

**Investigation into the circumstances surrounding the  
death of a man in March 2010 at hospital whilst in the  
custody of HMP Peterborough**

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

**November 2011**

This report considers the circumstances surrounding the death of a man, a prisoner at HMP Peterborough. He died in March 2010 at hospital.

I would like to convey my condolences to his family and others affected by his death. I hope that this investigation provides some understanding of the events surrounding his death. I apologise for the delay in issuing this report and for any further distress this may have caused.

The investigation was led by one of my investigators. A review of the man's clinical care in prison was carried out by a clinical reviewer on behalf of the local Primary Care Trust (PCT), for which I am grateful. I also thank the Director and staff of HMP Peterborough for their cooperation.

The man was remanded in custody at HMP Peterborough in March 2007. After a short period on bail he returned to Peterborough in August 2007 having been convicted of a number of offences. He was sentenced to life imprisonment in November 2007 and remained at Peterborough until a few days before his death.

He was 63 years old and had a long and significant medical history, including heart disease, kidney disease and a severe spinal deformity. During February and March 2010 the man began to deteriorate and following a fall on 23 March he was admitted to hospital the following day. Whilst in hospital he received treatment for a collapsed lung and his condition initially improved. Sadly, his condition then deteriorated very rapidly over a 24 hour period and he died. His cause of death was found to be ischemic heart disease along with pulmonary oedema and coronary atherosclerosis.

This report outlines the overall high standard of care received by him during his time at Peterborough. However, it also reveals a number of areas where improvements are needed with regard to clinical governance and the management of clinical processes at the prison. I make a total of five recommendations on these issues.

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

**Thea Walton**  
**Acting Deputy Ombudsman**

**September 2011**

## **CONTENTS**

Summary

The Investigation Process

HMP Peterborough

Key Events

Issues

Conclusions

Recommendations

## SUMMARY

The man was remanded into custody at Peterborough on 16 March 2007, charged with a number of serious offences. He had a long and significant medical history, including heart disease, kidney disease and a severe spinal deformity. Due to his age and general ill health he was admitted to the Healthcare Centre where he remained for the entire period of his custody.

On 4 July, he was bailed by Crown Court. He was then convicted of his offences at Crown Court on 31 August and sentenced to life imprisonment on 5 November. On his return to Peterborough ACCT<sup>1</sup> processes were initiated for him as there were concerns about his mood. The ACCT was subsequently closed on 8 November following a well documented period of monitoring.

He made several visits to hospital during his time in custody, including as an inpatient for breathing difficulties and on a separate occasion for severe gastritis. He also had appointments with specialists in relation to his ongoing medical conditions, including his spinal deformity which, on occasion, caused him difficulties eating solid food.

During February and March 2010 his health began to deteriorate. He complained of feeling unwell, stomach upsets and diarrhoea and spent three days in bed. On 23 March, following a fall and a more pronounced decline in his health, one of the prison doctors made a referral to the hospital, outlining his conditions in significant detail and requesting that he was seen urgently. He was admitted to hospital the next day and was treated for a collapsed lung.

His condition improved over the following days and by 27 March, medical staff at the hospital decided that he would be ready to be discharged back to the prison the next day. Sadly, the following day saw a sudden and dramatic decline in his condition. His family were contacted and travelled to the hospital where they spent several hours with him. His family left the hospital at 9.35pm and he died at 11.50pm that evening.

His complex health needs were well managed whilst he was at Peterborough and the care he received was equal to what could be expected in the community. Members of his family praised staff for the way in which they cared for him. However, although they have no direct bearing on his death, this investigation has highlighted a number of areas where clinical care and governance could be improved. This report contains three recommendations relating to this. My report also contains a recommendation relating to the handling of staff complaints and one relating to the importance of disclosure of information to my investigators.

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<sup>1</sup> ACCT (assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

## THE INVESTIGATION PROCESS

1. On 1 April 2010, my investigator opened the investigation and was briefed about the circumstances leading to the man's death. He was provided with all prison and medical files for the man. Notices were issued to prisons and staff to inform them of the investigation into his death.
2. A post mortem examination was carried out on the man. His report, dated 8 April 2010, concluded that death was caused by;
  - a) Pulmonary oedema<sup>2</sup>
  - b) Ischaemic heart disease
  - c) Coronary atherosclerosis<sup>3</sup>
3. On 13 April, it was confirmed that a clinical reviewer of the local Primary Care Trust (PCT), would be carrying out the clinical review into the care and treatment of the man whilst at Peterborough.
4. On 28 April my Senior Family Liaison Officer contacted the man's family. The family had no issues or concerns they wished to raise and praised that care that he had been given at the prison. The family had the opportunity to comment on a draft of this report as part of the consultation process and had no comments to make at that stage. They did, however, tell my Family Liaison Officer that, having been informed by the prison that he had remaining funds, it was not made clear to them what they needed to do with this information. The prison explained that a further member of the family had been in contact, who appeared to be his official next of kin, and so they were seeking legal advice on the handling of his funds.
5. During the course of the investigation, my investigator became aware that a PCO had made a complaint about a clinical member of staff, in relation to the treatment of the man. Once he became aware of this allegation my investigator requested all the relevant paperwork, which was provided after some delay.
6. A total of nine staff were interviewed in the course of my investigation.
7. A draft of my report was sent to NOMS who accepted all of my recommendations. The specific responses are listed on page 21 of this report.

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<sup>2</sup> A build up of fluid in the blood vessels surrounding the lungs

<sup>3</sup> Thickening or hardening of the inner lining of the arteries surrounding the heart

8. **HMP PETERBOROUGH**

9. HMP Peterborough was opened in March 2005 and is privately run by Kalyx (formerly UK Detention Services). Its role is that of a category B local prison serving the counties of Cambridgeshire, Nottinghamshire, Lincolnshire, Leicestershire, Northamptonshire, Norfolk and Suffolk. It holds both men and women prisoners in separate accommodation. A category B prison is defined by the Prison Service as suitable to hold prisoners for whom the very highest conditions of security are not necessary, but for whom escape must be made very difficult.

10. Her Majesty's Inspectorate of Prisons for England and Wales is an independent inspectorate which reports on conditions for and treatment of those in prison, young offender institutions and immigration detention facilities. The then HM Chief Inspector of Prisons conducted a follow up inspection of the prison in June 2008. The conclusions of this inspection were:

“Peterborough prison had clearly made progress since the last inspection. No area gave rise to the acute concerns that we expressed at the time of the last inspection. However, there is still considerable room for improvement, particularly in the crucial area of staff-prisoner relationships, which remains the prison’s weakest link.”

11. The Independent Monitoring Board (IMB) is a group of members of the public from the local community who independently monitor all aspects of day-to-day life within the prison. Their role is to ensure that proper standards of care and decency are maintained. The Board produces an annual report focussing on the strengths and weaknesses of their prison. The last published report by the (IMB) was for the period 2008-2009. This report concludes:

‘In previous reports produced by the Board many problems in respect of Healthcare and Mental Health provision in the prisons have been raised, although the report of 2007/8 recognised that some changes had been made and some improvement achieved.... The HMCIP revisit report of 2008 also recognises that changes and improvements have been made and reduced the number of recommendations to forty, albeit that some of these were new. Despite the fact that there still remains some way to go if the service is to achieve the best it is able, the Board is pleased to report that the improvements already made have been built upon in the reporting year and progress made.’

12. There have been nine deaths in custody in the male part of Peterborough since the prison opened in 2005, including the death of the man. Two of these deaths were unclassified and six were attributed to natural causes. There are no links in terms of issues or learning points between his death and the previous deaths at Peterborough.

## **Healthcare at Peterborough**

13. Peterborough has a type three healthcare facility, which means that the health service provided is clinic based (similar to a doctor's surgery in the community). The local Primary Care Trust has commissioned Kalyx to provide the nursing and management of healthcare within the prison.
14. The inpatient accommodation can hold 13 patients and consists of a four bed ward, a two bed room and seven single rooms.
15. Prison Custody Officers (PCOs) work in the inpatient unit and deal with non clinical matters. They do not normally carry out any other duties outside of the healthcare facility and therefore have in depth knowledge of the unit and the prisoners within it.

## KEY EVENTS

16. The man had a long and significant medical history including heart disease, high blood pressure, chronic kidney disease and a severe curvature of the spine which caused him considerable difficulties swallowing.
17. On 16 March 2007, he was remanded into custody at HMP Peterborough to await trial at Crown Court. A healthscreen was carried out by a Healthcare Assistant during which it was noted that he had suffered a heart attack in late 2006. It was also noted that he suffered from the following conditions<sup>4</sup>:
  - Ischaemic heart disease with Myocardial Infarction
  - Hypertension (high blood pressure)
  - Chronic Kidney Disease stage three
  - High Dysphasia secondary to thoracic Kyphosis with subluxation of the third Cervical Vertebra
  - Osteoporosis
  - Ankylosing Spondylitis
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Severe cervico-thoracic deformity with loss of horizontal gaze awaiting corrective surgery to his Gastritis.
18. He also complained of chronic constipation and said that he was a smoker. He was taking 17 different medications when he arrived in prison:
  - Ipratropium (for breathing problems)
  - Etidronate (for thin bones)
  - Didroel, aspirin, clopidogrel, co-amilofruse, amlodipine, lisinopril, prazosin and simvastatin (for heart disease)
  - Co-codamol (for pain relief)
  - Lactulose (for constipation)
  - Nedocromil and carmellose (for irritation of the eyes)
  - Metoclopramine, prochlorperazine and omeprazole (for gastric problems)
19. His conditions are described by the clinical reviewer in the following way:

**Ischaemic cardiac disease:** permanent damage and subsequent scarring in the heart muscle caused by an interruption to the heart's blood supply, his previous heart attack is assumed to be the cause of the Ischaemia.

**Kidney disease:** His high blood pressure had, over time, reduced the ability of his kidneys to filter out the toxic substance produced by the normal workings of the body such as muscle contraction and digestion. Advanced renal failure stage three is determined by the levels of toxins in the blood and refers to an advanced stage of kidney failure. He also had chronic inflammation of the stomach causing indigestion

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<sup>4</sup> These conditions are explained in more detail on the following page.

**High dysphagia:** a problem swallowing high up the food tube (oesophagus) due to the kink in the food tube caused by his severely forward bent upper spine. Subluxation is a partial dislocation of a joint. In his case the 3<sup>rd</sup> neck spinal bone was partially pushed forwards.

**Osteoporosis:** a loss of the calcium content of bone, causing them to become prone to deformity and breaking.

**Ankylosing spondylitis:** a form of rheumatic arthritis that specifically affects the spine, causing the joints to lose flexibility.

**COPD:** the progressive onset of cough and phlegm production associated with damage to lung tissue caused by smoking

**Cervico-thoracic deformity:** the severe bend in the upper spine that he had due to his spinal arthritic disease. His head was so severely and permanently tilted down by the neck deformity he was unable to look straight ahead.

20. A second healthscreen was carried out the following day, 17 March, by Prison Doctor A who recorded further medical details, including those relating to his previous heart attack.
21. He continued to take the above medications, or medicines of similar effect, throughout his time at Peterborough. Owing to his complex medical conditions, he was sent to the Healthcare Centre as an inpatient rather than being sent to one of the wings and remained there for the duration of his time at the prison.
22. On 22 March an ACCT document was opened for him following a conversation with PCO A when he had told him that he 'has had enough of everything now – feels like ending it all'. He had been asked to sign a 'vulnerable prisoner compact', which he did not agree with and was upset about. (Prisoners can be given vulnerable prisoner status if they need to be separated from the main prison population for their own safety. This is usually because of the nature of their offence). It was later decided that it was not necessary for him to sign the compact as he was located in the Healthcare Centre. The ACCT was subsequently closed on 2 April, following appropriate monitoring of him.
23. On 24 May he was escorted to hospital. This was to review his medications. In the course of the consultation there was a discussion about his recent difficulties eating, owing to the severe curvature of his spine. This was followed up by a letter from the Registrar in Gastroenterology, stating that he:

'was quite keen to have a PEG inserted but having discussed with the doctor we feel that we should just monitor him with his current Fortisips<sup>5</sup> for now which he is managing to drink quite well.'

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<sup>5</sup> A PEG is a feeding tube that is fitted to the abdomen to allow nutrition to be given to patients who have difficulty eating. Fortisips is a nutrition supplement, taken in liquid form.

24. Between 23 May and 14 June his solicitor made three requests for Peterborough to provide a medical report on his current condition. The report, dated 15 June, listed the following:
- ‘He is a 60 year old man with severe nutritional problems resulting from complications of advanced osteoporosis. His nutritional issues will be handled through an upcoming operation to insert a tube directly through his skin into his stomach to allow him to receive a more substantial diet. His other conditions are also severely debilitating and combine ischaemic cardiac disease, advanced renal failure stage 3, advanced osteoporosis and ankylosis spondylitis. He walks with difficulty and spends most of his time in bed.’
25. On 4 July, he was bailed by Crown Court. His bail conditions stated that he must reside at a Bail Hostel and that he would be subject to a curfew. He was therefore released from Peterborough.
26. He was convicted of his offences at Crown Court on 31 August. He was remanded into custody at Peterborough to await sentencing and on arrival at the prison was returned to the Healthcare Centre.
27. Three days after his return to the prison, Prison Doctor B sent a letter to a consultant physician at the hospital on 3 September, requesting that he be seen again. A care plan was written on 4 September (a care plan is used to plan and co-ordinate the clinical support provided to a prisoner), outlining that he was:
- Currently unable to eat solid food due to curvature of the spine but could tolerate soups and custard
  - Needed adequate nutrition by taking Fortsips six times daily
  - Prone to constipation
  - To receive adequate nutrition to maintain weight
  - To be weighed weekly
28. Between September and November 2007, he was described as being in generally good spirits and very pleasant to staff. On 2 October Prison Doctor C requested an opinion on his health from the Gastroenterology Department at hospital. This was followed by an appointment on 22 November. The prison also requested an opinion from the Consultant Rheumatologist at the hospital about his spinal angulation (bent bones in the spine), raising concerns that this may affect his long term ability to walk. An appointment with the Rheumatologist was arranged for 19 November.
29. He was sentenced to life imprisonment at Crown Court on 5 November. On his return to the prison an ACCT was opened by PCO A. The reasons for opening this document were recorded as:

‘He has received a long sentence today – he has mentioned that he does not think it is worth living – as a precaution I have opened this [ACCT] book – very low in mood. He is elderly and very frail’.

30. The ACCT was subsequently closed on 8 November following a well documented period of monitoring.
31. He had several visits to hospital between January 2008 and December 2009, including as an inpatient for breathing difficulties and on a separate occasion for severe gastritis. He had had a PEG fitted by this point, although it is not clear from the records exactly when this took place. He also had appointments with specialists in relation to his ongoing medical conditions, including the curvature of his spine. In relation to the latter condition, an assessment by a Consultant Orthopaedic and Spinal Surgeon at hospital in November 2008 concluded that:

‘... Anything short of major surgery in terms of osteotomy is not going to address this gentleman’s problem. This has significant risk to life and limb and may not even be technically possible because of his osteoporosis. He certainly is willing to consider this and I am going to refer him to Nottingham for a second opinion.’
32. (An osteotomy is an operation during which the bones are cut in order to alter the way in which they fit together. In his case this would have been to attempt to alleviate the curvature of his spine.)
33. His condition was assessed at hospital throughout 2009 and it was agreed that the surgery would be carried out in late 2009 subject to him being fit enough for general anaesthetic. However, in October 2009 he suffered a respiratory (chest) infection and the surgery was therefore not carried out.
34. By February 2010 his health had begun to deteriorate. He complained of feeling unwell, stomach upsets with both diarrhoea and constipation. He occasionally refused to accept the nutritional supplement for his PEG, although he would eat orally.
35. On 23 March he was seen at the request of a PCO by Prison Doctor D as he was chronically constipated. The doctor prescribed an enema which was effective and alleviated his discomfort.
36. He had a bath later that evening and at around 7.00pm collapsed as he was getting out of the bath. The doctor diagnosed his collapse as a syncope (a faint), which is not uncommon after a successful enema. His blood pressure was found to be low<sup>6</sup> and an Electrocardiogram (ECG, a simple test that records the electrical activity of the heart) was carried out. There is no indication in the medical notes of the reason why an ECG was carried out but

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<sup>6</sup> Sudden low blood pressure can have the effect of causing dizziness and there is a decreased flow of blood to the brain. It can be an indicator of underlying health problems

the results of the test showed no suggestions that he was experiencing a heart attack.

37. Prison Doctor D instructed that his blood pressure be taken every 30 minutes for the following three hours. He was moved into the Care Suite for the night and arrangements made to leave his door open all night. (The Care Suite is a secure room on the Healthcare ward that allows staff better supervision of any prisoner located within it.)
38. A retrospective note in the clinical records, made on 25 March, suggests that blood pressure readings were only taken every hour and those taken at 9.25pm and 10.15pm showed his blood pressure to be very low. The reading recorded at 11.30pm was typed incorrectly and was therefore meaningless as a blood pressure recording. The readings following the 11.30pm reading indicate that his blood pressure had returned to normal.
39. Prison Doctor E made an entry into his clinical record shortly after Prison Doctor D had prescribed the enema, noting that he had had a 'change of bowel habit'. He then wrote a letter to the Department of Colorectal Surgery/Gastroenterology at the hospital asking for an urgent referral. The doctor made no written notes in the clinical records to suggest that he suspected that this change of bowel habit might be an indicator of bowel cancer. At interview he explained that he was concerned that the curvature of the spine made it difficult to examine him thoroughly and he therefore thought an urgent hospital referral appropriate.
40. A PCO working in the Healthcare Centre, PCO B, told the investigation team that he had asked Prison Doctor E, who had been regularly involved in the man's treatment throughout his time at Peterborough, to see him on several occasions leading up to 23 March. The PCO said that the doctor had refused to see him. The doctor disagreed with this account of events at interview and the investigation found no evidence to support the PCO's claim.
41. He was seen by Prison Doctor E at 8.30am on 24 March, the day following his fall. The doctor assessed that he needed to be sent to hospital and at 10.25am he was sent to the hospital's Accident and Emergency Department. Whenever a prisoner is escorted to outside hospital a risk assessment is carried out to establish appropriate arrangements for that visit, including the number of staff that will escort the prisoner and the type of restraints that would be used. It was decided that, as he was mobile, he would be handcuffed to an officer with an escort chain (a long chain with a handcuff at each end).
42. A retrospective note was made in the clinical records that evening by one of the nurses which recorded that he had told Prison Doctor E he was feeling lethargic, had diarrhoea and felt unwell. He was breathing at a very rapid rate (26 breaths per minute). There was no reference in the note to whether his chest was examined or whether he was experiencing chest pain or a shortness of breath.

43. Although there was no reference to him complaining of chest pain in the prison's clinical records prior to his admission to hospital on the morning of 24 March, at interview Prison Doctor E said he could recall him complaining of being in pain when he examined him that morning. The hospital admission notes refer to him having experienced increasing shortness of breath and chest pain in the 24 hours prior to his admission. On arrival at hospital he was x-rayed then admitted for treatment for a collapsed lung.
44. He responded well to treatment for the collapsed lung although there were various fluctuations in his heart rate and blood pressure. On 26 March hospital staff were concerned about his low blood pressure and he was given another x-ray and prescribed pain relief medication. By 27 March, his condition had improved and by early that evening nurses told the prison staff escorting him that he would be discharged back to Peterborough the next day.
45. At 12.15 on 28 March, his condition rapidly deteriorated. He was examined by a doctor and his restraints (handcuffs) were removed in the event that his condition may worsen. The escorting staff contacted the prison and asked for his next of kin to be informed. At 14.25 his mother, sister and brother-in-law arrived at the hospital.
46. He was unresponsive and staff briefed the family on his condition and agreed with them that he would not be resuscitated in the event that he stopped breathing. A doctor informed the escorting staff that he was 'likely to pass away within the next few hours'. At 21.35 his family left the hospital after agreeing with prison staff at the hospital that they would be contacted by telephone if he were to die during the night. At 11.40pm he stopped breathing and his death was pronounced at 11.50pm.

#### **After the man's death**

47. The prison's death in custody contingency plan was put into action and a 'Decision Log' was completed. (This log records the action taken during the management of an incident.)
48. At 1.40am on 29 March, two hours after his death, his brother-in-law was telephoned by Peterborough's Head of Public Protection to inform him that he had died. This was in line with what had been agreed with the family at the hospital.
49. Peterborough's Family Liaison Officer (FLO) maintained contact with the family and they were also later visited in person and offered the opportunity to visit the prison. He also discussed funeral costs with the brother-in-law and explained that the prison could make a contribution to these. This offer was later declined by the family.
50. A 'cold debrief' was held on 20 April. (This debrief is intended to check that contingency plans after a death were correctly followed and changes are made in light of any lessons to be learned.)

51. The funeral was held on 26 April and was attended by members of his family, and representatives from the prison.

## ISSUES

### Clinical Care

52. The man had complex medical needs, including heart disease and severe swallowing problems caused by the curvature to his spine pressing against his oesophagus (the tube used for swallowing). During his time in prison he was assessed by rheumatologists, orthopaedic surgeons, gastroenterologists and dieticians and attended many outpatient appointments, mainly to alleviate the problem of his swallowing difficulty.
53. He was admitted to hospital on 24 March 2010, following a fall the previous day. He had developed chest pain and a shortage of breath. Although he initially seemed to be responding well to treatment, he died four days later from a fluid overload in the lungs secondary to pre-existing heart disease. The clinical reviewer describes this as essentially heart failure of a severe degree which carries a high mortality even in a hospital setting, especially in a patient with significant medical problems, such as his.
54. Neither I, nor the clinical reviewer, have found any evidence that the earlier prison management of his neck and swallowing problems and his chronic constipation had any influence on his death. However, my investigation has highlighted a number of areas where improvements are needed to improve the general standards of medical care. These are summarised below.

#### Concerns raised by PCO B

55. During the course of my investigation, it became clear that one of PCOs who worked in Healthcare, PCO B, had raised concerns about the care provided to the man by medical staff within Healthcare. He had worked in Healthcare for over three years and his duties involved the supervision of prisoners who are attending appointments in the Healthcare centre or who live on its wards.
56. He told my investigator that he had asked Prison Doctor E to see him on at least three occasions and that the doctor had refused to see him. My investigator and the clinical reviewer carried out interviews with PCOs, managers from Healthcare and the doctor to explore whether there was any evidence that he had not seen him on every occasion when this was requested. They concluded that there was no evidence to support the allegation.
57. While there was no evidence to suggest that the doctor had repeatedly refused to see him, it is clear that, on 23 March, he was not available to see him to deal with his severe constipation due to his work load. He was therefore treated by another doctor who had not been involved in his day to day care. The clinical reviewer is satisfied that the treatment he received from the second doctor, Prison Doctor D, was appropriate and effective.
58. PCO B made a written complaint about Prison Doctor E several days after the man's death and was told by a Senior Officer that 'it would be dealt with'. The

complaint was then passed to the then Head of Healthcare. It is surprising that such a complaint does not appear to have been acted upon. Furthermore, the complaint was not brought to the attention of my investigator until some time afterwards and several requests had to be made for a copy of the complaint before it was forthcoming. I therefore make the following recommendations:

**The Director should ensure that all information relevant to the PPO's investigation should be brought to the investigator's attention at the earliest opportunity**

**The Director and Head of Healthcare should ensure that they have robust procedures in place to deal with such complaints, including appropriate involvement of the Primary Care Trust (PCT) where necessary**

#### Staff Workload

59. Throughout my investigator's interviews with Prison Doctor E, he stressed the heavy workload in Healthcare and the lack of time available to carry out proper assessments. Managers and PCOs also indicated their concerns that doctors were unable to do all the work that was required in the time available.
60. I am aware that a number of meetings were held between January and March 2010 to discuss the need for daily ward rounds by a doctor. These discussions involved both medical and non medical staff and on occasions the GP provider company Cimarron. At a meeting on 30 March 2010 it was agreed that due to lack of doctor capacity and the heavy workload in Healthcare, ward rounds would not be routinely carried out. Inpatients in Healthcare who needed to see a doctor at other times were to be booked into the daily clinic held in the doctor's room. It was hoped that the new arrangements would provide better confidentiality for the patients and also access to the computer record for note keeping in a timely manner.
61. Prison Doctor E told my investigator that the change in process took place at the beginning of March and that daily rounds were in place prior to that time. Some non-clinical staff had a different understanding of when the changes to the ward round system had taken place. It is surprising that there appears to be a lack of clear understanding of such a fundamental process within Healthcare. The clinical reviewer outlines the importance of such significant changes being discussed as part of the clinical governance meetings. The outcome of such meetings should then be clearly disseminated to staff. The Director and Head of Healthcare will wish to pay close attention to the clinical reviewer's findings.

#### Staff Awareness of Local Medical Procedures

62. In any case where a patient is referred to hospital with suspected cancer, formalised referral forms have been developed by local doctors and the hospital to improve the sensitivity of cancer diagnoses, and to help the doctor

make an informed decision on the need for an urgent referral. In interview, Prison Doctor E explained that he was unaware of these forms, or how to access them electronically. Updates on such standard local processes are sent to all NHS community GPs in Peterborough on a regular basis. His inclusion in this distribution system would benefit both him and patients at Peterborough. The clinical reviewer's report addresses this issue in some detail and the Governor and Head of Healthcare will wish to pay close attention to this. I make the following recommendation on this issue:

**The Head of Healthcare should ensure that all doctors at the prison have the same access and awareness of patient referral protocols as doctors in the community**

#### Medical Record-keeping

63. It is clear from interviews and the medical notes, that records were not entered in a timely manner on all occasions. Records of the treatments planned during ward rounds were rarely entered on the computer record, and there is little record of follow up of these actions so assessment of whether they were completed is not possible in most cases. Additionally, it is not possible to ascertain from the computer record whether notes are of a consultation with a patient or of discussions with staff. It is therefore also impossible, on occasion, to verify if the man was physically seen or examined.
64. Following his collapse on 23 March, Prison Doctor D instructed that his blood pressure should be taken every 30 minutes for the next three hours. The entry in the medical records was made retrospectively (on 25 March) and it is therefore not clear whether all the blood pressure checks were carried out but not recorded or some of them were not carried out. In either event it is concerning that all the observations requested by the doctor do not appear to have been carried out, or at the very least documented, at a time when his blood pressure was very low.
65. The clinical reviewer concluded that the process for recording observations, reporting them to the doctor in a timely manner and for transferring them to the computer record are unclear. Fortunately, the very low blood pressures recorded did not have any ill effect on him and it returned to within a normal range within a few hours.

**The Head of Healthcare should ensure that the standards of record keeping are in line with the standards endorsed by the Nursing & Midwifery Council Debriefs.**

66. A 'hot debrief' of the escorting staff was carried out by the duty manager on their return to the prison following the man's death. (A 'hot' debrief is designed to give staff who have been involved in a death in custody the opportunity to discuss how they are feeling and to identify any immediate issues that need to be rectified, such as problems with equipment.)

67. It is encouraging that a 'cold debrief' was also held a few weeks after his death but unfortunate that no clinical staff were in attendance. (A 'cold' debrief is designed to help identify learning point or issues that may still need to be addressed. The meeting would ordinarily include staff involved in a prisoner's care or the events surrounding their death). As he had been receiving clinical support throughout his custody, and had been living in the Healthcare Centre, it is surprising that clinical staff were not involved.
68. The cold debrief is an opportunity to identify issues and learn lessons to improve future practice and an action plan should be formed to address any issues highlighted. It would have been beneficial for a number of clinical issues to be raised at the debrief and then referred to the next clinical governance meeting for action.

**The Director and Head of Healthcare should review local procedures for the inclusion of clinical staff in debrief meetings. In addition, robust processes for developing and implementing action plans resulting from debriefs should be introduced.**

## **CONCLUSION**

70. The man arrived at Peterborough with a range of complex medical conditions, the most significant of which was a severe spinal deformity which caused him difficulties swallowing.
71. The care he received was generally of a good quality. However, this investigation has identified some areas of clinical practice at Peterborough that are in need of improvement. It is, however, important to note that his family felt that he was very well cared for at the prison and that he had been happy and content with his treatment.

## RECOMMENDATIONS

**The Director should ensure that all information relevant to the PPO's investigation should be brought to the investigator's attention at the earliest opportunity**

Accepted- There is now a system in place to ensure that all relevant documentation is collated by the appointed liaison officer and passed to the PPO at the earliest opportunity.

**The Director and Head of Healthcare should ensure that they have robust procedures in place to deal with such complaints, including appropriate involvement of the Primary Care Trust (PCT) where necessary**

Accepted- All staff who work in the healthcare units are aware that any concerns they may have in relation to patients can and should be raised with the clinical lead. This will be reinforced at team meetings.

**The Head of Healthcare should ensure that all doctors at the prison have the same access and awareness of patient referral protocols as doctors in the community**

Accepted- There are two full time GP's on site who are made aware of any changes to protocols/procedures via the Prison health Liaison meeting. Visiting GP's work within the community and should already be aware of such changes, but do have a Registered Nurse that accompanies them who can advise them of any prison specific issues.

**The Head of Healthcare should ensure that the standards of record keeping are in line with the standards endorsed by the Nursing & Midwifery Council**

Accepted- All nurses conform to the NMC regulations. We monitor this by auditing the System One on a frequent and random basis.

**The Director and Head of Healthcare should review local procedures for the inclusion of clinical staff in debrief meetings. In addition, robust processes for developing and implementing action plans resulting from debriefs should be introduced.**

Accepted- A list of staff involved in any future incidents will be supplied to the Duty Manager to ensure their attendance at debriefs.  
The system for follow up after an incident will be included in the Duty Manager's briefing pack.