to make a decision about whether to do that and for others to comply.

Recommendation

In the event of a prisoner's health deteriorating, that every reasonable effort is made to assess, determine and record the prisoner's needs by taking baseline observations on a regular basis

4. Whilst most staff were offered care and support following the man's death, others felt that a formal and timely debrief of events leading up to his death would have been useful and reassuring. The clinical review has also highlighted the need to provide adequate debriefing to staff following a death in custody.

Recommendation

That the Director give consideration to a timely formal debrief of key staff involved in a death in custody in accordance with Prison Service Order 2710

5. The clinical review established that although there seems to have been a lot of activity in regard to sightings of the man, these were not documented.

Recommendation

That the Healthcare Manager reminds all staff who have contact with patients to record their observations, however minimal in the patient's medical record or appropriate observation log.

6. Whilst the night duty SO was able to confirm that he had seen the man, my investigator has not been able to contact or confirm this with the night duty PCO.

Recommendation

That the Director ensures that, in the event of a death in custody, a written statement should be taken from key staff involved. Statements taken at the time or soon after provide a more accurate record and may reduce the need for staff to be interviewed as part of an investigation.