

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

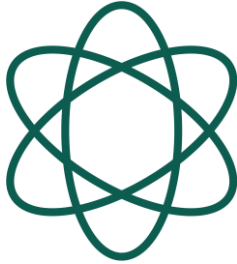
# **Independent investigation into the death of Mr Felix Petersen, a prisoner at HMP Berwyn, on 11 July 2022**

**A report by the Prisons and Probation Ombudsman**



## Our vision

To carry out independent investigations to make custody and community supervision safer and fairer



## Our values

**We are:**

**Impartial:** we do not take sides

**Respectful:** we are considerate and courteous

**Inclusive:** we value diversity

**Dedicated:** we are determined and focused

**Fair:** we are honest and act with integrity

**OGI**

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## Summary

1. The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Felix Petersen died in Wrexham Maelor Hospital on 11 July 2022 of sepsis (a life-threatening organ dysfunction caused by an infection) caused by metastatic lung cancer, while a prisoner at HMP Berwyn. He was 67 years old. We offer our condolences to Mr Petersen's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Petersen received at Berwyn was equivalent to that which he could have expected to receive in the community, with some areas exceeding this standard. He found that Mr Petersen's suspected cancer was investigated at the earliest opportunity, to ensure he could receive the appropriate treatment and care.
5. However, we were concerned to find that there were unnecessary delays to Mr Petersen's cancer treatment following diagnosis. Two hospital appointments were delayed due to failures in transporting blood tests from the prison to the hospital. While there were unavoidable issues caused by COVID-19 restrictions at the time, we found procedural problems that contributed to the delays and that should be addressed by the healthcare team.

## Recommendations

- **The Head of Healthcare should review systems for pre-treatment processes and the sending of medical samples to ensure they are fit for purpose and to prevent delays in patients accessing urgent treatment.**

## The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Petersen's clinical care at HMP Berwyn.
7. The PPO investigator investigated the non-clinical issues relating to Mr Petersen's care, including his location, the security arrangements for his hospital escorts, liaison with family and whether compassionate release was considered.
8. The PPO family liaison officer contacted Mr Petersen's family, to explain the investigation and to ask if they had any matters he wanted us to consider. The family had no questions but requested a copy of our report.
9. Mr Petersen's family received a copy of the initial report. They did not raise any factual inaccuracies of this report but pointed out some factual inaccuracies with the clinical review, which have been passed onto NHS England.
10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

## Previous deaths at HMP Berwyn

11. There were nine deaths at Berwyn in the two years leading up to Mr Petersen's death. Of the previous deaths, seven were from natural causes, one was of non-natural cause, and one was self-inflicted. There are no similarities between our findings in the investigation into Mr Petersen's death and our investigation findings for the previous deaths.

## Key Events

12. On 20 July 2021 Mr Felix Petersen was sentenced to four years custody and was sent to HMP Forest Bank. He was transferred to HMP Berwyn on 27 July 2021.
13. Mr Petersen had a long history of high blood pressure that needed regular medication and monitoring.
14. On 12 August, Mr Petersen told wing staff that he was feeling sick and dizzy. He was seen by a nurse, who referred him for further investigation of his inner ear and for a review with the prison GP.
15. A prison GP saw Mr Petersen on 18 August for a full clinical review. He noticed that Mr Petersen had a rare but concerning sign of cancer, identified by a change of shape in his fingernails (known as clubbing). He referred Mr Petersen for urgent tests including a chest X-ray for suspected cancer.
16. On 23 September, Mr Petersen's hospital appointment for a bronchoscopy was cancelled because the hospital did not have the right personal protective equipment (PPE) for escorting prison officers. Mr Petersen's appointment was scheduled during a spike in the COVID-19 pandemic, during which a bronchoscopy was considered a high-risk clinical procedure because it generates aerosols. The hospital rearranged the appointment for 30 September so that officers could be professionally fitted with the required FFP3 (face fitting) masks. The appointment was delayed further due to an administrative error at the hospital. Mr Petersen was finally seen for his bronchoscopy on 20 October, which confirmed suspected cancer.
17. On 18 November, Mr Petersen had a biopsy to confirm his diagnosis and to identify a treatment pathway.
18. On 18 November, Mr Petersen was told by a prison GP that tests had confirmed he had a type of lung cancer. The GP shared with Mr Petersen that his cancer could be treated but not cured. Mr Petersen said that he did not want surgery and at an appointment on 25 November he was referred to the oncology specialist team to plan his treatment.
19. On 9 December, Mr Petersen had a routine COVID test before a chemotherapy session, and the result was positive.
20. On 10 December, prison staff told the healthcare team that Mr Petersen was short of breath. Mr Petersen said he had accidentally taken a dose of his codeine medication earlier than it was due. A nurse took Mr Petersen's observations and found that his pulse rate was slightly raised, so a referral was made to the prison doctor. The healthcare team was satisfied that the overdose was not intentional, and that Mr Petersen understood the risks and was not trying to harm himself. They followed the prison doctor's guidance to monitor Mr Petersen's observations throughout the day. No concerns were raised.
21. On 24 December, Mr Petersen moved into a single cell to ensure his care needs could be met. Healthcare put a care plan in place to ensure that arrangements were reviewed daily.

22. On 5 January 2022, Mr Petersen was unable to attend his first chemotherapy session because his pre-chemotherapy blood samples had been sent to the wrong laboratory for processing. Mr Petersen's first chemotherapy session finally took place on 11 January.
23. On 1 March, the hospital had to rearrange Mr Petersen's third session of chemotherapy for 4 March because his pre-chemotherapy blood tests went missing between HMP Berwyn and Wrexham Maelor hospital.
24. On 7 March Mr Petersen met with an occupational therapist. She assessed Mr Petersen's needs and provided support aids for his personal care and a wheelchair for his mobility.
25. On 7 April, the healthcare team met to review Mr Petersen's care. The cancer had spread to his spine and Mr Petersen's pain medication was reviewed in line with national guidelines. They started an application for his early release on compassionate grounds, on the basis of Mr Petersen's terminal illness.
26. On 12 April, Mr Petersen made the decision that he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.
27. On the evening of 5 July, staff found that Mr Petersen's health had started to deteriorate. He was very confused and had fallen on three occasions during the evening. On the morning of 6 July at 8.51am, a prison GP reviewed Mr Petersen at the request of the prison nursing team. He did not believe that Mr Petersen's pain was being managed effectively in prison, and he arranged for emergency admission to Wrexham Maelor hospital for end of life care.
28. On 7 July, the prison healthcare submitted the application for Mr Petersen's early release on compassionate grounds, having completed all of the relevant sections.
29. Over the following days, Mr Petersen's health continued to deteriorate, and he was given medication to keep him comfortable in hospital. The prison facilitated visits from his family and, on 11 July at 8.30pm, Mr Petersen died in hospital.
30. The outcome of the compassionate release application was not received before Mr Petersen died.

## **Post-mortem report**

31. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Petersen's cause of death as sepsis (a life-threatening organ dysfunction caused by an infection) with an unknown source, caused by metastatic lung cancer (cancer that has spread within the body).

# Clinical Findings

## Cancellation of medical appointments

32. On 5 January and 1 March, Mr Petersen's chemotherapy treatment appointments were rescheduled due to blood samples going to the wrong laboratory and going missing between prison healthcare and hospital prior to his appointments. We are concerned that these serious procedural issues were not followed up by the prison. Although there is no evidence of an impact on the outcome for Mr Petersen, it is important that the process is revised in order to prevent delays for future patients, for whom timely treatment might make a difference. We make the following recommendation:

- **The Head of Healthcare should review systems for pre-treatment processes and the sending of medical samples to ensure they are fit for purpose and to prevent delays in patients accessing urgent treatment.**

## Inquest

33. An inquest was held for Mr Petersen on 17 May 2023. The Coroner confirmed that Mr Petersen's cause of death was sepsis (a life-threatening organ dysfunction caused by an infection), the source of which was unknown. The underlying cause was recorded as metastatic lung cancer (cancer that has spread within the body).

**Tallulah Frankland**  
**Assistant Ombudsman**

**March 2023**

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