Investigation into the circumstances surrounding the death of a man, a prisoner at HMP Norwich, in April 2008

Report by the Prisons and Probation Ombudsman for England and Wales

March 2009

This is the report of an investigation into the circumstances of the unexpected death of a man in Norfolk and Norwich University Hospital on 5 April 2008. The man was aged 55 years at the time of his death and was a prisoner at HMP Norwich.

I would like to offer sincere condolences to the man's family. The Man's suicide attempt in May 2000, the serious disablement he suffered as a consequence, and finally his death while still a prisoner, must be particularly difficult for the family to bear.

My colleague conducted the investigation on my behalf. An independent review into the man's care was undertaken by a Clinical Governance Manager, Norfolk Primary Care Trust. I am particularly grateful to the clinical reviewer for her very valuable contribution. I would also like to thank the Governor and Deputy Governor of HMP Norwich, as well as Head of Healthcare, for their cooperation with the investigation. I am particularly grateful to an officer who provided a very high standard of liaison.

I conclude that the care the man received while at the Norwich Nelson Unit was very good. The staff demonstrated a high level of care and commitment to him. The clinical reviewer has inferred that the man did not enjoy a similar level of care and commitment while a patient at Norfolk and Norwich University Hospital, but this is outside my remit. The Chief Executive of the Norfolk Primary Care Trust, may wish to draw my report to the attention of her counterpart at the hospital.

I make four recommendations in my report. Three relate to poor liaison between healthcare, the prison and the family. The fourth proposes that a memorandum of understanding should be agreed between the prison and Norfolk and Norwich University Hospital setting out clear boundaries regarding the respective roles and expectations of prison and NHS nursing staff.

The Prison Service response to my recommendations is at page 18 of this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2009**

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SUMMARY

On 19 November 1998, the man was convicted of murder and sentenced to life imprisonment. Records show that he found prison a very difficult experience. He lacked the necessary coping skills and this, combined with family problems in the United Kingdom and bereavement in India, appeared to increase his frustration and heighten his sense of isolation. Throughout 1998 and up until an attempt to take his own life in May 2000, a number of F2052SH documents were opened by staff who were concerned by his state of mind and consequent behaviour. (An F2052SH was a document opened by any member of staff concerned about a prisoner who was believed at risk from self harm. This has since been replaced by the Assessment, Care in Custody and Teamwork (ACCT) document and process.)

On 4 May 2000 at 9.25am, at HMP Swaleside, the man attempted to take his life by ligature. He was resuscitated in his cell by staff but suffered anoxic brain damage as a result of the attempt. Records show that he spent around a month in hospital but his recovery would never be complete and he was returned to Swaleside where he received 24 hour nursing care.

In 2005, the man's condition deteriorated and Swaleside were no longer able to meet his needs. He was accepted into the Nelson Unit at HMP Norwich following a referral by Swaleside.

The Nelson Unit managed the man's physical and psychological needs very well. I judge that he received a very high standard of care delivered by committed and caring staff. Appropriate referrals were made for expert advice on issues such as dealing with his challenging behaviour and his diet (as he was unable to swallow normally due to his injuries).

Despite every effort, the man ingested food into his lungs (silent aspiration) at times. This meant that he regularly suffered chest infections. Following significant weight loss in September 2007, a referral was made to Norfolk and Norwich University Hospital. A subsequent scan in March 2008 showed that the likely cause was tuberculosis (TB), a communicable disease. This could not be confirmed as the man was too unwell to give samples.

In hospital, the man became reluctant to take his medication. The bedwatch log records that a bedwatch officer assisted nursing staff in giving medication. It is not clear whether the man had given his consent or if the officer wore any protective clothing such as a mask when entering the man's room. I have made a recommendation that a memorandum of understanding governing codes of behaviour and setting clear boundaries between the prison and the Norfolk and Norwich University Hospital should be agreed.

A mental health capacity review was held at the Nelson Unit on 19 March 2008. The review was held in order to decide whether it was in the man's best interests to be resuscitated following a heart attack. It was concluded it was not. The family were neither informed of, nor invited to the review, and I make a recommendation in that regard.

Just after midday on 5 April 2008, the man was found dead by a member of hospital staff. The man's brother was told of his death by a telephone call from the Head of Healthcare. I make a recommendation that best practice should be adhered to and, wherever possible, such news should be delivered in person, usually by the prison's Family Liaison Officer and another member of staff.

I note with disappointment that the man's brother was not invited to the memorial service held in Healthcare. He would have been happy to have attended, and I make a recommendation that invitations to memorial services should be extended to the family whenever those services are held in the prison.

My recommendations aside, I judge that the care the man received before his admission to hospital was of a very high standard. Staff at the Nelson Unit are to be commended for the level of commitment and care they demonstrated. I am unable to comment on the care he received at the Norfolk and Norwich University Hospital as this is beyond the remit of my office.

No post mortem was held.

THE INVESTIGATION PROCESS

1. My office was notified of the man's death on 5 April 2008. Terms of Reference and Notices were issued to staff and prisoners at Norwich telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. My investigator requested copies of the man's core record, medical record and other records relevant to his time in custody and to his death.

2. My Investigator also contacted HM Coroner. The purpose was to inform him of the nature and scope of the Ombudsman's investigation. I understand that a post mortem was not undertaken as the cause of death was given by the Norwich and Norfolk University Hospital where the man died. The cause of death is recorded as:-
    a) 1a. tuberculosis
    b) 1b. anoxic brain injury
    c) 1c. disseminated malignancy.

3. A clinical review of the man's medical care was commissioned by Norfolk Primary Care Trust. It focuses on the medical care the man received at HMPs Swaleside and Norwich and at the Norfolk and Norwich University Hospital where he died.

4. The Clinical Governance Manager Norfolk Primary Care Trust (PCT) and my investigating colleague visited the Nelson Unit at Norwich prison on 23 June 2008. They met the Head of Healthcare and were given a tour of the unit. The facilities available to the unit and equipment purchased specifically for the man were shown and explained. The Clinical Governance Manager Norfolk Primary Care Trust (PCT) and my investigating colleague met informally with prisoners on Nelson Unit who knew the man.

5. One of my Family Liaison Officers together with my investigator met the man's brother at his home. He raised a number of concerns on behalf of the family. My investigator and FLO also received a copy of a letter from another brother in India, addressed to my office, in which he raised additional concerns. I am unable to address matters relating to the man's immigration difficulties or his appeal against conviction and sentence as these are outside my terms of reference. The matters I have investigated on behalf of the family are:

    a) Was there an investigation into the man's near fatal attempt to take his own life at Swaleside?
    b) Was it in the man's best interests to be moved to Norwich from Swaleside?
    c) Why representatives from the prison were not present at the funeral even though the prisons were aware of the dates?
    d) Why was the man's brother not invited to the prison to attend the memorial service held in Healthcare and meet with other prisoners who knew his brother?
    e) Was the man well looked after at Norwich because, to his brother, he appeared to deteriorate after the transfer?

f) How did the man contract TB and what treatment was offered?

6. The FLO made a number of unsuccessful attempts to reach other members of the man's family. She spoke with his daughter who chose not to raise any concerns for consideration at that point. The family will be given an option of receiving the draft report and can participate in the investigation at that stage.

7. My Investigator contacted HMP Swaleside and spoke with the Deputy Governor to ask if there had been an investigation in respect of the man's attempt to take his life in 2000.

8. My investigator has consulted investigation reports relating to the deaths of prisoners at Norwich since 2004. The investigator has also read the reports by HM Chief Inspector of Prisons, of an announced inspection of Norwich in 2006 and an unannounced follow-up inspection. A copy of the prison's Independent Monitoring Board (IMB) report dated 1 March 2007 to 29 February 2008 was also consulted.

HMP NORWICH

9. HMP Norwich is a local male training prison and young offender institution holding remand and sentenced prisoners. It serves the courts of East Anglia.

10. The prison comprises nine units (formerly known as wings) with an operating maximum capacity of 823 prisoners. Healthcare is located over two floors. The upper floor has 32 beds for inpatient care; the ground floor accommodates the Nelson Unit, a special unit for older prisoners. The upper healthcare centre also provides inpatient care for HMP Wayland and HMP Blundeston. In addition, it has an x-ray facility and provides regular clinics in chiropody, dentistry, asthma and opticians.

11. The 15 bed Nelson Unit, where the man was located, is based on a residential home model. It is an example of good practice and a national resource for the Prison Service. It is dedicated to providing intensive nursing care, mostly for life sentenced prisoners over the age of 60 years. Palliative care, such as the man would have received, is delivered through a multi-disciplinary approach, and there are good links to health services in the community to aid delivery of care. In the Independent Monitoring Board's report for 2007-08, the Board have commented that, "The Nelson Unit for elderly prisoners has introduced an innovative 'open door' policy … It has also used the voluntary sector to develop various social activities."

KEY FINDINGS

12. On 13 March 1998, the man was remanded to HMP Wormwood Scrubs. He transferred to HMP Highdown on 15 October 1998 during his trial. On 19 November, he received a life sentence following his conviction for murder.

13. Prison records show that, from the start, the man found prison a very difficult experience. He stated his innocence to staff and became increasingly frustrated with the prison regime. It was also clear that, in the early stages of his sentence, some staff found his poor coping skills demanding of their time and patience. My investigator noted that some entries in the wing sheets were frank in expressing that view. A more positive entry on 2 November 1999 showed that, "overall … he has worked hard for staff and is generally respectful to all staff. He does suffer 'bad' days when he is down … He is on enhanced level of IEP." (IEP refers to the Incentives and Earned Privileges Scheme.)

14. At Wormwood Scrubs on 10 April 1998, a F2052SH self-harm document was opened by staff who had received a faxed letter from the man's solicitor raising concerns about him. (The letter was not attached to the document and therefore the precise contents are now unknown.) The F2052SH records that the man had told staff that in 1995 he was in a psychiatric hospital and had been prescribed anti-depressants in the community. They were therefore aware of his previous mental health difficulties. In order to deal with his isolation and distress, staff found a suitable prisoner willing to share his cell to combat the loneliness he said he felt at the time.

15. On 14 January 1999, while at Highdown, the man received notification that his 'tariff' (the 'tariff' is the minimum time that has to be served in prison before release on licence can be considered) was set at 18 years. Wing records show that the next day the man harmed himself by cutting. He attended the healthcare centre for treatment and another F2052SH was opened. The probation officer who chaired the review referred to a "multiplicity of other problems which are receiving attention by the relevant people". On 5 March 1999, the F2052SH document was closed.

16. Another F2052SH was opened on 19 April 1999 because information given to staff indicated that the man intended to take his life. The doctor who spoke with the man on 19 April noted he was "angry with the system" and was threatening to refuse food. The document was closed on 11 May when the crisis appeared to have subsided. A further F2052SH document was opened again on 26 October in response to concerns raised by staff and the Sikh minister. The man said that while he would not harm himself, he had received "three lots of bad news" including difficulties with his family, the loss of his appeal and a transfer to HMP Swaleside. The support plan said that the man and a member of staff were to make a referral to psychiatric services. There is no evidence to show that this was done, but detailed entries in the F2052SH say that he was closely observed by staff in view of their concerns he might harm himself because of his imminent transfer.

17. The man was transferred to Swaleside on 4 November 1999. A further F2052SH document was opened by Swaleside on 3 March 2000 because of the difficulties the man had expressed to staff at Highdown in coping with his family relationships, his appeal and his sense of hopelessness. Staff allowed him a telephone call to India to speak to his mother and made referrals to the psychiatrist and wing psychologist for continued support. Swaleside also offered a healthcare admission but the man declined this. A F2052SH review, held on 8 March 2000, noted that his depression had passed and he had been seen by the psychiatrist who was "now aware of his situation and placed him on medication". It was felt by staff and the man that the support provided by the F2052SH was no longer necessary as he was more focussed, and the document was closed.

18. On 18 April 2000, the man's mental state and behaviour deteriorated. He was admitted to the healthcare department and a F2052SH document was opened detailing a suicidal gesture on the previous night. He was placed in a protected cell and on continuous watch by staff. A review of the F2052SH was held the following day. Those attending included the duty governor and two members of the prison healthcare staff, but there is no evidence that mental health care staff were present. The review concluded that poor relationships with staff and anxiety regarding his mother being in a coma in India were the contributing factors to his attempt to take his life. Recommendations on the man's management included the need for him to be seen by counsellors and "to do anger management course in due course. Review by wing psychologist in view of his extreme uncontrollable anger." It is notable that there is no evidence of a referral to psychiatric services for an opinion.

19. On 4 May 2000 at 9.25am, the man was relocated to the segregation unit from healthcare for an adjudication upon a matter which he disputed. At 1.30pm, the man was found hanging in his cell. (Once more in one of my reports I must draw attention to the special riskiness attached to segregation.) Staff conducted cardio pulmonary resuscitation (CPR) and an emergency ambulance was called. Records show that the man was breathing unaided by the time he left the prison for the hospital. Sadly, he suffered irreversible anoxic brain damage.

20. Anoxic brain damage is caused by a severe lack of oxygen to the brain. The clinical reviewer has identified a range of symptoms including problems with thinking skills, emotional and behavioural difficulties. Physically, the man was severely incapacitated and needed 24 hour nursing care until the end of his life.

21. During her investigation, my investigator spoke with the Deputy Governor at Swaleside to ask whether an investigation had been conducted into the circumstances of the man's near fatal attempt to take his life in 2000. Following enquiries, the investigator was told that no report was found and healthcare staff who were at Swaleside at the time confirmed that, to their knowledge, no investigation took place. At the time, there was no national requirement that such 'near deaths' should be investigated. Current guidance is that they should be, and the terms for such investigations (including their compliance with Article

2 of the European Convention on Human Rights) are currently the subject of a case that is before the House of Lords.

22. After a lengthy period in hospital, the man returned to Swaleside where he remained until 2005 when his condition deteriorated. He was bedridden, and needed 24 hour nursing and personal care, and the prison met these needs with difficulty. Staff found the man to be a difficult individual because, at times, he presented with challenging and inappropriate behaviour, particularly towards female staff. (In interview with my investigator, the Head of Healthcare at HMP Norwich said that she found the man easy to manage. However, records suggest that this was not the experience of all staff and the man's challenging behaviour continued with some staff at Norwich.) Swaleside made a referral for the man to be transferred to the Nelson Unit at Norwich, which could provide the more specialist and intensive care that the man needed. The Head of Health Care informed my investigator that she had visited Swaleside with a colleague in order to assess the man for the Nelson Unit. She accepted him into the unit despite the fact that he did not meet the unit's minimum age criterion of 60. She told my investigator that she did this because she felt the unit would be better able to meet his challenging and complex needs.

23. The man's medical record shows that staff at the Nelson Unit had a consistent, dedicated and multidisciplinary approach to his care, with regular monitoring of his physical and emotional wellbeing. This included best practice in seeking advice in managing his aggressive and inappropriate behaviour with staff by identifying possible trigger factors. Specialist equipment such as a hoist and a special chair were purchased in order to meet his specific physical needs.

24. A letter dated 20 December 2005 from the Adult Speech and Language Therapy, Sheppey Community Hospital, to Speech and Language Therapy, Norwich Community Hospital, shows appropriate continuity of care from Swaleside to Norwich. The man was regularly reviewed by the speech and language service and his abilities and dietary needs were adjusted as necessary. His speech was limited to 'yes' and 'no' responses and he made his basic needs known to staff through his facial expressions. His difficulties swallowing were managed through a 'soft' diet with liquid taken from a spouted cup to encourage him to feed himself.

25. The family told my investigator and the Family Liaison Officer in this case that they felt the quality of care the man received at Norwich was less than at Swaleside where he had a designated carer. The family raised a concern that the man had been "parked" in front of the television in the lounge and left. My investigator discussed this issue with the Head of Healthcare. She told my colleague that on some days, with his consent, the man was placed in the lounge in front of the television to stimulate him and to encourage him to socialise with other prisoners. From the medical record, my investigator saw that when the man indicated to staff that he wished to remain in bed this was respected. My Investigator visited Nelson Unit and noted there was a television in the man's room for his sole use.

26. An entry in the medical record dated 11 September 2007 says that the man had experienced significant weight loss since his previous weight observation on 24 August. Chest problems persisted and his appetite varied from day to day. The medical record shows very good entries detailing efforts by staff to encourage him to eat. Staff closely monitored his health and appropriate prescriptions were given to address his weight loss.

27. On 31 January 2008, the man attended an appointment with the Doctor a Consultant Physician. This followed a referral by the prison because of concerns regarding his numerous chest infections, recurrent silent aspiration (food going into the lungs) and significant weight loss. A member of the Nelson Unit nursing staff, who knew the man well, attended the appointment to assist with communication. This was good practice.

28. On examination, the consultant physician found that the man was "emaciated and cachectic" (weakness associated with chronic illness) with," muscle wasting of all limbs". The Physician arranged for further investigation including a high resolution computerised tomography chest (CT) scan. An appointment was made for 19 March 2008. The report of the scan found that, "there appears to be a large mass in the left upper quadrant'" and recommended that an enhanced scan be carried out for further assessment. There was "extensive bronchiolitis throughout both lungs" with the conclusion that tuberculosis (TB) was the most likely cause. The Head of Healthcare confirmed that it was not possible to pinpoint exactly when and how the man contracted TB. From hospital records, the clinical reviewer has noted that a TB specialist nurse went to the Nelson Unit to assess the risk of infection to staff and prisoners. Screening was offered to those who were in contact with the man for a period of time in excess of eight to ten hours.

29. On the morning of 19 March 2008, a mental health capacity review was held at the Nelson Unit. This was attended by a locum doctor, Head of Health Care, Senior Nurse, the man himself, and a Doctor who would speak for him. The review concluded that, in the event of a heart attack, the man would not be resuscitated because cardiopulmonary resuscitation (CPR) was unlikely to be successful. Even if it were successful, it was judged that it would not be in the man's best interests to sustain the quality and length of his life. My investigator noted that the family was neither consulted regarding the review nor informed of the decision. This was a regrettable omission.

30. The man was admitted to the Norfolk and Norwich University Hospital for treatment for TB on 23 March 2008. On 26 March, the hospital confirmed that they were treating the man for active TB. They said this was a working clinical diagnosis as they were unable to take samples from the man and he was not well enough to withstand invasive procedures such as a bronchoscopy. (This is when a thin flexible tube is passed down the throat to diagnose some conditions of the airways.)

31. On 26 March, Head of Health Care informed the man's brother by telephone that the man was very unwell. The brother visited the man on 27th March. He

told the bedwatch escort staff that he would probably visit again at the weekend.

32. A Principal Officer (PO) was on bedwatch duty on 3 April. The bed watch log says that he assisted a nurse to give the man his medication. While well-intentioned, it is not clear whether this was with the man's consent and the clinical Governance Manager of Norfolk has addressed the issue in her clinical review attached to this report. The PO said he assisted because the man had refused his medication the day before and the nurse was concerned.

33. My investigator spoke with a Senior Officer (SO) who was on the same bedwatch as the PO. He told her that patient confidentiality is paramount and, respectful of that, staff were not told the nature of the man's illness. The man had a working diagnosis of TB, a serious communicable disease. If staff have to enter a room where a prisoner has a serious communicable disease for any reason, appropriate protective clothing must be worn. By example, a note on the bedwatch log handover dated 31 March clearly states that "mask to be worn when entering room". In interview, the PO was unclear as to whether or not he placed himself at a risk of infection.

34. The bedwatch log records that the man was fed by nursing staff at the hospital at 8.00am and was not seen again by any member of staff until 12.20pm when a nurse entered the room and found he had died. This is supported by another Senior Officer who was on bedwatch duty outside the room. In his statement he said that at about 8.00am nursing staff went into the room to give the man his medication and food, and to attend to his personal hygiene. The SO remained outside the man's room. He described hearing the man during the morning as if he was moving his head from side to side and groaning. The SO said that at midday he could no long hear anything and thought that the man must be "motionless". He said that at 12.40pm the nursing staff entered the room and said that the man had died. Although the matter is outside my terms of reference, it is both a sadness and a cause for concern that hospital staff apparently did not check the man for over four hours and that he died alone in his room.

35. Head of Health Care told my investigator that she had been surprised to learn of the man's death as it had come sooner than the prison had expected. She said that they had been preparing for the man's return on or around 8 April. They had started preparations for end of life care, as they suspected the mass found on the scan might have been an underlying malignancy.

ISSUES

Clinical care

36. The clinical review was undertaken by the Clinical Governance Manager, Norfolk Primary Care Trust. She concludes that, "the quality of care provided by the team at Norwich was of a very high standard. Up to the point of his transfer into the Norfolk and Norwich University Hospital, the man had thorough multi-disciplinary assessment and care." The inference to be drawn from the clinical review is that the standard of care the man received at HMP Norwich was superior to that he received at Norfolk and Norwich University Hospital. I am unable to investigate the matter of the man's care at the hospital as this goes well beyond the terms of reference for my office.

37. The family has raised concerns regarding the man's transfer from Swaleside to Norwich. In the clinical Governance Manager's judgement, the transfer was in the man's best interests and I agree. In the clinical Governance Manager's view, Norwich demonstrated a high level of care ensuring the purchase of equipment, appropriate referrals and a holistic approach. Challenging behaviour was managed through referrals to other expert agencies for advice and guidance in identifying trigger factors.

38. The clinical reviewer visited Norfolk and Norwich University Hospital and spoke with the TB specialist nurse who had visited the prison on 2 April 2008 to assess the risk of infection to staff and prisoners. Screening was offered to those who had been in direct contact with the man for a period of time in excess of eight to ten hours. While the clinical reviewer was able to view hospital records relating to the TB nurse's visit, she was unable to find such an entry in the prison medical record.

Family Liaison

39. My investigator judged that some aspects of the liaison between Healthcare, the prison's Family Liaison Officer and the family were disappointing. In particular, Healthcare did not invite the man's brother to the mental capacity review when important decisions regarding whether the man should be resuscitated in the event of a heart attack were discussed.

    The Head of Healthcare should consider inviting the next of kin to meetings and reviews where decisions regarding resuscitation of prisoners and end of life care are discussed.

40. The brother of the man expressed some dismay at not being invited to the memorial service held in Healthcare for the man. He said that, had he received an invitation, he would have liked to have attended to speak to those who knew his brother. I share the man's brother's disappointment. I believe this oversight on the part of HMP Norwich was unintentional, but there are lessons to be learned.

In the event of a prisoner's death, the Governor should invite the deceased's next of kin are invited to any memorial service held at the prison.

41. My investigator spoke with the liaison officer, the prison's Family Liaison Officer, regarding the brother's concern that the prison was not represented at the man's funeral. The Liaison Officer explained that the undertaker had spoken with her over the telephone and told her the date of the funeral. She said that the undertaker then rang back and told the liaison officer that they had made a mistake in telling her the date as this was not for release. In the circumstances, the prison was not represented at the funeral, but a condolence wreath was sent to the family.

42. A further concern is that the Head of Healthcare acted alone when she told the man's brother of the man's death over the telephone. Guidelines regarding support for the family of deceased prisoners are to be found in chapter 4 of Prison Service Order 2710. Supplementary guidance to FLO's recommends, "that the family should be informed face to face as soon as possible after a death. Wherever possible this should be done by a dedicated Family Liaison Officer." Good practice would have been for the prison's Family Liaison Officer to have been informed and a joint visit made with the Head of Healthcare to the family. Paragraph 4.13 states that, "using the telephone is too impersonal to use in delivering news of a death to the family and should be used only as a last resort." There is no evidence that all other methods of informing the family had been exhausted in the man's case.

The Head of Healthcare should inform the prison's Family Liaison Officer of expected as well as unexpected deaths, whether in the prison healthcare unit or in hospital, so the family can be informed appropriately and in accordance with the Prison Service Order.

Roles and responsibilities of bedwatch staff

43. The bed watchlog completed immediately before the man's death records that the PO assisted a member of the hospital nursing staff to administer medication (an antibiotic injection) to the man. In interview, the PO was unclear as to whether this was with the man's consent or not. I conclude that on the balance of probabilities (particularly taking account of the bedwatch log entries indicating that the man had refused medication previously) that it was administered without his consent. In her clinical review, the clinical governance manager says that, while this was with the best of intentions, "it is imperative that consent is always clearly established before treatment goes ahead". In speaking with my investigator, the clinical governance manager indicated that there are very clear National Health Service guidelines regarding consent and these should be observed.

44. My investigator was told that bedwatch staff are not informed of the nature of a prisoner's illness. It is clear from the bedwatch log that, while prisoner/patient confidentiality is respected, staff are told whether or not they should wear protective clothing. The PO says he cannot recall whether he wore protective

clothing or not when he entered the man's room to assist the nurse. However well-intentioned his actions, I think it most likely that he did not wear appropriate protective clothing, thereby placing himself at risk of contracting a communicable disease.

The Governor and the Primary Care Trust should agree a memorandum of understanding setting out very clear boundaries governing the respective roles, responsibilities, expectations and codes of behaviour between nursing and prison bedwatch staff.

45. I have reported on many occasions on the excellent end-of-life care provided by the Nelson Unit at HMP Norwich. In large part, this report into the death of the man continues that tradition. Nevertheless, some matters were not handled as well as they might have been and this is reflected in my four recommendations. Even centres of excellence should be looking to improve further.

46. The Prison Service's response to my recommendations follows each of my recommendations as set out on page 18 of this report.

RECOMMENDATIONS

1. **The Head of Healthcare should ensure next of kin are invited to attend meetings and reviews where decisions regarding resuscitation of prisoners and end of life care are discussed.**

   'Partially accepted. While it is accepted that it is good practice to involve next of kin in end of life decisions, in line with UK Resuscitation Guidelines, this is advisory. In this case, there was difficulty in establishing next of kin, and the Independent Mental Health Capacity Advocate acted on behalf of the decision making.'

2. **The Head of Healthcare should inform the prison's Family Liaison Officer of expected as well as unexpected deaths, whether in the prison healthcare unit or in hospital, so the family can be informed appropriately and in accordance with published guidance.**

   'Accepted. All expected deaths are notified in advance to a designated Family Liaison Officer (FLO). Unexpected deaths are notified as an immediate action.'

3. **In the event of a prisoner's death, the Governor should ensure that the deceased's next of kin are invited to attend any memorial service held at the prison.**

   'Partially accepted. Because of the nature of L wing, Norwich held a memorial service for the benefit of the patients that reside there. This was distinct to the memorial service for the family as set out in PSO 2710. Family members will be invited to memorial services at Norwich in future.'

4. **The Governor and the Primary Care Trust should agree a memorandum of understanding setting out very clear boundaries governing the respective roles, responsibilities, expectations and codes of behaviour between nursing and prison bed watch staff.**

   'Accepted. A memorandum of understanding will be drafted and agreed with the local Acute Trust.'