

**Investigation into the circumstances surrounding the
death of a man in hospital in November 2009
while in the custody of HMP Peterborough,**

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

February 2011

This is the report of an investigation into the death from natural causes of a man at hospital in November 2009. He was 36 years of age. At the time of his death, he was a prisoner in the custody of HMP Peterborough.

I extend my sincere condolences to the man's family and friends and all those affected by his loss. I apologise for the delay in issuing this report and any additional distress this may have caused. The delay was due, in part, to the time taken before I received the final clinical review.

I should like to thank the then Director of Peterborough and his staff for their co-operation. A clinical review of the man's care and treatment was carried out by a clinical reviewer from the local Primary Care Trust (PCT) in conjunction with a clinical review panel appointed by the PCT.

The man had been diagnosed and treated for cancer of the colon in 2007 while living in his homeland of Lithuania. In June 2009 his cancer was confirmed to have recurred. Despite treatment, he began to deteriorate rapidly and he died before he could return to Lithuania. His cause of death was septicaemia (blood poisoning) secondary to metastatic carcinoma of the colon (cancer of the colon).

The clinical review panel found that his clinical care was equitable with that which he could have expected in the outside community. The panel made two recommendations. One was about providing medication and the other about recording of staff debriefs. The panel made a further recommendation which is addressed to the hospital.

The arrangements made by Peterborough to facilitate visits from the man's mother is an example of good practice.

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.

Jane Webb
Acting Prisons and Probation Ombudsman

February 2011

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SUMMARY

1. The man was a Lithuanian national who came to the United Kingdom (UK) in 2008 to seek employment.
2. On 27 January 2009, he was remanded into HMP Peterborough having been arrested two days earlier charged on two counts of attempted murder and wounding with intent.
3. During a health assessment consultation with a prison doctor shortly after his arrival into Peterborough, he reported that two years previously while still living in Lithuania, he had been diagnosed with cancer of the colon leading on to major treatment and regular follow-ups. The doctor sent a referral letter to the local hospital to ask for a review appointment. The hospital arranged an outpatient appointment for 4 June.
4. Starting in May, the man began suffering symptoms such as recurring abdominal pain, very frequent bowel movements and vomiting blood. He attended his hospital appointment on 4 June, but he refused a bowel examination. He agreed, however, to having a CT (computerised tomography – a type of x-ray) scan and colonoscopy and the hospital made a referral for these investigations to be carried out.
5. On 23 June, the man saw another of the prison doctors to report the sudden development of a growth on his neck. The doctor referred him to hospital and, in the middle of July, the growth was excised and a biopsy taken. Examination of the biopsy confirmed that the lump was a spread of the original bowel cancer.
6. The man received a course of radiotherapy but this was only palliative treatment as it was evident that he did not have long to live. Peterborough contacted his mother in Lithuania letting her know her son was very unwell. She came to the UK with other family members and Peterborough made arrangements for the family to have extended time with the man.
7. By this time, the man had been convicted on two counts of wounding with intent to do grievous bodily harm and sentenced to five years imprisonment. Not long afterwards, his solicitors wrote to the UK authorities requesting repatriation back to Lithuania. In due course the UK and Lithuanian authorities approved the application for repatriation. Plans were made to transfer the man to HMP Wandsworth on 2 November ahead of flight details being finalised. Unfortunately, he deteriorated suddenly and he became too unwell to travel. He was transferred to hospital on 8 November and died the following day.
8. The clinical review panel found that the recurrence of cancer was diagnosed quickly and requests were made appropriately to outside hospital for follow-up care. The panel found that the man's pain management followed the standard National Health Service pathway, although there were instances of late

provision of medication which led to him experiencing breakthrough pain¹. The difficulties with pain management might have been compounded through his reluctance to transfer to the prison healthcare unit.

¹ Breakthrough pain is defined as abrupt, short lived and intense pain that 'breaks through' the 'around the clock' analgesia that controls persistent pain.

THE INVESTIGATION PROCESS

9. The Ombudsman's investigator obtained copies of the man's records from HMP Peterborough and had informal discussions with some of the staff. Notices were published at the prison to inform staff and prisoners about the investigation and to invite them to speak with the investigator. No responses were received however.
10. The clinical reviewer submitted his report to a panel appointed by the PCT to review the report, to examine the cause of death, to consider possible failures in the provision of care and any learning points and to make recommendations if appropriate. The final review forms one of the annexes to this report.
11. The investigator contacted the Coroner, to whom a copy of this report will be sent to assist in his enquiries.
12. One of the Ombudsman's Family Liaison Officers contacted the man's mother to inform her of the scope of the investigation and to give her the opportunity to ask any questions or to raise any concerns she wished to be considered as part of the investigation.
13. She raised a number of issues. All related to her son's clinical care and management. She felt that there was a delay carrying out tests to investigate if her son's cancer had recurred, despite the fact that his symptoms included episodes of vomiting blood. She questioned whether her son had been told about the findings from x-rays. She thought that her son's pain relief had been inadequate and asked why his treatment plan did not include chemotherapy. She also believed that her son needed psychological counselling, but received none.
14. She also thought that her son's care from hospital nurses in his final hours was inadequate. (As the care provided at NHS hospitals is outside of my terms of reference, I am not able to investigate this matter.)

HMP PETERBOROUGH

15. HMP Peterborough is privately run by Kalyx Limited (formerly UK Detention Services). It opened in March 2005. It is a category B local prison serving the counties of Cambridgeshire, Nottinghamshire, Lincolnshire, Leicestershire, Northamptonshire, Norfolk and Suffolk. It holds over 800 prisoners.
16. The then Chief Inspector of Prisons conducted a short follow-up inspection of Peterborough in June 2008. (The previous inspection had been in 2006.) She found that Peterborough had made progress since the time of the earlier inspection, including progress in healthcare provision. Despite the improvements, she concluded that there remained considerable room for improvement.
17. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. In their report for the period 1 April 2008 to 31 March 2009, Peterborough's IMB referred to its criticism in previous reports of healthcare provision. The IMB was pleased to report improvements made in the current reporting year. The IMB highlighted that staff training was much improved with all nurses receiving an induction programme. The IMB also referred to the development of robust care planning and patient group directives. Another improvement was a reduction in the use of agency staff.
18. In the 12 months before the man's death, two other male prisoners at Peterborough died through natural causes. None of the circumstances surrounding those deaths were directly relevant to his death.

KEY EVENTS

19. The man was born in Lithuania in August 1973. In 2008, he came to the UK with his wife in order to seek employment and they moved into accommodation in Cambridgeshire. Their two children remained in Lithuania with relatives. The man soon obtained work at a factory making aeroplane parts.
20. On 25 January 2009, the man was involved in an incident that resulted in him being arrested and charged on counts of attempted murder and wounding with intent. He remained in police custody for two days before being remanded into HMP Peterborough on 27 January.
21. The man received a standard health screening assessment on his initial reception into Peterborough when he reported having chest pain but no other significant health concerns. At a follow-up health assessment five days later with a prison doctor, the man reported having been treated for colonic cancer two years previously when living in Lithuania. He said that his treatment included surgery, chemotherapy and follow-up checks every three months. To aid the consultation, the doctor used a telephone interpretation service to obtain information from him. The doctor's treatment plan included blood checks and referral to an oncologist (a doctor specialising in the treatment of cancer). Following on from that the doctor wrote to the local district hospital's oncology department asking that they see the man for a review. The doctor added that the man spoke very little English so it would be advisable to use an interpreter.
22. A consultant oncologist at the local hospital wrote back to the doctor on 10 February telling him that her Trust did not routinely follow-up colorectal cancer patients. She recommended that the man should have an annual computerised tomography (CT) scan (computer processed medical imaging) and a colonoscopy every three to five years.
23. The man failed to attend two clinical consultations on 13 February. One appointment was for a review at a "male health" clinic. The other appointment was with a doctor for follow-up of a complaint about abdominal pain that he had reported to a nurse several days previously.
24. He did attend a consultation with another of Peterborough's doctors on 10 March to report that he was depressed about his history of cancer. He also reported having back pain and the doctor noted that follow-up was needed to consider the possibility of secondary spread of cancer into the lung. He had a chest x-ray at the local hospital on 17 March, but this revealed no abnormalities. (There is no entry in his prison clinical records which indicates whether he was informed about the x-ray result.)
25. As with many prisons, Peterborough operates a personal officer scheme. Among other things, the personal officer is a prisoner's first port of call if they have questions, complaints or need advice. A typical entry for the man made by his personal officer on 19 March, read:

“Respectful and co-operative with the regime and the staff. No issues at all. Enthusiastic to go to work. No problems to date.”

26. On 14 April, the district hospital wrote to the man to say that an outpatient appointment had been made for him for 4 June.
27. The man consulted a doctor on 29 April, reporting back pain. The doctor prescribed pain killers (diclofenac) and noted the possibility that the pain might be related to the spread of the cancer and suggested that efforts be made to expedite the outpatient appointment. (There is no evidence to indicate whether any enquiries were made of the hospital to try to expedite the appointment already set for 4 June.)
28. Meanwhile, the man continued to attend work and continued to be respectful towards staff and prison rules. At the beginning of June his good behaviour resulted in him being moved to enhanced status. (The Prison Service seeks to encourage responsible behaviour by prisoners through complying with rules, through effort and achievement in work or other constructive activity and through addressing their offending behaviour. Such behaviour is rewarded through the Incentive and Earned Privileges (IEP) scheme where prisoners at the highest level – enhanced status – are granted a greater range of privileges compared to prisoners at lower levels.)
29. The man attended a smoking cessation clinic on 7 May. He had previously reported smoking around 20 cigarettes a day and had been doing so for 16 to 18 years. He was given nicotine patches and advised to return to the clinic the following week.
30. At a consultation with Prison Doctor B on 20 May, the man reported recurring abdominal pain and very frequent bowel movements as well as lower back pain. The doctor noted that a specialist referral to the local hospital had already been made by the first prison doctor. He prescribed Tramadol (an opioid painkiller, stronger than diclofenac). Another prisoner accompanied the man to interpret for him.
31. On 25 May, the man saw another prison doctor having reported to a nurse the previous day that he had vomited blood. The doctor arranged for the man to have blood tests and these detected no abnormalities. A diagnosis of gastritis (irritation of the stomach lining) was made and an antacid (omeprazole) was prescribed.
32. Further monitoring of his blood tests over the next few days led to the man being reviewed by a prison doctor at a consultation on 30 May. The doctor telephoned the registrar at the local hospital and they agreed that he should be referred for an upper gastrointestinal endoscopy examination (examination of the stomach using a camera). The doctor wrote a referral letter to the hospital noting that the man was a Lithuanian and would need a translator. (The man had been accompanied by an interpreter at both of his consultations with the prison doctor.)

33. A prison doctor saw the man as an emergency appointment in the early afternoon on 3 June after a further episode of vomiting blood. The doctor noted that at that point there were only traces of blood. He had reminded the man that his oncology appointment was set for the following day. The man was admitted to healthcare later that afternoon due to his condition. A note was made in his records to say that the reason for the move was explained to him by his cellmate as they spoke the same language.
34. The man attended the district hospital on 4 June as planned. In a letter back to the prison, the consultant nurse wrote:

“Today he complains of left iliac fossa pain (pain in the left lower quadrant of the abdomen) which he states has been present for the past 2 - 3 weeks ... I did want to examine him in clinic today, however he refused, I have therefore advised him that we really need to undertake surveillance CT scan and colonoscopy as soon as possible and have requested these for him.”
35. On returning from hospital, the man should have returned to healthcare. He asked, however, to return to the standard wing where he was previously resident and this was allowed.
36. His pre-arranged gastrointestinal (endoscopy) examination was carried out at the local hospital on 12 June. The procedure identified no significant abnormalities.
37. At a consultation with a prison doctor three days later, the man complained that he was experiencing severe lower back pain due to a damaged spinal disc. The doctor re-wrote the prescription of Tramadol, doubling the dose. He also complained about stomach problems, reporting that he had not received his omeprazole antacid for several days. He was accompanied by an interpreter at this consultation.
38. On 23 June, the man consulted a prison doctor to report a rapid (seven day) growth of a golf-ball sized lump in his neck. The doctor noted that the growth was possibly metastasis (secondary spread of cancerous growths to another part of the body). The doctor wrote to the department of oncology at the local district hospital asking for an urgent review. By then, Peterborough had obtained information about the man's care at Vilnius University when he was treated for bowel cancer in Lithuania. The information had been translated into English and the prison sent a copy to the department of oncology.
39. The review took place three days later when a CT scan revealed presence of irregular tissue suggestive of lymphoma and other growths. A biopsy was ordered. The lump was surgically removed on 13 July and a biopsy was taken for examination. Examination confirmed that the lump was a secondary growth of the original cancer. Further scanning showed that the cancer had also spread to the spine and to the lymph nodes in the neck.

40. On 23 July, the man was prescribed fentanyl patches. (Fentanyl is another opioid painkiller. The fentanyl patch is worn continuously allowing steady absorption of the drug into the bloodstream. Patches have to be replaced every 72 hours.) He was first prescribed 25 microgram patches (releasing 25 micrograms of fentanyl per hour). Over the following 18 days, the prescription was increased first to 50 microgram patches and then increased again to 100 microgram patches.
41. At Crown Court on 24 July, the man was convicted on two counts of wounding with intent to do grievous bodily harm. He was sentenced to five years imprisonment. His barrister told the court that his client had just been informed that he probably had less than two years to live.
42. The following day, a landing officer noted the man telling him that he had received the news that he had cancer and that there was nothing more that could be done for him. The officer noted that the man was distressed so he advised him about support from Listeners² and Samaritans.
43. At the end of July, the man declined to take any further nicotine patches, telling staff that he was unable to stop smoking. Also, at some stage in July, the man became too unwell to continue to attend work.
44. The man was reviewed at hospital on 10 August. In a letter to the prison about the consultation, a specialist registrar in medical oncology noted that the man's grandmother had died of colorectal cancer and went on to say that:

“... we have arranged today that the patient be reviewed by our palliative team who suggested to increase the dose of fentanyl to 100 [micrograms] and control the breakthrough pain with 60 [milligrams] of Sevredol³ as needed. Ibuprofen has been added to his medication as well ...”
45. The man returned to hospital on 14 August when he was reviewed by a consultant oncologist. In a letter to the prison's healthcare unit, the consultant oncologist explained the proposed treatment plan. She indicated that his disease was probably incurable so his proposed treatment, which would include radiotherapy, would be palliative (limitation of pain) only. She added that an interpreter had been used to assist the consultation and that the man understood his prognosis.
46. Upon his return to Peterborough, the man was due to be admitted to healthcare as part of the care planning process. He refused to be admitted, but nothing was recorded to explain the reason for his refusal. (His solicitors subsequently wrote to Peterborough to say that their client understood from his consultant in Lithuania that certain exploratory operations might pose a higher risk compared to the risk of not undertaking them.)

² Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

³ Sevredol is another opioid painkiller which contains morphine sulphate.

47. At a consultation with a prison doctor on 18 August, the man complained that he did not always receive the Sevredol tablets that he had been prescribed. He also said that he was unable to report anything from his hospital appointment on 14 August as he had not understood what he had been told. The doctor made a note that he would await the medical report from the hospital. He did not record whether he took any action to deal with the complaint about non receipt of medication.
48. On 26 August, the man's solicitors wrote to Peterborough requesting their client's repatriation to Lithuania. (Lithuania is one of many countries with which the UK has reciprocal arrangements allowing prisoners to return to their homelands to serve their sentences. Repatriation is not guaranteed as the consent of both countries involved is required in each individual case.)
49. On this same day, the man started a course of radiotherapy at hospital as a day patient. On his return to Peterborough the man moved into the prison's healthcare unit. Up to this time he had been reluctant to transfer to healthcare but one of Peterborough's doctors spoke to him to explain that a move would mean an improvement in the provision of clinical care. From this time onwards the man spent all his remaining time at Peterborough in the healthcare unit (dispersed with time at outside hospital).
50. An entry in the man's clinical records made on 5 September stated: "... now getting some breakthrough pain ... liaise with Macmillan⁴ team to adjust analgesia". A Macmillan nurse attended a care planning meeting five days later to discuss pain control. The plan of care included that the fentanyl dose should be increased to 150 micrograms and the Sevredol dose increased to 90 milligrams, but only as needed.
51. Entries in the man's records from this time onwards show that he was spending more and more time in bed and it is also clear that healthcare staff struggled to control his pain. These difficulties included several documented instances when his medication was not provided on time. Following a review by a Macmillan nurse on 21 September, an entry was made in his records to say that the level of pain relief being provided was insufficient so new pain killers were prescribed. These were OxyContin, with OxyNorm for breakthrough pain (OxyContin and OxyNorm are opioid medicines related to morphine). The possibility of a transfer to a local hospice was also discussed at this review.
52. At the end of September the man agreed to move from a single healthcare cell into a four bedded dormitory. It was recorded that the rationale for the move was so he would not be alone and also because the beds in the dormitory were larger. Language Line (a telephone interpretation service) was used to assist in the consultation. On the same day, he clarified that he was content for Peterborough to use another prisoner as an interpreter. Despite having agreed to move into a dormitory, he later refused to make the move. His reasons for refusing were not recorded.

⁴ Macmillan nurses specialise in the control of pain in terminally ill cancer patients.

53. On 6 October, the United Kingdom Border Agency wrote to the man about repatriation. He was invited to write with his written representations within the following 14 working days and told that at the end of that period a decision would be made about his possible repatriation.
54. A prison doctor had asked the consultant oncologist at the hospital for an opinion on the man's prognosis. She provided her opinion in a letter dated 8 October. She explained that it was always difficult to predict the outcome, but based upon the extent to which his cancer had spread, she suggested a prognosis of 18 months to two years.
55. The man was transferred to hospital on 12 October and remained an in-patient for the next three days. He received two blood transfusions and antibiotic treatment for a suspected infection of the bile duct. He asked to be discharged three days later and to return to prison. He signed a declaration at Peterborough saying that he did not wish to remain in hospital as his belief was that the hospital could no longer do anything for him (it also seems that he wanted to continue smoking which was easier in prison than in the hospital). The next day, a second consultant oncologist wrote to the man's solicitors saying that he probably had less than three months to live so his extradition should take place while he was still fit enough to travel.
56. After he asked to see another Lithuanian speaking prisoner, Peterborough arranged a visit which took place on 18 October.
57. On 19 October, the man's solicitor visited, accompanied by an interpreter. The solicitor wanted to find out if he was satisfied with the care that he was receiving. He said that the hospital doctor had told him that they could not treat him and that he felt more cared for in prison because he could smoke and had a television.
58. In anticipation of the possibility that he might be compassionately discharged from prison and to his remaining in the UK, thought was given to identifying a hospice to which the man could be discharged. However, on 21 October a note was made in his prison healthcare records saying that he had declined that option when spoken with through Language Line:

“... when asked if he would like to move to the local hospice ... he declined stating that he was comfortable here in HMP Peterborough where he is able to smoke. He stated that his pain control is generally good now but that he was in pain over night last night. The pain was resolved by morning. Denied any other problematic symptoms ... he was offered a more comfortable hospital bed which he refused. He was offered the services of a Lithuanian speaking priest which he again refused ...”
59. Peterborough had telephoned the man's mother in Lithuania by this time to inform her that her son did not have long to live. She came to the UK with other family members on 22 October and Peterborough made arrangements

for them to visit him for two hours every afternoon. The family stayed in the UK for the remainder of his life.

60. The man attended an outpatient appointment at hospital on 23 October. In a letter to the prison the consultant oncologist noted that she used Language Line to assist the consultation and went on to say that he was: "... now very frail and has deteriorated considerably since I last saw him". The oncologist noted that she was certain he was anaemic. She wanted him to have a blood test and she suggested to him that he should be admitted so he could receive a blood transfusion. He declined to be admitted as he wanted to return to the prison as his family were visiting. The oncologist went on to say that it would be prudent to repatriate the man as soon as possible as it was likely that he would soon be unfit to travel. The consultant oncologist subsequently wrote a further letter to Peterborough to say that in the event that he suffered a cardiac arrest, it would be futile and inappropriate to try to resuscitate him.
61. The man agreed to return to hospital the following day and agreed to receive a blood transfusion. He was discharged back to prison on the afternoon of 25 October.
62. On 28 October, the Ministry of Justice wrote to inform the man that the UK and Lithuanian authorities had both given their approval for his repatriation to his homeland to serve the remainder of his sentence. He was also informed that the Lithuanian authorities had indicated that he was likely to be compassionately released once repatriated.
63. Peterborough made arrangements to transfer the man to HMP Wandsworth, taking him closer to Heathrow airport for his flight to be arranged and the repatriation papers finalised. On the afternoon of 1 November, Peterborough's healthcare manager made separate telephone calls to Wandsworth's clinical lead nurse and Wandsworth's duty Governor to finalise arrangements for the transfer. The plan was for him to transfer on 2 November. Unfortunately, his condition deteriorated and he became too ill to be transferred to Wandsworth.
64. An entry in the man's records made on 4 November said that he had remained in bed all day and seemed to be in a lot of pain. His condition continued to deteriorate and on the morning of 8 November he was transferred to hospital as the prison was no longer able to control his pain. He died in hospital the following day. His family were with him when he died.
65. Peterborough offered the man's mother assistance with the funeral expenses.
66. My investigator was told that the prison held a hot debrief for the staff who had cared for the man. However, when the clinical review panel requested a copy of the minutes of the debrief, none could be located. Representatives from Samaritans visited healthcare to speak to the prisoners there.

ISSUES

The diagnosis of secondary spread of cancer

67. The man did not disclose his past history of colonic cancer on his initial arrival into Peterborough on 27 January 2009, but did so at a follow-up healthcare assessment with Prison Doctor A five days later. He added that in Lithuania, he had follow-up checks every three months. Following the consultation the doctor wrote to the local NHS oncology department asking for the man to be reviewed. The oncology department's response was to advise that the man should have an annual CT scan and a colonoscopy examination every three to five years. The clinical reviewer has confirmed that this practice is consistent with UK policy for bowel cancer.
68. Over the following months the man suffered a number of clinical conditions. He developed an irritation of the stomach and his symptoms included vomiting blood. However, examinations revealed minor irritation of the stomach only and he was treated with antacid. He also reported lower back pain but this was related to damaged spinal discs.
69. The man also complained about loose and frequent bowel motions, but the clinical reviewer points out that that is a standard problem in patients who have undergone certain types of extensive bowel surgery. The clinical reviewer has gone on to say that there were no reasons for staff to suspect a rapid spread of the cancer until 23 June when he reported the rapid growth of a lump in his neck. The clinical reviewer has explained that the appearance of a secondary growth in the neck would be highly suggestive of more widespread cancer from the primary site. Such a spread was confirmed by scanning meaning that any treatment could only be palliative. The clinical reviewer has confirmed that the diagnosis of the secondary spread was timely and in keeping with that which would apply to all NHS patients.

The treatment of the man's cancer after diagnosis

70. Arrangements were made for the man to attend hospital for a course of radiotherapy. As already mentioned, this was for palliative care only. That is, symptomatic relief only, especially of the pain of the illness. The clinical reviewer has confirmed that this was appropriate. He has also explained that it is not usual to offer chemotherapy at this stage as the effect of such treatment is uncertain while the side effects are toxic and certain.

Pain management

71. Peterborough brought in the services of a Macmillan nurse to assist the multidisciplinary team in supporting the man. The clinical reviewer has confirmed that the provision of pain relief in situations such as with the man follows a standard rising level in the potency of drugs. He found that that these standards were largely followed with the use of a combination of anti-inflammatory drugs together with opiates and morphine syrup. As the man's condition developed, increasingly powerful drugs were used. These were

supplemented with other drugs which counteract the side effects of the pain killing drugs while also increasing their effectiveness. The clinical reviewer has confirmed that the prescribing decisions were appropriate.

72. However, there were some problems with the administration of the medication. The man complained several times about delays in receipt of medication and it is also clear that there were times when he experienced a great deal of breakthrough pain. The clinical reviewer points out that the use of opiate medication in a standard prison setting is fraught with difficulties. Staff made concerted attempts to try to persuade the man to move to the healthcare unit, but for a period of time he was resistant to this. His reasons in part would seem to have been the restrictions on smoking in healthcare. (Prisoners are permitted to smoke in cells on standard prison wings. However, smoking in healthcare cells is not permitted as clinical staff are required to spend time in these cells when delivering care.) Another possible reason was because there seem to have been at least two other prisoners on his main landing who spoke his language, while there were presumably none who did so in healthcare.
73. The clinical reviewer confirms that the man's pain management improved significantly once he had moved to healthcare in early September. The clinical reviewer has made a recommendation in this area, which I endorse. The problem of access to medication when outside the healthcare wing is likely to recur, especially when potent opium like drugs are used or for medications where accurate timing is crucial for their effect:

I recommend that when patients are being managed on standard wings, frequent audit of timings of administration of potent and time critical drugs should be conducted and reported to the prison clinical governance group for follow up action

Psychological counselling

74. My investigator asked the clinical reviewer to comment on the man's mother's remark that her son should have received psychological counselling. The clinical reviewer explained that routine counselling in terminal illness does not occur in the United Kingdom. Such support will be provided only in the case of a request being made by the patient, and if supported by the multi-disciplinary team caring for the patient. I am satisfied that he was supported properly by prison and healthcare staff.

The use of translation services

75. The man spoke very little English. His records at Peterborough show that the clinicians there made extensive use of translation services during their consultations. Most regularly, they used a telephone interpretation service, but at other consultations he was accompanied by another prisoner who spoke the same language, as well as English. His records were noted to confirm that he was content for the prison to use a prisoner as interpreter. I am satisfied that Peterborough took appropriate steps to deal with his English language difficulties.

76. When one of the prison doctor's first referred the man to the local district hospital he explained in his letter that translation services would probably be needed during any consultations. However, the district hospital appears to have made little use of such services. The clear implication of this is that the man might not have always understood his treatment options.
77. Care provided to prisoners at outside NHS hospitals falls outside of my remit. I am nevertheless inclined to signal my disappointment if the man's care was compromised through a failure by the hospital to access translation services. The clinical reviewer has made a recommendation to the district hospital on this matter.

Contact with the man's family

78. As it was becoming clearer that the man would not live for more than a few more months, Peterborough contacted his mother in Lithuania. She then came to the UK with other family members to spend time with her son and Peterborough arranged for her to visit him for two hours every day. I consider this an example of good practice.

Arrangements for the man's extradition

79. Lithuania is one of the countries with which the UK has reciprocal arrangements allowing convicted prisoners to return to their homelands to serve their sentence. Prisoners do not have a guaranteed entitlement to extradition; instead both countries have to agree in the particular case under consideration. Such agreement was granted in this case and, by the end of October, arrangements were well advanced. The man was due to be transferred to HMP Wandsworth on 2 November ahead of the finalisation of his flight arrangements. Unfortunately, the man suffered a sudden deterioration in health making him too ill for the transfer. His condition continued to decline so extradition never again became an option.

Post incident support for staff

80. My investigator was told that the prison held a hot debrief for the staff who had cared for the man and the clinical reviewer was assured that debriefs are always carried out following a death. However, when the clinical review panel requested the minutes of any debriefs following his death, none could be located. The Director and Head of Healthcare will wish to reassure themselves that clear records are always made of hot and cold debriefs, out of which the clinical governance team identify patient care issues and staff learning needs as appropriate.

CONCLUSION

81. The man was a 36 years old and died from secondary spread of cancer of the colon. His diagnosis and treatment were in accordance with how his condition is generally treated in the UK. There were some problems in the management of the man's pain, but this was mainly due to problems associated with the management of extensive pain for prisoners on a standard prison wing –he preferred to remain on a standard wing and for a long time was resistant to transfer to healthcare. I am pleased that steps were taken to try to repatriate him to his homeland but a rapid deterioration in his condition prevented this from happening.

RECOMMENDATIONS

The clinical review panel made two recommendations to the prison which are contained in their report. I include these below together with the response from the Service:

1. I recommend that when patients are being managed on standard wings, frequent audit of timings of administration of potent and time critical drugs should be conducted and reported to the prison clinical governance group for follow up action.

Response from Service: Recommendation accepted and implemented. Those requiring potent and time critical drugs will be located in the healthcare centre as in-patients.

2. Clear records of hot and cold debriefs should be held. The cold debrief in particular should be reviewed by the clinical governance team at the prison to identify patient care issues and develop learning from them.

Response from Service: Recommendation accepted. This has already been addressed and forms part of the clinical governance team meeting.

The review panel also made a recommendation to the hospital.

GOOD PRACTICE

1. Peterborough made early contact with the man's mother in Lithuania when it became apparent that he did not have long to live. When she came to the UK Peterborough arranged for her to visit her son for two hours every day. I consider this an example of good practice.

RESPONSE TO DRAFT REPORT FROM THE MAN'S FAMILY

In response to the draft report the man's family provided several pages of comment.

The family's main concern was about the provision of pain relief. In letters to his family he mentioned many times that he was in pain and that medication was either not helping, or it had been stopped or missed.

The family considered that it was degrading for him to be handcuffed to escorting prison officers while he was a hospital in-patient.

The family also considered that the arrangements for his repatriation to Lithuania had "dragged for a long time".

The family had a number of positive comments to make. They signalled their recognition of the support and assistance provided by some clinical and non clinical staff. They were grateful about being in good time that he did not have long to live and this allowed them to be with him at the end. They were also grateful that a priest was called to deliver the Last Rites.