Investigation into the circumstances surrounding the death of a man HMP Peterborough in 2006

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is a report into the circumstances of the death of a man at HMP Peterborough on 1 May 2006. The man was 38 years old, and died in the prison's healthcare unit shortly after being moved there from his residential wing where he had complained of feeling unwell. Post mortem examination revealed that the man died of acute pneumonia as a direct result of 'crack lung'.

I offer my sincere condolences to the man's family and friends on their very sudden and sad loss.

The investigation was conducted by one of my investigators. She and I would like to thank the Director of HMP Peterborough, and his staff for their help and assistance in this investigation. We are also grateful to the Family Liaison Officer with Cambridgeshire Constabulary, and to the Peterborough Primary Care Trust Incident Investigation Team for their detailed and thorough clinical review into the man's death. I must apologise for the delay in producing this report. However, the clinical reviews were only concluded in January 2007 and I felt it right to wait for them before issuing my findings.

I make15 recommendations, incorporating those made by the clinical reviews. I also propose to share this report with the Independent Police Complaints Commission to enable them to consider if further investigation is required into the management of the man's arrest and detention after his probation officer had his licence revoked.

Acute pneumonia is one of the potential complications of long-term crack cocaine smoking. I understand that the optimum treatment in the man's case would have been corticosteroids. However, neither of the two doctors who saw the man on 28 and 30 April chose to treat him with steroids. Whether the man would have survived had he been treated in this way is necessarily speculative. Nevertheless, I agree with the clinical review panel that all doctors treating those who take crack cocaine should familiarise themselves with the possible complications of prolonged cocaine abuse and how these complications should be managed. Given the number of prisoners with a history of abuse of crack cocaine, this is an issue of wider significance that I draw to the attention of Prison Health.

In this final report four recommendations have been partially accepted and six recommendations accepted in regard of healthcare issues. Peterborough Prison has accepted one recommendation and the Cambridgeshire and Peterborough Mental Health Partnership have accepted two recommendations. The Police Complaints Commission did not implement an investigation into the man's arrest and detention. One point of good practice has been accepted.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

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SUMMARY

The man died on 1 May 2006 in the healthcare unit at HMP Peterborough. On 20 December 2005, the man had been released on licence from Peterborough. Less than three weeks later, on 6 January 2006, he was received back into Peterborough after being remanded by a Magistrates' Court. The man was released on 3 February after sentencing when he was punished with a fine.

In February, the man was sectioned under section 3 of the Mental Health Act 1983, to a hospital. Cambridgeshire Probation Area was unaware that the man had been sectioned. Indeed, when the man failed to attend his supervision sessions with his probation officer, an application was made for revocation of his licence on 10 March. It seems that this was done without fully checking the reasons behind his non-attendance.

On 23 April, the man absconded from hospital. Two days later, he walked into a Police Station in Cambridge and, because of the licence revocation, was returned to custody at Peterborough.

The clinical review commissioned as part of this investigation found that the man commenced antibiotics on 28 April 2006, although the prescribing doctor did not write anything in the medical record. In the early morning of 30 April, the man was assessed by healthcare staff. It was reported that he was having an asthma attack. A member of healthcare staff went to see the man in his cell, and subsequently made an entry in his medical record that he was breathing normally. Later that day, he was examined by the medical officer and prescribed medication for his breathing.

At 11.15am on 1 May, the man was seen by another nurse. His observations were taken and it was recorded that he was coughing. After seeing the nurse, the man went to the gym, but after only a few minutes of playing football became breathless and stopped. He borrowed a friend's inhaler and then went back to the wing and asked to go to healthcare. He did not move to healthcare at this time, but did see a nurse at 12.15 pm when he was issued with his prescribed medication. The man told the nurse he felt fine. At 1.30 pm, a Prison Custody Officer (PCO) unlocked the man's cell for afternoon movements. The PCO saw that the man was breathless and looked unwell.

At around 1.55 pm, the man was taken to the healthcare centre as he was breathless and sweating. He was given paracetamol and some antibiotics. After some persuasion, he agreed to be admitted as a patient. The man requested a Listener (a prisoner trained by the Samaritans to offer support to their peers). The Listener arrived to sit with the man in his cell and spent the next hour and a half with him.

At about 3.15pm, the man collapsed in front of the Listener who immediately sought out staff to alert them to what had happened. Healthcare staff attended and started cardio pulmonary resuscitation. An emergency ambulance was called, and on arrival the paramedics took charge of the resuscitation efforts. At 3.53pm, despite the best efforts of all concerned, the man was pronounced dead.

My investigation has revealed a significant number of shortcomings in the care and treatment of the man.

The man should have been returned to hospital on 25 April after walking into the Police Station. I have asked the Independent Police Complaints Commission (IPPC) to consider whether they should investigate why Cambridgeshire Police took the man to HMP Peterborough instead of returning him to hospital. Thereafter, staff at Peterborough also failed to arrange a transfer for the man as they should have done.

It would appear that the man must have complained of feeling unwell with pneumonia-like symptoms on 28 April 2006, as he was prescribed antibiotics. However, the prescribing doctor failed to make any entry in the man's medical records. By the morning of 1 May, his condition had not improved. He was seen again by a nurse and at 1.55 pm arrived in healthcare looking unwell, breathless and sweating.

The man was most likely suffering from a condition known as 'crack lung'. Crack lung is a serious condition that affects people who are long term crack cocaine users. The condition is not easily detectable unless the patient reports their crack habits. If pneumonia-like symptoms are not treated properly, they can lead to death. Treatment is with corticosteroids. Medical staff at the prison seemed unaware both of the condition and of the appropriate treatment.

I have recommended that Prison Health give consideration to training and/or advice to all professionals about the range of conditions, complications and treatments that may affect substance misusers. I also make recommendations concerning the quality of the medical record entries at Peterborough and urge the introduction of a national electronic healthcare records system.

THE INVESTIGATION PROCESS

On 5 May 2006, my colleague, visited HMP Peterborough. My colleague met with the Director. The Director outlined the circumstances of the man's death. (At the time of this meeting, the cause of death was unknown.) Notices and terms of reference were handed to the Director, to informing both staff and prisoners of the Ombudsman's investigation.

Later that day, my colleague met with a Detective Inspector and a Detective Sergeant of Cambridgeshire Constabulary. The Inspector told my colleague that the police would be taking statements from staff and prisoners who had contact with the man on the day of his death.

My colleague spoke to the Prison Service Union (PSU) representative and a representative from the Independent Monitoring Board (IMB), to inform them of the nature and scope of the investigation. My colleague also reviewed all the man's prison records and requested copies for the investigation. On 26 June, my colleague received a photocopy of the man's current file and medical notes from Cambridgeshire Police.

On 4 July, following the completion of enquiries by Cambridgeshire Police, my colleague again visited Peterborough to arrange interviews with prisoners and staff. On 10 and 11 July, my colleague carried out interviews with prison and healthcare staff.

On 14 February 2007, my colleague re-visited Peterborough and spoke to a nurse and collected statements from staff involved in the attempted resuscitation of the man.

One of my Family Liaison Officers wrote to the man's family informing them of the investigation and inviting them to participate in the process and identify any concerns they might have about the care their brother received. The family has declined to engage with my office to date.

A clinical review of the man's medical care was carried out by Peterborough Primary Care Trust (PCT). A panel of managers, including the medical director of the PCT, reviewed the man's clinical interventions whilst in custody. My colleague and my Deputy Ombudsman were invited to be part of this process, and the Deputy Ombudsman attended two panel meetings held to discuss the findings and conclusions of the review. The review findings have been incorporated in this report. A further report was undertaken by Cambridgeshire and Peterborough Mental Health Partnership National Health Trust.

HMP PETERBOROUGH

Peterborough is a privately-managed prison run by Kalyx (formerly known as 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. Healthcare is provided by the Greater Peterborough Primary Care Partnership through a service level agreement. There are separate healthcare facilities for male and female prisoners. The male healthcare centre has capacity for 13 inpatients.

Peterborough's first and only inspection by Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, was in September 2006. Her report has yet to be published and I am therefore unable to comment on any relevant findings of the inspection team.

The death of the man was the second death from apparently natural causes to have occurred at Peterborough since its opening. After the investigation into the previous death, I made seven recommendations, four relating to healthcare and three for prison management. There are no similarities in the findings of that earlier report with the death of the man.

KEY EVENTS

On 25 April 2006, the man walked into a Police Station in Cambridge. Because of the licence revocation, the police arranged for the man to be transferred to HMP Peterborough later that day. It is not recorded on his prison file why he was taken to Peterborough instead of being returned to hospital. His sectioning under the Mental Health Act should have taken precedence, and the man should have been taken directly to hospital.

A first reception health screen form was completed by a nurse on the man's arrival at Peterborough. His medication regime was later confirmed by phone with staff at the hospital. The man said he was 'using drugs', but declined to supply a urine sample for drug screening or give further information about the degree of his substance misuse. He told the nurse that he had no concerns about his physical health. The screening identified that the man had a history of self harming, albeit in a minor way. It was also noted that the man was prescribed inhalers for his asthma. The assessment recorded that he should see a doctor.

There is no entry in the man's medical notes to indicate that he saw a doctor following his reception, although he was prescribed the medication for his mental health problems and inhalers for his asthma. There is no evidence of further enquiries or applications for the man to be returned to hospital in his medical record. However, the Cambridgeshire and Peterborough MHP Trust report indicates that a Prison Custody Officer (PCO) rang the hospital on 26 April to request that the man be transferred back to hospital. The hospital was asked to provide an ambulance for 1.00 pm. The PCO reported that the man's mood was good and that he had been no problem. He had apparently admitted to using crack cocaine whilst being unlawfully at large. Later that day, the hospital was apparently rung back by someone in the prison and told that the man would not be transferred after all, although no reason was given. Enquiries at Peterborough have been made to trace the PCO . It seems very unlikely that a PCO would have set about making transfer arrangements for a prisoner and it is believed that the PCO may have been a member of the mental health in-reach team. This person has since left Peterborough.

On 1 May, the man was seen in his cell at 11.15am by a nurse. He was complaining of a cough and chest pain. On examination, his chest was apparently clear. No wheeze was heard, but a cough was noted. The man used his inhaler, said he felt better and then decided to go to the gym.

On arrival at the gym, the man played football for a few minutes and then started to become breathless. A friend and fellow prisoner, was also playing football and saw the man struggling with his breathing. He offered the man his inhaler, and told him to ask to go to healthcare. The man returned to his wing where he saw a PCO. The man asked the PCO if he could be taken to healthcare. The PCO told the man that he had seen the nurse less than an hour previously and, after seeing her, he had gone to the gym. The PCO then saw the man splashing water onto his face from a cup. He felt that the man did not need to go to healthcare at that time.

At 12.15pm, the man was again seen by a nurse when she was giving him his medication. He told the nurse he was feeling fine and took his medication. The man was in his cell over the lunchtime period and the PCO did not see whether he actually ate any lunch. At 1.30pm, the PCO went to the man's cell to unlock for afternoon movements. He saw the man was breathless and looked unwell and arranged for him to be taken to the healthcare centre.

At 1.55pm, the man was seen in the healthcare centre. He was complaining of feeling hot, breathless and lacking sleep. On examination by a nurse, he was noted to be sweating. She took his observations and suggested that the man stay in healthcare. He was reluctant to do so, saying he needed his tobacco from his cell. At 2.20pm, the man agreed to be admitted but asked to speak to a Listener. (A Listener is a prisoner trained by the Samaritans to support prisoners in times of crisis.) the man was also given his previously prescribed paracetamol. The medical notes end by noting, 'Doctor to review tomorrow.' The man was located in cell 1 and a Listener was requested.

The Listener, arrived in healthcare very shortly afterwards. The Listener knew the man previously and they sat on the bed and talked. The Listener saw that the man was breathing heavily, sweating, and generally looking unwell.

At 3.10 pm, a nurse attended the cell and thought the man was having a panic attack. The nurse offered the man a brown paper bag to breathe into to help him control his breathing. (There is no record of this intervention in the man's medical notes. The nurse offered this information in a statement very shortly after the man's death.) After a short while, the man's breathing returned to normal and he told the nurse he felt better. When the nurse left the cell, the Listener was still sitting talking with the man.

A short while later, the Listener noticed the man's speech pattern became confused. He subsequently described him as speaking with a very strong Caribbean accent and then becoming incoherent. The Listener then saw the man slump onto his side on the bed. He immediately left the cell and called for help.

A nurse was walking near to the cell at about 3.20pm when she was called by the Listener. On entering the cell, she saw the man lying on the side of the bed. The nurse left the cell and called for extra help. The nurse responded to this call and two nurses entered the man's cell. one of the nurses checked the man for a response. The nurse noted that his pupils were fixed and dilated and that he did not respond when she called his name. The nurse asked the second nurse to call for an ambulance over her radio. The second nurse radioed the communications room to request an emergency ambulance. The nurses then moved the man onto his back. Having done so, the nurses both saw that the man had red fluid coming from his nose and that he had stopped breathing. The first nurse started chest compressions and the second nurse went to fetch oxygen. A third nurse arrived at the cell and took over the chest compressions, whilst the first nurse placed an airway in the man's mouth and administered oxygen. The first nurse requested an electrocardiogram (ECG) machine to try and get a heart reading.

At 3.30pm, the ECG machine was brought to the cell, arriving moments before the first ambulance crew. A second ambulance crew arrived two minutes later. The paramedics took over the resuscitation attempts at this stage. Sadly, it became clear that resuscitation would not be successful and the paramedics pronounced the man dead at 3.53 pm.

A member of Peterborough's chaplaincy, together with a senior manager, visited the man's brother at his home to tell him what had happened. The prison offered financial assistance towards the cost of the man's funeral.

ISSUES

The man's death was initially the subject of a police enquiry. Those enquiries were completed in July 2006. The police concluded that there was no criminality or third person involvement in the man's death. This enabled my investigator to commence the investigation on behalf of my office.

The clinical review

A report into the circumstances surrounding the man's medical care has been provided by the Peterborough Primary Care Trust Incident Investigation Team. This team was drawn from senior managers within the Primary Care Trust (PCT).

The team reviewed documentation from all of the man's medical notes. Statements were also taken from the doctor providing care and treatment for the man whilst he was in HMP Peterborough. This was further underpinned by a discussion and review of mental health records with the Director of Cambridgeshire and Peterborough Mental Health Trust. The team also considered extensive research into the condition known as 'crack lung'. A chronology of events leading to the man's death forms the basis of their report. The findings of the investigation focus on his previous physical and mental health status and the events preceding and following his death. Jointly, our investigations consider the following areas:

- The man's detention
- Healthcare reception screening procedures
- Healthcare records and entries on the man's medical notes
- Diversity
- Treatment of the man's pneumonia and the condition known as 'crack lung'
- Efforts to resuscitate the man
- Following the death of the man

A report by the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust has been included following the clinical review panel's observations and findings.

The man's detention

The man walked into a Police Station Cambridge on 25 April 2006. At 12.30pm, someone from the police rang staff at a hospital to tell them that the man was in police custody and that they would be transferring him to HMP Peterborough later that day.

The police were apparently unwilling to give information to hospital staff about why the man was being transferred to prison. In turn, the hospital staff informed police that he was a detained patient under a section of the Mental Health Act 1983. This should have meant that the man was taken directly to hospital, not to HMP Peterborough, notwithstanding the licence revocation and recall notice. In fact, the man was taken to Peterborough later that day.

The following day (26 April), a staff member at the prison rang the hospital to tell them they wanted to transfer the man back to the hospital. However, during the course of the afternoon, someone else at the prison rang the hospital to say the man was going to stay at Peterborough. No explanation was given for this decision.

My investigator has tried to find out who made these telephone calls at Peterborough, but no clear records exist. A member of the mental health team who may have telephoned the hospital that morning has subsequently left the prison.

It is noted in the clinical review that the man's transfer back to hospital should have taken place within 24 to 48 hours of his arrival into Peterborough. The clinical review says this did not take place as the man's bed had been allocated to another patient and there was no capacity to re-admit him to hospital. However, there is no evidence that this was the case from reading the man's prison core file or his medical record, nor in the report from Cambridgeshire Mental Health Partnership. I am therefore unclear where this information is sourced.

My investigator made contact with the Mental Health Unit (MHU) based within the Home Office. The Mental Health Unit manage and co-ordinate the transfer of all prisoners to and from psychiatric hospitals. MHU had no documentation in relation to the man or any request for a transfer to hospital.

The report by the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust says, "Between the man's detention, and his death on 1 May, there is a lack of clarity as to why he was not transferred to hospital following his reception into Peterborough. It is also unknown why Cambridgeshire Police did not ascertain the correct protocol in terms of the man's absence under the Mental Health Act 1983."

The report goes on to say that, "On 1 May, the ward was informed by the patient's brother that he had died from what was being perceived as a severe asthma attack. On 2 May, the Charge Nurse the ward contacted Peterborough requesting further information on the patient's death and also reiterating that he had remained under a section of the Mental Health Act 1983. A fax was subsequently sent on 2 May, again seeking further information, which was not forthcoming. However, information was made available to the Prison In-Reach Team which was communicated to the Cambridge Locality through the Area Director."

There are two recommendations arising from the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust report which I endorse:

The report should be reviewed at the Adult Mental Health Executive and the Clinical Risk and Safety Group.

Communication pathways between Mental Health Services in Cambridgeshire and the Probation Service should be reviewed.

I am concerned about the apparent failure of both Cambridgeshire Police and Peterborough prison to act appropriately in detaining a patient sectioned under the

Mental Health Act. Whilst it has no direct bearing on the death of the man, in other circumstances it could be critical. I propose to share my report with the Independent Police Complaints Commission, inviting them to consider reviewing the actions of Cambridgeshire Police. I also ask HMP Peterborough to provide written advice and guidance to the healthcare professionals working there as to their responsibilities and duties in respect of patients sectioned under the Mental Health Act. This should include clear guidance about documenting all conversations and decisions made.

The Independent Police Complaints Commission should be invited to review the actions of Cambridgeshire Police in relation to the man's return to prison as opposed to hospital.

Healthcare staff at HMP Peterborough should be given written advice and guidance about their responsibilities and duties in respect of patients sectioned under the Mental Health Act.

Healthcare reception screening procedures

The clinical review team felt that the initial screening form for the man was completed adequately and noted that the man was misusing illicit substances. The form recorded his past medical history. Whilst staff quickly established his current medication by contacting staff at the hospital, this was not confirmed or followed up in writing.

Where prisoners' current medication needs are obtained by telephone from an external health provider, written confirmation should be requested.

The clinical review identified the importance of obtaining an accurate picture of substance misuse, and felt that the reception health screen form did not encourage a meaningful dialogue between the healthcare professional and the man. This was felt to be because of an over reliance on 'yes' or 'no' answers. The man did not give a detailed history of his previous drug use, asthma or use of inhalers, but admitted to currently using drugs. The team makes the suggestion that the form may need re-viewing to ensure meaningful dialogue between the history taker and the prisoner.

Declared substance misuse must be documented in full, listing the substances used and frequency/length of time taken. For current users, this should be confirmed with the detoxification doctor within 24 hours of admission. For ex-users of substances, this information should be clarified at a later appointment if not captured at the reception interview.

The man responded to questions raised in his healthscreen document that pointed towards the need for him to see a doctor as soon as possible following his reception. There is no documentary evidence in his medical notes to indicate that the man saw a doctor within 24 hours of his reception, or that he was referred for detoxification.

A referral to see a doctor during the first reception healthscreen must be followed up, and the consultation recorded in the patient's medical record within 24 hours.

Healthcare records and entries

The healthcare team ensured all the records they held were photocopied before the original set was sent to the Coroner. The entries on the man's medical notes were examined by the Acting Medical Director for Peterborough PCT. The acting medical director found that the records were frequently incomplete, rarely signed or in chronological order. The disjointed nature of the records made identification of the man's physical and mental healthcare needs difficult and time consuming. Missing information reduced and may have prevented doctors and other healthcare professionals from making an accurate diagnosis and appropriate treatment decisions. The acting medical director felt that the Prison Service would benefit from an electronic records system which could be readily accessed by any healthcare professional. The acting medical director suggested an annual audit of medical record entries made by nursing staff, doctors and other healthcare professionals. This would ensure the prison was in line with PCT procedures.

The reception health screen forms just one part of the reception process. A multi-disciplinary computerised electronic record system is currently under development. This should reduce duplication of effort and provide easy-to-access information for discipline and healthcare staff. I welcome this initiative.

A national electronic healthcare records system, capable of linking to NPfIT and the National Offender Management Information System (NOMIS) should be introduced as a matter of priority to ensure effective communication and continuity of care.

The Head of Healthcare should carry out an annual audit of medical record entries made by doctors, nurses and other healthcare professionals.

The Head of Healthcare should remind healthcare staff of their professional responsibility to ensure appropriate standards of record keeping are maintained, in accordance with the standards laid down by their professional bodies. All consultations with a doctor or other healthcare professional must be recorded in the inmate medical record with the time, date, name and signature of the person.

Diversity

A friend of the man's, told my investigator that he heard the man ask a PCO to be taken to healthcare when he arrived back on the wing from the gym on 1 May. The friend said the man was upset and distressed at this time and obviously unwell. The friend felt that the PCO had ignored the man's requests and was unfamiliar with recognising how ill he looked in relation to his race. The friend declined to offer any more information and only wished to say it was around cultural issues.

My investigator spoke to the PCO in reference to the man's request to see healthcare before lunch on 1 May. The PCO told my investigator that he did not think it appropriate to send for healthcare again as the man had been seen by a nurse only one hour before. The man had then gone to the gym following that consultation. There was no evidence in the interview with the PCO that any

inappropriate considerations affected his decision in not calling for healthcare staff to attend to the man. He had been examined by a nurse earlier that morning and had then elected to go to the gym. The man had also seen by a nurse at lunchtime when she had given him his medication. The PCO had been observing the man after his return from the gym, and was instrumental in sending him to healthcare after afternoon unlock.

Peterborough has a published diversity policy which is comprehensive and available to all staff. All PCOs and auxiliary staff receive diversity training as part of their initial training course, although for staff such as administrative grades it is not compulsory. There is no evidence that the man raised a complaint about a race related incident when he returned from the gym on the day of his death.

Whilst the man's friend indicated that the PCO's decision was racially motivated, I am satisfied that the PCO acted appropriately. I do not judge that the PCO's actions were influenced by any perceived race, diversity or cultural prejudice.

Treatment of the man's pneumonia and the condition known as 'crack lung'.

The acting medical director reviewed the man's medical intervention in regard to his treatment of pneumonia. The man was prescribed antibiotic treatment (amoxicillin) on 28 April 2006. However, the prescribing doctor did not write up his consultation or this medication in the man's medical notes. His treatment and symptoms were later reviewed by a different doctor on 30 April. Neither doctor seemed fully to appreciate the danger of acute pneumonia in a long-term crack cocaine smoker or that the optimum treatment was with corticosteroids.

The clinical review team identified that the man suffered from periods of breathlessness, relieved by the use of prescribed respiratory inhalers. However, the symptoms and observations recorded did not fit the profile for asthma. The lung damage noted at the post mortem was consistent with damage documented in published research papers for a condition known as 'crack lung'. Crack lung can occur following a prolonged period of cocaine and tobacco use.

Crack cocaine can cause patients to become critically ill with symptoms similar to those of pneumonia. However, although patients give outward signs of suffering from pneumonia, most do not respond to antibiotics or other standard pneumonia treatments. However, they can be successfully treated with corticosteroids (anti-inflammatory drugs).

It is of concern that, although the man admitted to regularly smoking crack cocaine, cannabis and tobacco, there was no direct reference to this in the medical record on any of the occasions that the man complained of breathlessness or chest pain. It is assumed, therefore, that the clinicians were not aware of any possible connection.

Whether the man would have survived had he been treated with steroids is speculative, but best practice would have been served had he been so treated. All doctors dealing with crack cocaine users should familiarise themselves with the possible complications of cocaine abuse and how they should be treated in the event of respiratory problems.

The clinical review team felt that prison doctors and healthcare professionals require specialist knowledge to enable appropriate detection, diagnosis and treatments of condition specifically associated with drug and alcohol misuse.

Prison Health should consider providing additional training or written advice and guidance to all prison healthcare professionals detailing the range of conditions, complications and treatments available that are relevant to patients who are substance misusers.

Efforts to resuscitate the man

Healthcare staff showed good clinical judgement by keeping the man under observation when he arrived in the healthcare centre on the afternoon of 1 May. At the time, the centre was staffed by qualified nurses and healthcare assistants. All staff on duty were up to date with basic life support training.

The acting medical director advised the investigation team that the resuscitation actions after the man's collapse were exemplary. Support from PCOs and the communications officer in accurately requesting a Cardiac Arrest Ambulance, and ensuring rapid admittance for the paramedic teams, is to be commended.

Healthcare and communications staff on duty at the time of the man's collapse should be commended by the Director for their professionalism in responding to the emergency.

In response to questions identified during the investigation, the acting medical director confirmed that ECG readings taken before, during and after a cardiac arrest can provide additional information for patient care, or for the Coroner in the event of death. An ECG trace should be attempted, where possible, but this would not take precedence over the resuscitation action immediately necessary to sustain life.

Healthcare staff should be proactive in achieving electrocardiogram (ECG) trace readings during a cardiac arrest. This information should be included in emergency protocols and Basic Life Support/ Cardiac Pulmonary Resuscitation training.

Events following the man's death

Relevant staff were encouraged to complete statements to record their actions as soon as possible following confirmation of the man's death. These statements enabled the investigation team to capture an accurate timeline of what had occurred during the afternoon of 1 May.

A 'hot' de-briefing session was held involving discipline and healthcare staff.

Ambulance staff and paramedics are required to complete a Patient Report Form at the conclusion of every call attendance. On this occasion, prison healthcare staff were concerned to be asked questions by the paramedic team in what they felt was an interrogative style. The clinical review proposed that both parties should meet in

order to facilitate a closer understanding of organisational procedures and the prison environment.

Prison healthcare staff and paramedic staff should arrange a meeting in order to share the experience of working in prisons and emergency call attendance. This should include sharing of documentation and national requirements.

Both the man's friend and the Listener, spoke to my colleague of their regret that a memorial service had not been held at Peterborough for the man.

Prison Service Order 2710, Follow up to Deaths in Custody, Chapter 5 sub section 5 indicates, "The chaplaincy team and, in particular, the chaplain from the faith tradition of the prisoner must always offer support to, and pray with prisoners and staff. This will include holding a memorial service for the deceased's family, prisoners and staff subject to any faith considerations and the views of the family, staff and prisoners."

The Listener was aware that a short service of prayers and reflection had been held in healthcare the day following the man's death. This service was not open to all prisoners. It is noted from his prison file that he was a Muslim. A non-denominational memorial service, held in the chapel, would have been appropriate following the man's death so that all his friends in the prison could have paid their respects.

After the death of a prisoner, the chaplaincy team should ensure that prisoners are offered support and should, where appropriate, hold a memorial service for the prisoner as outlined in Prison Service Order 2710.

RECOMMENDATIONS AND GOOD PRACTICE

For Peterborough PCT, providers of healthcare at HMP Peterborough:

1. Where prisoners' current medication needs are obtained by telephone from an external health provider, written confirmation should be requested.

Accepted. This is good practice. Difficulties may occur when the information is then not faxed through as requested.

2. Declared substance misuse must be documented in full, listing the substances used and frequency/length of time taken. For current users, this should be confirmed with the detoxification doctor within 24 hours of admission. For ex-users of substances, this information should be clarified at a later appointment if not captured at the reception interview.

Partially accepted. Prisoners are always screened for substance misuse at reception and asked about previous and current substance misuse. However, very few members of staff have enough substance misuse knowledge to do more than record a brief account of their substance misuse history.
For some ex-users it may not be clinically significant to collect a complete and detailed account of previous drug use. It is not always practical to confirm current substitute prescribing within 24 hours as external drug agencies only work Monday to Friday, but as with Recommendation 1 we will ensure that written confirmation is requested.

3. A referral to see a doctor during the first reception healthscreen must be followed up, and recorded in the patient's medical record within 24 hours.

Accepted. This is standard practice.

4. Healthcare staff at HMP Peterborough should be given written advice and guidance about their responsibilities and duties in respect of patients sectioned under the Mental Health Act.

Accepted. Some training and information would be helpful for healthcare staff who are not mental health trained (which is most of them), Head of Healthcare to raise this with Mental health In reach Service

5. The Head of Healthcare should carry out an annual audit of medical record entries made by doctors, nurses and other healthcare professionals.

Accepted. Head of healthcare will, having discussed the audit criteria with PCT colleagues, carry out an annual audit.

6. The Head of Healthcare should remind healthcare staff of their professional responsibility to ensure appropriate standards of record keeping are maintained, in accordance with the standards laid down by their professional bodies. All consultations with a doctor or other healthcare professional must

be recorded in the inmate medical record with the time, date, name and signature of the person.

Accepted. This is done, but needs to be continually reiterated. A clinical IT system is now in place so signing and dating is not an issue. The record automatically records the date, time and name of staff member.

7. Healthcare staff should be proactive in achieving electrocardiogram (ECG) trace readings during a cardiac arrest. This information should be included in emergency protocols and Basic Life Support/ Cardiac Pulmonary Resuscitation training.

Partially accepted. The defibrillator in use at the prison records but does not print out an ECG when it is used. Use of the defibrillator is included in Basic Life Support Training, which all staff have to attend.

8. Peterborough healthcare staff and paramedic staff should arrange a meeting in order to share the experience of working in prisons and emergency call attendance. This should include sharing of documentation and national requirements.

Partially accepted. The Head of Healthcare has spoken to the paramedic lead about this recommendation. Many paramedic staff are already familiar with coming in to the prison. Clarification would be welcomed about exactly what documents should be shared.

For HMP Peterborough:

9. After the death of a prisoner, the chaplaincy team should ensure that prisoners are offered support and should, where appropriate, hold a memorial service for the prisoner as outlined in Prison Service Order 2710.

Accepted. PSO 2710 should be adhered to.

For Prison Health:

10. A national electronic healthcare records system, capable of linking to NPfIT and the National Offender Management Information System (NOMIS) should be introduced as a matter of priority to ensure effective communication and continuity of care.

Accepted. This has been completed and staff are due to undertake further NPfIT training within the next few weeks.

11. Prison Health should consider providing additional training or written advice and guidance to all prison healthcare professionals detailing the range of conditions, complications and treatments available that are relevant to patients who are substance misusers.

Partially accepted. Substance Misuse is a huge area of clinical expertise and it is unrealistic to expect all staff to understand this in depth. All staff should have an awareness of these issues and there should be some staff with specialist knowledge. Relevant written advice would be welcome, but is not a substitute for experience. Head of healthcare will review in-service training.

For Cambridgeshire and Peterborough Mental Health Partnership:

12. The report should be reviewed at the Adult Mental Health Executive and the Clinical Risk and Safety Group.

The report will be taken to three management fora:

a. The Trust Healthcare Governance Committee to ensure learning is shared Trust wide.
b. The Trust Adult and Older Peoples Directorate Management Meeting.
c. The Specialist Services Management Forum.

13. Communication pathways between Mental Health Services in Cambridgeshire and the Probation Service should be reviewed.

To prevent a recurrence

The communication pathways with the local probation service have been reviewed. Meetings have taken place with the local police to ensure a shared understanding of the communication pathway between the three services, police, probation and Mental Health Trust. The recommendation is being taken forward at senior level to ensure that systems in place countrywide, within the three organisations, will facilitate effective communication in such circumstances through the use of new information technology systems.

For the Independent Police Complaints Commission:

14. The Independent Police Complaints Commission should be invited to review the actions of Cambridgeshire Police in relation to the man's return to prison as opposed to hospital.

The Independent Police Complaints Commission did not think it appropriate to review the action of Cambridgeshire Police in relation to this recommendation.

GOOD PRACTICE

1. Healthcare and communication staff on duty at the time of the man's collapse should be commended by the Director for their professionalism in responding to the emergency.

Accepted.