Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Clark, a prisoner at HMP/YOI Norwich, on 24 April 2025

A report by the Prisons and Probation Ombudsman

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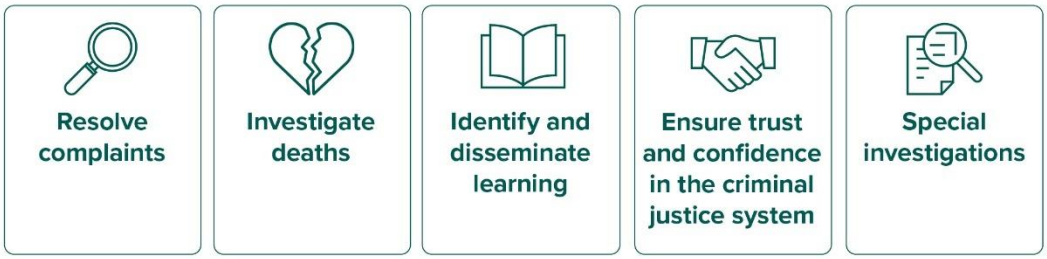
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. On 3 July 2008, Mr Andrew Clark was sentenced to an imprisonment for public protection (IPP) sentence, with a tariff of eight years and 230 days for arson. He died from stage 3 oligodendroglioma (a type of brain tumour) on 24 April 2025, at HMP Norwich. He was 66 years old. We offer our condolences to Mr Clark's family and friends.

4. The Ombudsman's office wrote to Mr Clark's next of kin to explain the investigation and to ask if they had any matters they wanted us to consider. They had no questions but asked for a copy of our report.

5. The PPO investigator investigated the non-clinical issues relating to Mr Clark's care.

6. We did not find any non-clinical issues of concern. We make no recommendations.

7. NHS England commissioned an independent clinical reviewer, to review Mr Clark's clinical care at HMP Norwich. The clinical reviewer's report is attached as Annex 1.

8. The clinical reviewer concluded that the clinical care Mr Clark received at Norwich was partially equivalent to what he could have expected to receive in the community. She considered that the care Mr Clark received for his general health care was of a reasonable standard; had appropriate care plans put in place and his on-going health concerns were addressed accordingly.

9. The clinical reviewer concluded that Mr Clark's care around Dying Well in Custody was partially equivalent. Although Mr Clark's wishes were documented, his care was not in line with the Dying Well in Custody charter due to the lack of a joined up multi-agency approach to prescribing his anticipatory medications. There were missed opportunities by the prison healthcare team to ensure that his medications were prescribed. There was evidence of severe terminal agitation prior to his death and at the time of his death, but Mr Clark did not have any 'as required' anticipatory medications prescribed. Additionally, at the time of his death, Mr Clark did not have a third syringe driver in place as recommended by the community palliative care team. We make the following recommendations:

   The Head of Healthcare at HMP/YOI Norwich should review palliative provision, including provision of a palliative healthcare lead and MDT, in line with the Dying Well in Custody Charter 2024, to ensure that anticipatory medications recommended by the Community Palliative Care Team are appropriately prescribed in a timely manner.

   The Head of Healthcare at HMP/YOI Norwich should communicate the out of hours prescribing process, including the nurse prescriber rota, to all

healthcare staff and this should be included in the prison's induction process.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

11. Mr Clark's next of kin received a copy of the draft report. They did not make any comments.

Adrian Usher **October 2025**
Prison and Probation Ombudsman

Inquest

At the inquest held on 19 December 2025, the Coroner concluded that Mr Clark died of natural causes.

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