

**Investigation into the death of a man whilst in the custody
of HMP Peterborough in March 2009**

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

October 2009

This is a report into the circumstances surrounding the death of the man, a prisoner at HMP Peterborough at Peterborough District Hospital in March 2009. He had been receiving treatment for liver disease for some time. I would like to offer my condolences to his family for their loss and to all those who were touched by his death.

My investigator conducted the investigation on behalf of the Ombudsman. The local PCT were also commissioned to conduct a clinical review into the standard of healthcare he received while in custody. I would also like to thank the Director of Peterborough and his staff for their co-operation and assistance with the investigation.

The man had been in custody at Peterborough since July 2007. He had a long history of illicit drug use and, on his reception, was receiving methadone. A health screen identified that he was hepatitis C positive as a result of his continued drug use and he had abdominal pain caused by a hernia. During the remainder of 2007, he was seen regularly by the medical staff at Peterborough and attended both Peterborough District Hospital and Addenbrooke's Hospital. He was seen at both hospitals on a regular basis as his condition deteriorated and he developed further symptoms as a result of liver damage.

He was admitted as an emergency to Peterborough District Hospital in February 2009, where he remained for the next two weeks. Fluid was removed from his abdomen and he underwent an operation to treat internal bleeding. He developed a bacterial infection that appeared resistant to antibiotics and his condition deteriorated. His condition deteriorated rapidly during the morning of 10 March and he was pronounced dead at 12.45pm. The cause of his death has been given as bacterial peritonitis caused by hepatitis C and liver cirrhosis.

I highlight one area of good practice in relation to Peterborough's use of interpreting services due to the man's language difficulties. I agree with the clinical reviewer's conclusion that the standard of care given to him at HMP Peterborough was good and that staff made great efforts to obtain specialist care for him. The reviewer makes three recommendations relating to care provided by Peterborough District Hospital, which are outside the Ombudsman's remit, and I am content for him to take them forward on behalf of the PCT.

Neither the Prison Service nor the man's family had any comments on the content or accuracy of the draft report. The local PCT are to respond to the recommendations made by the clinical reviewer.

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

Jane Webb
Deputy Prisons and Probation Ombudsman

October 2009

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SUMMARY

The man was remanded into the custody of HMP Peterborough in July 2007. He was assessed by a nurse when he arrived who completed an initial health screen. It revealed that he had been an intravenous drug user for some time and had regularly used heroin prior to coming into custody. The health screen also indicated that he had recently undergone a hernia operation at PDH, but it had been unsuccessful. (A hernia is when an internal part of the body, such as an organ, pushes through a weakness in the muscle or surrounding tissue wall.) He was seen the following day for a secondary health screen by the prison doctor. It was also recorded at this time that the man's English was not very good and interpreters would need to be considered during future consultations.

The doctor wrote to the consultant at PDH, who had previously treated the man's hernia, asking for a further review as it continued to cause discomfort. During the remainder of 2007, he continued to experience problems and was seen regularly at both PDH and Addenbrooke's Hospital. Tests confirmed in late November 2007 that he had liver damage and cirrhosis. He was seen at Addenbrooke's in December and it was decided that he should undergo an assessment of his suitability for a liver transplant.

His health problems continued and, in August 2008, he was admitted to Addenbrooke's for the assessment. Unfortunately, the tests indicated that he was unsuitable and this information was passed to the prison doctor. The prison doctor was told that, although he had been considered unsuitable, a referral would be made for a second opinion at the Royal Free Hospital, London. The second assessment was carried out at the Royal Free Hospital in November but it also indicated that he did not meet the criteria for a transplant.

He continued to be treated by medical staff at the prison as well as attending Addenbrooke's and PDH regularly. As his symptoms became progressively worse, he was admitted to PDH as an emergency on a number of occasions during 2008/2009. He was also encouraged to move to the prison healthcare centre but steadfastly refused to do so.

In February 2009, he was admitted to PDH as his condition had deteriorated further and the fluid in his abdomen had increased. Over the next two weeks, medical staff attempted to alleviate his discomfort but his condition continued to decline and he began to bleed internally. Despite the efforts of medical staff to try and treat him, in March his condition rapidly deteriorated and he was pronounced dead by a doctor at 12.45pm.

I highlight good practice in relation to the use of translating services. The clinical reviewer has made three recommendations that relate to the medical care provided by PDH which he intends to follow up as appropriate.

THE INVESTIGATION PROCESS

1. The Director of Peterborough, provided the man's prison and medical records for examination. Notices were issued to staff and prisoners to inform them of the investigation process and to give them the opportunity to speak with the investigator. No responses were received.
2. My investigator visited Peterborough in April and met the liaison officer. While at Peterborough, my investigator visited the residential unit where the man had lived and also the healthcare centre.
3. My investigator wrote to HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of the report will be made available to the Coroner to assist his enquiries.
4. The local (PCT) conducted the clinical review of the man's medical care. During this process, they looked at all the available documentation and also spoke with medical staff at HMP Peterborough. In addition, the local PCT has looked at the treatment the man received at PDH. The PCT's review is attached as an annex.
5. A Family Liaison Officer (FLO) from the Ombudsman's office. The man was a Portuguese national and his family still live in Portugal. My FLO contacted the man's sister to inform her of the investigation and give her the opportunity to raise any concerns. His sister was grateful to my FLO for her help, but said that a family friend was arranging the collection of her brother's property and she had no other concerns.

HMP PETERBOROUGH

6. HMP Peterborough is privately run by Kalyx (formerly UK Detention Services). It opened in March 2005, and is the newest purpose built prison in the United Kingdom. Its role is that of a category B local prison serving the counties of Cambridgeshire, Nottinghamshire, Lincolnshire, Leicestershire, Northamptonshire, Norfolk and Suffolk. It is also the only prison that holds both men and women, who are kept separate at all times. This makes it a very complex prison to manage.
7. HM Chief Inspector of Prisons, conducted a follow up inspection in June 2008. She concluded that Peterborough was making progress but some weaknesses remained. The areas of improvement included healthcare but the inspection team thought that much more could be done. In HM Chief Inspector of Prisons' report also said that relationships between staff and prisoners were not positive with little or no interaction or support for prisoners from relatively inexperienced officers. It was also considered that more progress was needed in race, foreign national and diversity issues.
8. The Independent Monitoring Board (IMB) at Peterborough published an annual report in March 2006, a year after the prison opened. (The IMB independently monitors all aspects of day-to-day prison life, including considering prisoners complaints. Each Board produces an annual report focusing on the strengths and weaknesses of their particular prison.) At the time of their first report, the IMB at Peterborough judged that although there were things that still required more attention, the prison was operating effectively in its first year.
9. There have been four deaths in custody since the prison opened in 2005. One was self-inflicted and the other three were attributed to natural causes. There are no previous recommendations from these deaths that are relevant to this investigation.

KEY FINDINGS

10. The man had been living in the United Kingdom since February 2000, after arriving from Portugal. He had a long history of drug misuse from the age of 18 and had begun using heroin in his mid-twenties.
11. The man was remanded into custody for possession of class A drugs in July 2007 and taken to HMP Peterborough. (This was the first time that he had been in custody although he had been subject to several community sentences for possession of drugs.) On arrival at Peterborough, he was assessed by a nurse who completed a first health screen. He had recently seen a doctor for a large hernia in his stomach. He told the nurse that he smoked heroin twice a week before coming into custody and was receiving methadone as part of a detoxification programme. The nurse carried out a urine test that confirmed he was positive for methadone and a referral was made for him to be seen by the doctor regarding his drug use and physical health. (When a prisoner claims to be receiving methadone, a urine test is carried out to confirm this.) The man spoke little English but was able to make himself understood. During his time at Peterborough interpreting services were used to assist him on a number of occasions, including medical consultations.
12. In July, the prison doctor assessed him. He told the doctor that he had previously been admitted to hospital for suspected lung disease during which tuberculosis was ruled out. However, there is nothing that specifies the nature of the lung disease. The doctor recorded that the man had a large umbilical hernia that had been operated on in April 2007 at PDH, but it had been unsuccessful. It was also recorded that he was suffering from a persistent cough that he said he had for the last three weeks. The doctor recorded that there were possible prostate problems and that the man was Hepatitis C negative and had received an inoculation against Hepatitis B. No concerns were raised regarding the man's mental health or risk of self-harm.
13. The man settled in well on the residential wing. Staff recorded that he complied with the regime and got on well with both prisoners and staff. Due to concerns about the man's hernia, the prison doctor referred him to a doctor who had previously treated him at PDH and a letter was sent on 23 July. The man was provided with a bandage to keep the hernia in place. His medical record shows that he was to be reviewed every two weeks as there were concerns that he might have jaundice. (Jaundice is the yellow appearance of the skin and whites of the eyes that occurs when the blood contains an excess of the pigment called bilirubin.)
14. The man went to the clinic at PDH on 13 August. However, an entry in his medical record indicates that the consultant was not there and the appointment had to be re-booked. The man told the prison doctor later that he was having pain when passing urine and was prescribed medication. He was seen on a number of occasions during August by healthcare staff. He complained of being unable to sleep due to his hernia and continued pain. In August, the prison doctor assessed the man who complained of swelling in both legs. Concerns about possible liver dysfunction were recorded. The doctor recorded

that there were difficulties getting blood from him for testing due to his previous intravenous drug use.

15. The appointment originally booked for early August was attended by the man in August and another appointment was made for an ultrasound scan on his abdomen. This was carried out in September. (There are no letters from PDH in his records referring to the findings of this scan.)
16. The prison doctor examined him in October and, after diagnosing an enlarged spleen, arranged for his admission to the Surgical Assessment Unit (SAU) at PDH. The man remained in the SAU for a week while tests were carried out. He discharged himself, against medical advice, in October and returned to the prison. During his stay at the SAU tests ruled out the presence of any blood clots in his legs but indicated that he had fluid in his abdomen. The test results indicated possible liver problems and he was referred to gastroenterologist at PDH.
17. In October, the man was convicted of possession of class A drugs and sentenced to three and a half years imprisonment.
18. The prison doctor wrote to the gastroenterologist at PDH on 2 November. The prison doctor suggested that he was unhappy with the assessment that the man received during his earlier referral on 5 October. He said:

“... I am writing to express my concerns over his health as it has been deteriorating steadily since his arrival at HMP Peterborough in July 2007. His previous medical history includes drug abuse and he is hepatitis C positive. No blood test can be carried out at HMP Peterborough due to the inability to draw blood from his venous system destroyed by years of veno-puncture.

“He presented with what appeared to be a recurrence of his umbilical hernia which had been operated by a doctor at PDH in April 2007. It took a few months to arrange an appointment with the doctor at PDH. I must say that I did not receive any report from the meeting. As his abdomen and legs began to swell, I managed to have him admitted for one week in October where minimal investigations were carried out ...”
19. The prison doctor also told the gastroenterologist that due to the man’s limited English translation arrangements might need to be made before the appointment. The letter also refers to the man being hepatitis C positive. However, the information given on reception was that he was hepatitis C negative. (The clinical reviewer found that the notes for the secondary medical screening identified that he was actually hepatitis C positive and not negative as indicated, and the records were updated accordingly.)
20. The man’s medical record also indicated that the prison was not satisfied with the assistance he was given by the Haematology Department at PDH. (The clinical review found that there was a significant delay in the hospital’s

response to the prison's request for blood sampling and refers to this in his report.)

21. An entry made in the man's medical notes by the prison doctor in November says that he still has "a massive abdomen, probable ascitis". (Ascitis refers to fluid in the abdomen usually due to liver failure.) The doctor recorded that, due to his frustration with the hospital's lack of interest in the man's condition, he prescribed a course of frusemide (a diuretic treatment to reduce the fluid).
22. The prison doctor saw the man again in his surgery the following day. The doctor discovered that an appointment made for the man to attend PDH had been cancelled by the prison for administrative reasons. The doctor contacted the duty manager and informed him that the man needed to attend for an assessment urgently. He was told that it would not be possible that day and he would be taken on the Monday. The doctor recorded that the man was to be reviewed daily by the duty doctor over the weekend. Either Addenbrooke's Hospital or PDH were to be contacted the following Monday to arrange the man's admission. The man was subsequently admitted to the prison healthcare inpatients unit for supervision over the weekend.
23. The man was admitted to Addenbrooke's Hospital in November due to the fluid in his abdomen and swelling in his legs. Tests were carried out the following week that indicated liver failure and cirrhosis. (Cirrhosis is a consequence of chronic liver disease. Ascites, fluid retention in the abdominal cavity, is the most common complication of cirrhosis. It is associated with a poor quality of life, increased risk of infection, and a poor long-term outcome.) The man was discharged from Addenbrooke's in December with a course of diuretics and vitamins.
24. On his residential unit, the man's behaviour continued to receive favourable reports from staff. He was employed as a wing cleaner and carried out this task to a high standard despite his ongoing medical problems.
25. The prison doctor assessed the man in December after he received a letter from a doctor at Addenbrooke's Hospital. The doctor said that the man had been assessed as suitable for a possible liver transplant, due to liver failure caused by Hepatitis C. He said that he hoped that a transplant would be possible in the next 12 to 24 months. The doctor told the prison doctor that he would like to see the man regularly in his clinic. Over the next two months the man was seen regularly by healthcare staff at Peterborough and attended PDH in order for blood tests to be carried out.
26. An appointment was made for the man to attend the doctor's clinic in January 2008, but it was rescheduled. However, after the man was given the letter by mistake, this appointment was also rescheduled and another made for 5 February. (All letters referring to prisoners' medical appointments are sent directly to prison healthcare. Security considerations mean that if a prisoner is made aware of an appointment it is necessary to cancel and rebook.)

27. The doctor at Addenbrooke's Hospital wrote to the prison doctor following the man's appointment on 5 February, explaining that he appeared to have responded to the diuretic medication. The doctor said that he still had fluid in his abdomen and swelling in his legs but there had been a visible improvement. In relation to the possibility of a transplant, he said that it should still be considered, but with the man's progress, it might be possible to delay any assessment.
28. Between February and June, the man continued to be seen regularly by both prison healthcare staff, the prison doctor and also Addenbrooke's Hospital's clinic. The man's liver function tests did not change and, apart from the swelling in his legs, his condition was well controlled. On 24 June, the man went to a routine appointment to Addenbrooke's Hospital. In a follow up letter to the prison doctor, the doctor from Addenbrooke's Hospital said that he had seen the man in the presence of prison staff and felt that he was not as talkative when they were present. However, he said that the man's health appeared stable. Despite this, the doctor said that it would be sensible to admit the man for a transplant assessment within the next two months. Two prison officers escorted the man to all outside medical appointments and he was handcuffed to an officer at all times.
29. On receipt of the letter from the doctor at Addenbrooke's Hospital, the prison doctor responded by saying that he would make arrangements for the man to attend the appointment without an escort. A Release on Temporary Licence (ROTL) form was submitted on 21 July requesting that the man be allowed to go unescorted to the appointment at Addenbrooke's. Concerns were raised about the man's immigration status and, that as a possible deportee, he might pose a risk of absconding. Despite these concerns, the man received favourable reports from his wing staff and the Probation Service raised no concerns. Unfortunately, in August the man was informed that due to providing a positive sample at a Mandatory Drug Test (MDT), his application for ROTL had been suspended. (MDTs are conducted in all prisons as part of the Prison Service anti-drug strategy and prisoners are selected at random to provide a urine sample for testing. The tests are sent away to be tested independently.)
30. The man went to Addenbrooke's in August to undergo an assessment for a possible liver transplant. He remained in hospital until 22 August before returning to Peterborough. Unfortunately, tests carried out indicated that he was an unsuitable candidate for a transplant. The discharge summary from Addenbrooke's says:

"All information discussed with patient with the help of an interpreter. It was explained that a transplant is not possible because of a blood clot in a vessel around the liver (superior mesenteric vein.) It was explained that this may account for the recent worsening of his symptoms. It was explained that at the moment it is felt that his symptoms of fluid retention can be controlled with medication but in the future this will not be possible and he will deteriorate at which point a transplant will not be possible. We have agreed to refer him to another

transplant centre for a second opinion. In the meantime he will continue to be reviewed in the clinic.”

31. Over the next four weeks, the man continued to receive treatment at the prison and was seen regularly as his symptoms continued to cause concern. On 11 September, the prison doctor assessed him as he said that he had been vomiting blood and he was subsequently admitted to the healthcare wing for observation. The prison doctor recorded that he should be sent to PDH if the bleeding persisted. The prison doctor reviewed the man on 19 September and he appeared drowsy, sleepy and mildly confused. He recorded that he felt that this could possibly be encephalopathy (a poisoning of the brain due to failure of the liver to deal with normal poisons in the blood). He was admitted to PDH the same day.
32. Prior to his admission, the prison doctor again wrote a letter to PDH telling them that, due to the man’s language problems, an interpreter would be advisable. The hospital used Language Line to discuss the man’s history and symptoms with him. (Language Line is an interpreting service that is accessed via the telephone.) It was recorded that the man was drowsy, confused and incontinent when he was admitted to PDH. The man said that he did not feel that he was confused but was unsure about his medical condition due to the language barrier. He was diagnosed with liver encephalopathy and remained at PDH until the following day when he was discharged back to Peterborough. On his discharge it was recorded that he was “alert and well” and it was recommended that he should be provided with a high carbohydrate diet. He returned to the healthcare wing and the kitchen was informed about the need for a special diet. He remained in the healthcare wing until 22 September.
33. The prison doctor continued to pursue the appointment for a further assessment for a liver transplant. The man’s was finally admitted to the Royal Free Hospital, London, on 23 November. He remained there until 27 November while the assessment was conducted. The consultant at the Royal Free Hospital wrote to Addenbrooke’s and said that, due to the man’s past drug use and the fact that he had not abstained for two years (as stipulated under the transplant guidelines) he could not be considered for a transplant.
34. After the man was sentenced, his solicitor contacted the healthcare team at Peterborough and the UK Border Agency to address how his ongoing treatment might affect his deportation status. On receipt of the findings of the Royal Free Hospital, the prison doctor wrote to the UK Border Agency informing them that the second assessment also declined the man as a possible transplant patient. The doctor said that, in view of this, the man would be treated medically for his condition which had a life expectancy of one year for 80 per cent of patients with the condition.
35. On 14 December, a nurse went to see the man as he had failed to collect his medication. The man told her that he had been vomiting. The nurse offered to admit him to the healthcare wing but he declined. The nurse recorded that he was tearful and she told him that he would be seen by the prison doctor the following day. Before leaving the wing, the nurse spoke to Senior Prison

Custody Officer (SPCO) and asked him to instruct his staff to monitor the man overnight and to keep the nurse informed. The prison doctor assessed him the following day and recorded that he appeared better.

36. Staff on the man's wing recorded in his wing history file (page 16) that he was still not well during the week but, despite their efforts to encourage him, he continued to refuse to be admitted to the healthcare wing.
37. On 26 December, medical staff responded to a medical emergency on A wing and found the collapsed on the floor of his cell. It is recorded that he responded to pain stimulus but was not speaking. He had vomited and was unable to stand. An emergency ambulance was called and he was taken to PDH.
38. On his arrival, he was assessed in the Acute Assessment Unit. Apart from blood tests, the paperwork suggests that no other investigations were undertaken and he was discharged from PDH on 27 December. He returned to the prison and went back to A wing but healthcare staff were not aware that he had returned. The nurse who saw him initially recorded on the man's medical notes that she was made aware of his return when she received a telephone call from his wing to say that he had not had his medication. She spoke to the duty manager who confirmed that the man had returned at 2.00pm. No information regarding any medical findings or treatment given was provided by PDH. The on call doctor spoke to the man the following day and the man told him that a brain scan had been carried out while at PDH but no changes made to his medication.
39. The man's condition continued to deteriorate and medical staff advised him that it would be better for him to be admitted to the healthcare wing. However, despite advice from both wing and healthcare staff, the man continued to refuse. On 12 January, the prison doctor recorded that the man had been incontinent the previous day as well as being confused and aggressive. The doctor saw the man and recorded that he "appeared dishevelled". His symptoms continued until 15 January when he was admitted to PDH with suspected liver encephalopathy. The doctor wrote to PDH informing them that the man had recently deteriorated and was confused, mumbling, emotional, and aggressive and had recently become incontinent.
40. The man remained at PDH until the following day when he was discharged back to the prison. A discharge note indicates that there was no evidence of encephalopathy that would explain the recent symptoms. However, no alternative diagnoses were provided. (This issue is referred to by the clinical reviewer.)
41. The man went to Addington Hospital clinic on 30 January. The doctor there wrote to the prison doctor that it was his team's opinion that the man had undoubtedly suffered hepatic encephalopathy and further tests were required. The doctor explained that his team were organising the tests which were expected to take around three weeks to complete.

42. On receiving the information from the doctor at Addington Hospital, the prison doctor wrote to the man's case officer at the UK Border Agency. He explained that, following his recent consultation, the doctor at Addington Hospital's opinion was that deportation would be inappropriate in view of the man's illness and condition. The prison doctor also said that, as the man was unable to have a liver transplant, his condition might deteriorate further in the short term and lead to his death.
43. Prison staff notified healthcare staff of the man's continuing incontinence but, when he was seen by nursing staff, he denied that he had any problems. He also continued to resist attempts to admit him to healthcare. The prison doctor assessed the man on 4 February and, with the help of a Portuguese interpreter, explained that healthcare was considered the best place for him. The man was adamant that he did not want to move to the healthcare and the doctor arranged for him to sign a disclaimer to this effect.
44. The man continued to have his leg ulcers dressed daily and remained on the residential wing. During the morning of 27 February, staff on houseblock 3 asked a nurse to see the man as he was complaining of pain. The nurse contacted the on call doctor, who instructed the nurse to give pain relief and arrange his transfer to the healthcare wing so that he could be observed. He was admitted later that day to PDH as an emergency.

Treatment at Peterborough District Hospital from 27 February until his death.

45. The man's fluid retention had increased and he had severe leg swelling. Fluid was removed from his abdomen and a sample sent for testing. A risk assessment completed by the prison before he went to hospital indicated that he would need to be handcuffed as with previous appointments and these remained in place on his admission to hospital.
46. Over the next two days the man had further blood tests and was cared for by nursing staff. Two members of prison staff remained with him, one of whom was handcuffed to him at all times. Nursing staff raised concerns with the escort staff on 1 March about the man walking to the toilet as they felt that he was unsteady on his feet and should remain in his room. However, he insisted that he wanted to walk to the toilet. Due to his previous drug use, nursing staff had difficulty finding veins on his arms. A cannula (a tube that can be inserted into the body, often for the delivery or removal of fluid) was eventually inserted into his neck. Despite the cannula, nursing staff informed the escort staff that a "central line" might still need to be inserted, which would take place in the operating theatre. (A central line is an intravenous catheter placed into a large vein. It is needed to give the medical team access to a large vein that can be used to administer fluids, measure the amount of fluid in the body, or give medication.)
47. The man experienced problems in digesting food and fluids and was given anti sickness medication to alleviate his symptoms. During the evening of 1 March, a nurse attempted to insert a tube into the man's stomach to prevent him from being constantly sick. However, after three failed attempts, the nurse said that

she would leave it for a while as it was causing him some discomfort. He remained handcuffed.

48. Later that evening, nursing staff informed the escort staff that it would be advisable for the man's next of kin to be notified of his condition. The nurse told the escort staff that the doctor was considering stopping the man's treatment. The nurse also said that, if he deteriorated, he would not be resuscitated. (There is no evidence to identify who made this decision or whether it was discussed with either the man or his family. This is an issue highlighted by the clinical reviewer.) A translator was made available over the telephone who informed the man of the intentions. He was told that he needed to give his consent for another cannula to be inserted into either his neck or groin, and otherwise no treatment would be available. The man gave his consent. The request for the next of kin to be notified was passed to the prison by the escort staff. The escort staff told the duty manager at the prison that, if he started to bleed internally, medical staff had said that there would be very little treatment that could be provided.
49. The man was taken to the operating theatre in the early hours of the morning on 2 March for the cannula to be inserted. The escort staff remained with him during the procedure and the handcuffs remained in place. During the day, the man vomited blood and was given a blood transfusion. A camera (gastroscope) was also inserted into his stomach in an attempt to find the cause of the bleeding.
50. The liaison officer from the prison contacted the man's sister in Portugal on 2 March. He told her of her brother's condition and supplied her with a contact telephone number for the prison and the hospital.
51. On the afternoon of 4 March, the man was again taken to the operating theatre for an operation under general anaesthetic to place bands around the veins bleeding in his stomach. Escort staff sought permission to remove the handcuffs during this procedure. This was granted but the restraints were reapplied immediately afterwards.
52. The man continued to receive treatment and have fluid drained from his abdomen over the next few days. He was also able to speak with his family in Portugal via the telephone. Despite receiving pain relief medication the man continued to complain of increased pain, and so nursing staff provided additional medication. On 7 March, the results of tests carried out on the fluid from his abdomen confirmed an infection a course of antibiotics was started. Due to a water infection, a catheter was fitted and he was not allowed to eat. However, it is recorded that he remained polite and respectful to both nursing and escort staff despite being in pain.
53. Although permission was given for the handcuffs to be removed when necessary to allow him to wash or be examined, they were still in place at this time. Permission was given for his sister to have the mobile telephone number of the escort staff as he was unable to get to the telephone on the ward. His sister told the hospital that she would telephone daily and hoped to travel to

England within the next week. She asked the prison to keep her informed of her brother's condition.

54. Tests carried out on 8 March indicated that the man's stomach infection was resistant to the antibiotics and a stronger course of medication was prescribed. The following day it was recorded that he appeared to be slowly responding to the new medication. He remained confined to bed and began to experience difficulties breathing. A breathing tube was placed in his nose to provide oxygen but he removed it and was given a face mask which he also removed. During the morning of 9 March, the escort risk assessment was reviewed and the decision was made to remove his restraints but for two members of staff to remain with him.
55. During the following day, 10 March, he continued to have difficulty breathing and was advised by nursing staff that the oxygen mask would ease his discomfort. His condition deteriorated further in the afternoon and he was visited by the prison doctor and doctors from PDH at 12.25pm. They informed the escort staff that there was nothing more that could be done for him and that it was likely to be only a matter of hours before he passed away.
56. At 12.40pm, the escort staff recorded that his breathing had slowed and was laboured. A nurse who checked on him at 12.45pm told the escort staff that she could not find a pulse in his arm but there was one in his neck. At 12.48pm, he stopped breathing and the nurse went to inform the doctor. A doctor attended to him at 12.50pm. She confirmed that he had died and recorded the time of death as 12.45pm. The escort staff informed the manager at the prison.

Following the man's death

57. The manager from the prison contacted the man's sister in Portugal to inform her of her brother's death. He advised her of the Ombudsman's investigation and offered assistance to have the man's body repatriated. The prison met these costs. The manager remained in contact with both the family and other agencies to ensure that this process was conducted in a timely manner.
58. The manager also spoke to a family friend of the man who lived locally to Peterborough and arranged for her to collect his property and forward it to the family.
59. A post mortem was carried out which indicates that the cause of the man's death was bacterial peritonitis which was contributed to by hepatitis C and liver cirrhosis.

ISSUES

Escort arrangements

60. The use of restraints when escorting seriously ill or dying prisoners is an issue that has featured in many of the Ombudsman's reports recently. Although the prison completed the necessary risk assessment, which is a matter of fine judgement I believe that it could have been reviewed at an earlier stage. I consider the use of restraints, particularly when he was undergoing a medical procedure to have been unnecessary.
61. I entirely understand the current climate of avoiding risks when making decisions about restraints. Both public protection and the reputation of the Prison Service rely upon the Service's admirable achievements in recent years to reduce the number of escapes and absconds. As I have said above, risk assessment is a matter of fine judgement, and it is an inexact science at the best of times. However, as the Ombudsman has observed in previous investigations, this is far from being the first report which notes that, in a less risk adverse climate, very different decisions about restraints might reasonably be made. It is part of a prison's duty to ensure a balance between public protection and the compassionate management of seriously ill or dying prisoners. The Director will wish to consider with his senior colleagues whether that balance was achieved on this occasion.

Medical treatment at the prison and outside hospital

62. The use of interpreting services by both prison and medical staff ensured that the man was able to communicate his needs. The prison doctor's continuous efforts to ensure that these services were also provided when he went to hospital appointments also deserve particular mention. I consider this good practice.
63. The clinical reviewer, has said of the man's medical care:
- “...The man's care while in custody in HMP Peterborough met all the standards of reasonable care and it is clear that the medical staff at the prison went to great lengths to obtain the necessary specialist care for him. While there are some learning and change areas in his hospital care, it again met a standard of reasonable care...”
64. In particular I commend the prison doctor for his persistent efforts to improve the hospitals treatment of the man's condition.
65. The clinical reviewer has made no recommendations in respect of the prison healthcare system but makes three recommendations relating to matters concerning PDH which are outside the Ombudsman's remit. I have listed these recommendations below. The clinical reviewer has said that in his capacity as Medical Director of Peterborough PCT, he is willing to follow up his recommendations:

CONCLUSION

66. The man had been an intravenous drug user for a considerable time prior to coming into custody and this led to chronic health problems. It was clear from the documentation that he had engaged with drug services at Peterborough in an attempt to address his addiction. However, sadly the damage to his health had already been done. I conclude that the care he received while in the care of HMP Peterborough was good and that his medical care was equitable to that which he might have received in the community.

GOOD PRACTICE

The use of interpreting services by both prison and medical staff in ensuring that the man was able to communicate his needs are evident. The prison doctor's continuous efforts to ensure that these services were also provided when the man attended for outside medical appointments also deserve particular mention. I consider this good practice and wish to highlight it as such.

RECOMMENDATIONS

The following recommendations are those made by the clinical reviewer as a result of his review of the medical care provided to the man.

1. **Peterborough District Hospital should ensure equity of access to blood sampling to intravenous drug users, irrespective of their route of referral to the hospital.**
2. **Peterborough District Hospital should ensure that adequate evidence of fluid balance assessment is made and recorded in patient's notes.**
3. **Decisions not to resuscitate should include family members/guardians and this discussion should be recorded in a patient's notes.**