Investigation into the circumstances surrounding the death of a man in June 2011 at HMP & YOI Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of the investigation into the death of a man in June 2011 at HMP &YOI Norwich. He was diagnosed with terminal lung cancer on 26 May, while a prisoner at HMP Littlehey. The man transferred to the Nelson Unit at HMP Norwich on 9 June, for palliative care. Around 8.50am on 18 June, the man haemorrhaged blood from his lungs. Despite emergency treatment from the healthcare staff, he was pronounced dead at 9.05am by paramedics. The man was 63 years old.

Her Majesty's Coroner for Greater Norfolk District held a post mortem examination for the man and found he died of natural causes, specifically lung cancer. I extend my sincere condolences to his family and friends.

An investigator was appointed to carry out this investigation. A review of the man's clinical care was commissioned with Norfolk Primary Care Trust (PCT
I am grateful to the governors and staff of HMPs Littlehey and Norwich for their co-operation.

The investigation concludes that the man received medical care equivalent to that which he would have received in the community, although we and the clinical reviewer do identify certain improvements, which can still be made. We make one recommendation to the Head of Healthcare at Littlehey to develop an end of life pathway. The report also concludes that the suddenness of the man's death could not reasonably have been foreseen and that this created difficulties in terms of informing and supporting family members. In order to avoid such difficulties in future, I make a recommendation to the Governor of HMP Norwich, regarding family liaison arrangements following a death of a prisoner.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2012**

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SUMMARY

1. The man was remanded to HMP Norwich on 19 January 2009, for serious offences and sentenced to an indeterminate prison sentence three months later. (An Indeterminate Public Protection (IPP) sentence means that a prisoner can be retained in custody until the parole board reviews and assess the prisoner, as to whether they are able to live in the community without risk to the public.)

2. According to the man's medical record, he had heart disease, high cholesterol and was a smoker. On 17 July, he was transferred to Littlehey and did not report any serious health problems to medical staff until June 2010, when he told a doctor he had lost two stone. A month later, the man was referred for a chest X-ray and lung function tests. On 2 September, he was diagnosed with chronic obstructive pulmonary disease (COPD - a form of lung disease which affects breathing) and prescribed an inhaler.

3. In February 2011, the man told a nurse he was still concerned about his weight loss, so the nurse arranged a prescription for a nutritional protein drink to boost his calorie intake. On 9 April, the man was admitted to hospital following deterioration in his breathing. A month later, he was diagnosed with pneumonia following treatment and was discharged back to Littlehey.

4. Following medical tests in hospital, the man was diagnosed with inoperable lung cancer on 26 May. He was prescribed moderate pain relief medication. (Littlehey was not equipped to support Oramorph, a stronger, opiate-based pain relief.) The man was located in a cell with special comfort aids. A prisoner was assigned to help him with his day to day care and nursing staff visited him several times a day to administer medication and offer emotional support.

5. The man had no contact with his family during his time at Littlehey. His community offender manager visited his mother on 8 June and told her of her son's terminal illness. His family began to make plans to visit him. Arrangements were made for the man to be transferred to the Nelson Unit in Norwich, which has been specifically designed to provide palliative care support on 9 June. However, his health continued to deteriorate after arriving at Norwich and his brother and sister arranged to visit him on the afternoon of 18 June.

6. Around 8.50am on 18 June, the man haemorrhaged blood from his lungs, an unforeseeable complication of the cancer. Healthcare staff responded urgently, but he could not be saved and paramedics pronounced him dead at 9.05am. The clinical reviewer found that the man received care equal to that in the community.

7. A family liaison officer and duty governor went to break the news of the man's death to his son, who he had nominated as his next of kin. However, the man's brother and sister were on their way to visit him, not aware that their brother had died that morning. On arrival at Norwich, they were telephoned

by a family member who told them of the man's death. The family liaison officer and duty governor returned to the prison to offer support to them.

8. We consider the care afforded to the man as being equal to that he would have been shown in the community. His transfer to Norwich was appropriate given the palliative care nursing the man needed as his health was deteriorating. However, the liaison with the man's family should have been arranged to cover support for his extended family,

THE INVESTIGATION PROCESS

9. The investigation into the man's death was opened by an investigator on 24 June 2011 at HMP Norwich. She met the liaison officer , reviewed the man's prison and medical records, and arranged for copies of documents relevant to this investigation. Later that day, the investigator visited the Nelson Unit, where the man had been cared for in the last days of his life.

10. The Ombudsman's notices of investigation and terms of reference had been sent to the prison in advance of the investigator's visit. No members of the Independent Monitoring Board (IMB) or the Prison Officer's Association (POA) asked to see the investigator. Her details were made available to them should they wish to contact her. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, staff and prisoners. The POA is the prison officer's trade union.)

11. A review of the man's medical care while at Littlehey and Norwich was commissioned with Norfolk PCT. A primary care development manager with NHS Peterborough, carried out the review on behalf of the PCT.

12. One of my family liaison officers telephoned the man's son to inform him of the investigation and ask whether he had any concerns about the man's time in custody. The family's key concerns were as follows:

    - Why did a probation officer inform the man's mother of their brother's terminal illness?
    - Why were family not allowed extra visits to see the man?
    - Why did the family have problems in arranging to visit the man in Littlehey and Norwich?
    - The treatment of the man's brother and sister on 18 June, specifically, the man's family would like an apology from Norwich for the lack of sensitivity shown to them on the day of his death.

13. The investigation assesses the following aspects of the man's care and treatment:

    - Whether his diagnosis was made in a timely fashion?
    - Whether he was told about his condition and the treatment, which followed?
    - Whether he was treated properly and attended hospital appointments as necessary?
    - Whether the liaison with the family was appropriate?
    - Whether he was accommodated in the most appropriate part of the prison?
    - Whether consideration was given to compassionate release from prison?
    - Whether appropriate palliative care was provided?

14. In this final report, the NOMS have accepted both recommendations and a factual inaccuracy has been amended in paragraph 82 relating to the definition of the open door policy. .

15. The family liaison officer spoke to the man's brother after he had read the draft report. He made one comment in relation to the transcript of interview with a nurse. In the interview, she refers to the man not meeting the criteria on Littlehey's G wing when a suitable location for his care was being considered. The man was eventually transferred there after healthcare staff insisted that G wing was the most appropriate location for him. The man's brother was concerned that his sick brother should have had easy access to the most appropriate facilities in the prison, where he could be cared for without criteria being an issue.

16. The man's son asked for copies of the documents considered but not annexed to the draft report. On 16 February 2012, the family liaison officer sent the man's son the documents that he had requested.

17. On 13 March, the family liaison officer spoke to the man's son and invited him to comment on the draft report. He had no individual comments to make however, he disagreed with the clinical reviewer's opinion that the man had received equitable care in prison as to what he may have received in the community. The man's son said that healthcare staff were "slow to respond and react", to his father's weight loss.

HMP & YOI NORWICH

18. HMP Norwich is a local training prison serving the courts of Norfolk and Suffolk. It holds a maximum of 767 men, a mixture of adults and young offenders. The original buildings date back to the Victorian era and the site is geographically split into two locations. It also has a dedicated older prisoners' unit for those with chronic or terminal illnesses.

19. Healthcare services are commissioned by National Health Service (NHS) Norfolk and provided by a private company, Serco Health. Serco Health also provide healthcare at two other nearby prisons. Serco deliver the care in association with a number of partners, including Norfolk Community Health and Care (NCH&C). Close links have been developed with the Priscilla Bacon Lodge, an NHS facility located in Norwich, which specialises in the care of those prisoners reaching the end of their lives.

20. Her Majesty's Inspector of Prisons carried out an unannounced inspection of Norwich in February 2010. The inspection found that the healthcare provision was improving but the inpatient regime was insufficient. The report made the following comments about the older prisoner's unit in particular:

> "Many of the patients required full nursing care and staff were hard pushed to provide the required level of care despite their best efforts. The unit had excellent links with outside agencies, including the local palliative care team."

21. In Independent Monitoring Board's Annual report for February 2010, the Board noted :

> "Currently, there is a tendering process taking place, the outcome of which is unknown. It is hoped that this will address the longstanding problem of being provided with locum doctors, who can be unfamiliar with a prison healthcare setting."

22. Norwich has been the subject of a high numbers of deaths in custody investigations, the majority of which happen in the Nelson Unit. This unit cares for elderly prisoners and has a high number of natural cause deaths. The man was located in the Nelson Unit, which has been designed to provide palliative care for the terminally ill. (Palliative care is an area of healthcare that focuses on relieving and preventing the suffering of patients.) The man's death was the first natural cause death at this unit since 2010. The care provided by the Nelson Unit continues to be of a high standard as noted in previous reports.

HMP & YOI LITTLEHEY

23. HMP & YOI Littlehey is a male prison located outside the village of Perry in rural Cambridgeshire. It has a maximum capacity of 726 adult male prisoners with 480 young offenders accommodated in the new young offender unit opened early in 2010.

24. Healthcare at Littlehey is provided by NHS Cambridgeshire. The prison does not have 24 hour healthcare facilities. There is a GP service and a local out of hours medical service is available for medical emergencies when doctors are not on duty.

25. The IMB annual report for 2009/2010 is positive in a number of areas and acknowledges the challenges and upheaval in the prison during the construction of the young offender unit. The most recent inspection by HM Inspectorate of Prisons, was carried out in 2007. The resulting report described Littlehey as a well-performing prison.

26. There was one other death at Littlehey in the last year. While there are some similarities in the circumstances of the man's death and that of other natural cause deaths at Littlehey, no recommendations were made on that occasion.

ISSUES

27. The man was born in March 1948. He was single with children. In January 2009, the man was remanded to Norwich awaiting sentencing. His medical record shows that he was prescribed medication for high cholesterol and heart disease.

28. On 22 April 2009, he was sentenced at a Crown Court to an indeterminate prison sentence for serious offences. This was not his first time in custody. The man converted to Islam during his sentence enabling him to therefore follow the Muslim faith. He transferred to HMP Littlehey on 17 July 2009 and his medical history was sent by Norwich, via the electronic medical record system, to their healthcare unit.

29. The man complained of chest pain, so blood tests and medical observations were carried out on 9 February 2010. An Electrocardiogram (ECG), to measure the heart rhythm, showed that there were no abnormalities and his blood pressure was within the normal range of 130/80. Later, it was noted that his blood test did not indicate any further medical concerns other than his already diagnosed heart disease and high cholesterol.

The diagnosis of the man's terminal illness

30. The man was advised to stop smoking on 14 June 2010, and attended a smoking cessation clinic. A week later, he was seen by a doctor, who recorded that the man had told him he had lost two stone over the last year, but he was eating and drinking as normal. (His medical record does not note any weight measurement until this entry.) The doctor ordered a fasting blood test. (For fasting blood tests, the patient must not eat for a set number of hours before the blood sample is taken.)

31. On 28 June, the man did not attend the healthcare unit for his blood test, and healthcare staff were unable to take a sample on 5 and 8 July as the man had eaten. He weighed 67 kilograms (kgs). The blood sample was finally taken on 9 July.

32. A doctor examined the man on 20 July and referred him for a chest X-ray, and a Spirometry test, a procedure to assist in diagnosis of lung disease. The man told the doctor that he had a cough and was concerned about his weight. The doctor noted that the man's weight should be monitored but his blood test results were within normal range. It is not recorded whether the man was told of the result of his blood test. A month later, a doctor wrote that the man was not smoking because of Ramadan and his weight was 69kgs. (Ramadan is the islamic month of fasting in which participating Muslims refrain from eating, drinking and smoking during daylight hours.)

33. According to his medical record, the man was diagnosed with COPD on 2 September. He was prescribed an inhaler to help his breathing. The man failed to attend a smoking cessation course in October.

34. A nurse saw the man on 9 February 2011, he told her he was concerned over his weight loss. His weight was noted to be 68kgs and the nurse recorded that she would speak to the doctor for a nutritional supplement to be prescribed.

35. The clinical reviewer noted that the man first told healthcare staff he was losing weight in June 2010. A weight management plan was not implemented to check his weight on a regular basis, although one doctor had requested it be monitored. The man was prescribed protein drinks to boost his calorie intake and improve his weight control. The reviewer recommended that a weight loss policy should be developed at Littlehey.

36. The man was admitted to hospital on 9 April, because his breathing had deteriorated. (There was no entry referring to the man's symptoms prior to him being admitted to hospital.) He was diagnosed with pneumonia, treated and discharged back to Littlehey on 3 May. On 16 May, the man was escorted to hospital, as a day care patient, for a bronchoscopy, a procedure where a camera is inserted into the lung, and a computerised tomography scan (or 'CT' scan, which takes images of the body tissues) to assist diagnosis.

37. On 26 May, the man attended an out patients appointment at hospital and was given the news that he had primary lung cancer with secondary cancer in his bones. The clinical reviewer said:

> "The hospital consultant informed him [the man] that his cancer was inoperable and incurable and that the average prognosis for such a diagnosis was 6-12 months, but this was not patient specific [i.e. not a prognosis specifically for the man]."

38. Furthermore, the clinical reviewer noted that the man had a history of heart disease and was a smoker. Despite an invitation to attend smoking cessation clinics, the man declined to access this service until April 2011.

39. It was noted in the clinical review that the man was not told of his blood test results and his admission into hospital in April was "poorly recorded in the clinical record". The clinical reviewer recommends that Littlehey should undertake a regular audit of clinical records to ensure that record keeping is of an acceptable standard.

40. The man was referred to hospital when his health was a cause for concern and his symptoms indicated that further medical investigations should be undertaken. We are satisfied with the timely and appropriate diagnosis of his condition.

Informing the man about his condition and treatment

41. A nurse from a hospital spoke to healthcare staff on 26 May, to inform them that the man had been diagnosed with cancer. A nurse, visited the man on the wing when he returned from the hospital. He told the nurse he suspected

that he had cancer and was glad that they were honest with him. A wheelchair was ordered so that The man could have mobility around the wing.

42. A Macmillan Nurse (a specialist in caring for cancer patients) spoke to healthcare staff on 2 June, to offer her support and to arrange a pressure mattress for the man. (A pressure mattress is designed to encourage the blood to circulate while the patient is resting.) The nurse arranged to visit him within the next few days and she made herself available to healthcare staff when ever they needed her advice.

43. The clinical reviewer noted the arrangements for specialist equipment to aid the man's comfort. Discussions between him and nursing staff continued throughout early June, including the implications of his illness. The man was advised of his condition, the limitations of treatment available to him and was supported by staff throughout the latter stages of his illness.

The man's medical appointments and treatment

44. The man attended all his medical appointments at hospital. There is no record of him missing any appointments with healthcare staff, other than blood tests. However, it was noted that he failed to attend the smoking cessation clinics, and was entitled to do so.

45. Healthcare staff at Littlehey saw the man on a regular basis up to his admission into hospital on 9 April 2011. Following his diagnosis of cancer, he was seen up to three to four times a day to administer his medication, check his medical observations and offer support. The man's cancer was too advanced for chemotherapy (a treatment to reduce cancer cells) therefore, the only treatment that could be offered to him was pain relief.

46. A care plan was added to the man's nursing care on 5 June. (A care plan sets out the nursing support for a patient.) The man was provided with extra pillows. A wheelchair was noted to have been supplied. A prisoner specifically trained in assisting those with disabilities was assigned to help and support the man. The orderly regularly took the man for walks in the prison grounds. We acknowledge the good practice of using prisoners to support seriously ill prisoners. This was also endorsed by the clinical reviewer.

The man's pain relief and medication

47. A nurse from a hospital advised that the man should be prescribed Oramorph, an opiate-based medication for pain relief, following his out patient appointment on 26 May. However, Littlehey does not have a primary healthcare unit and cannot administer Oramorph outside nursing hours. (Littlehey's nursing staff are on duty during the day time only.) The hospital nurse suggested that the man be prescribed Tramadol instead, a pain reliever used to treat moderate to severe pain, paracetamol and Fortisips, a nutritional supplement.

48. The man told a nurse that he was concerned that he would be unable to receive Oramorph, a stronger pain reliever, at Littlehey. They discussed the advice from a hospital and the nurse agreed to speak to the doctor. The following day, a doctor spoke to the man and added Tramadol to his prescription of co-codamol and paracetamol. However, the clinical reviewer noted that the man's medication chart indicated that he did not receive Tramadol until 31 May, four days later.

49. On 2 June, the dosage of the man's pain relief was increased, as he was experiencing pain in his shoulder. Following his transfer to Norwich on 9 June, anti sickness medication was added to his prescription. His pain was under control with continued Tramadol and paracetamol. On 17 June, a doctor prescribed Oramorph for pain relief as the man told healthcare staff that Tramadol was no longer effective in controlling his pain .

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50. The clinical reviewer noted that the hospital originally advised that the man should be prescribed Oramorph. However, due to limited healthcare resources this was not an option. After discussion, it was agreed that the man's pain could be controlled without opiate based medication at this stage of his illness.

51. Furthermore, the reviewer noted that the man's medical record showed that there was a gap of four days before Tramadol was offered to him. There was no explanation given for this gap in prescribing pain relief. The clinical reviewer recommends the regular audit of medication charts so that prisoners receive their medication in a timely manner.

The man's location

52. When the man was diagnosed with cancer, he was a prisoner at Littlehey where there is no in patient unit or healthcare staff in the prison overnight. Following his diagnosis, he was able to remain on a wing with the support of nursing and wing staff, with help from fellow prisoners.

53. The man moved wings on 1 June and a disability liaison care plan was opened. (This wing was able to provide appropriate accommodation for the man by locating him in a larger cell with an en suite shower and toilet). The plan set out the man's needs for his continued care. A wheelchair had been provided to help with his mobility and prisoners were willing to assist him when he needed it. It was noted that the prison's disability officer would see the man weekly, to ensure all his needs were being met.

54. The clinical reviewer was pleased to note that nursing staff visited the man in his cell to ensure he received his medication. The reviewer found that this "systematic approach" was equivalent to 'home visits' undertaken in the community. Furthermore, the clinical reviewer commended the proactive management of the older prisoner population and the role of a lead nurse in supporting this population.

55. Following a discussion with a nurse over his future nursing care, the man accepted that he may have to be transferred to another prison where continuous medical care could be provided. He also told the nurse he had spoken to the Imam, a religious leader, who would be involved in supporting him. The man indicated that he would like to stay at Littlehey, or transfer to accommodation in Norwich, near to his sister.

56. A nurse made contact with the Nelson Unit at Norwich on 1 June. She discussed the possibility of transferring the man because his condition was deteriorating and the unit offered facilities for prisoners in need of intensive nursing care. The modern matron at Norwich agreed to consider his transfer. In the meantime, the man was moved to another wing with a larger cell which would enable healthcare staff to nurse him in a more suitable environment.

57. The Assistant Director of Clinical Quality and Patient Safety for NHS Norfolk, agreed to the man's transfer to the Nelson Unit on 8 June. They made an exceptional case for the man because he was not within NHS Norfolk's area for transfer. He transferred to the Nelson Unit on 9 June, where he received full palliative care until his death.

58. The man was consulted throughout his time in custody about where he wanted to live. Although he preferred to stay in Littlehey, he understood the limitations of the care he could receive there and was happy to move to Norwich. Littlehey were proactive in securing the transfer to a more intensive healthcare environment, and Norwich were flexible in accommodating The man when his condition became critical.

Compassionate release

59. Prisoners who are suffering from a terminal illness and for whom death is thought likely to be imminent (generally a life expectancy of three months or less) can be considered for release from prison early on compassionate grounds. An application must be sent to the Public Protection Unit (PPU) in the National Offender Management Service (NOMS) headquarters. The application form includes sections to be completed by the Governor, a prison doctor and an offender manager (OM – is responsible for assessing risk, managing the sentence plan and authorising any release accommodation). A full prognosis must also be provided. Once the form is submitted, caseworkers in the Public Protection Casework Section (PPCS) determine whether the application meets the criteria set out in Prison Service Order (PSO) 6000 (the instruction that deals with the release and recall of prisoners). In making this decision, they consult with the Parole Board and specialist medical advisors in the Department of Health. PSO 6000 states:

> "The criteria applied in medical and tragic family circumstances cases are as follows:
>
> <u>Medical</u>

i. the prisoner is suffering from a terminal illness and death is likely to occur soon; or the prisoner is bedridden or similarly incapacitated; and
ii. the risk of re-offending is past; and
iii. there are adequate arrangements for the prisoner's care and treatment outside prison; and
iv. early release will bring some significant benefit to the prisoner or his/her family."

60. A file was prepared by prison staff for the man's release on parole and sent to the Parole Board on 26 May. (This was his first review following his conviction.) However, evidence held in that file indicated that the man was deemed to be still a high risk to the public and would not be suitable for a move into the community.

61. Healthcare staff at Littlehey considered making an application for the man to be released under compassionate circumstances. (This application for release is not linked to the Parole Board decision on release.) The Deputy Governor, submitted a short report to the Early Release and Recall Section of the National Offender Management Service. She received a reply indicating that the man still posed some risk in the community, and an application for a compassionate release would be inappropriate at that stage. She was told that an application could be made at a later date. At the time of her application, the man's prognosis was unclear and his death on 18 June was unexpected. We are satisfied that appropriate steps were taken to consider the man for a compassionate release.

Palliative care plans

62. On 26 May, a palliative care plan was developed by healthcare staff at Littlehey following his diagnosis of cancer. The clinical reviewer noted that the Gold Standard Framework was not implemented. (GSF – is a systems based plan to ensure the best care for patients nearing the end of their life. It is a multi-disciplinary plan involving all the agencies caring for terminally ill patients.) Littlehey's initial care plan considered the man's pain relief including the concern that Oramorph could not be managed at Littlehey as they did not have 24 hour nursing cover.

63. On 3 June, the man discussed with two nurses, a Do Not Resuscitate (DNR) order. (A DNR order indicates that the patient does not wish medical intervention should they go into heart failure.) The man signed the order and this was witnessed by the two nurses. However, officers told nursing staff that they had a duty of care to attempt resuscitation should the man go into cardiac arrest. During interviews with healthcare staff, the investigator was told that a protocol was being developed between the healthcare staff and prison staff to ensure clear arrangements are made when a DNR has been signed. A second DNR form was completed when the man transferred to Norwich, witnessed by a doctor and the clinical healthcare lead.

64. The clinical reviewer recommends that a national policy should be developed for end of life care and the position of prison staff in their duty of care when a DNR has been signed by a prisoner. Whilst we note these recommendations, the Ombudsman is mindful that the NHS will be publishing a National End of Life Care Programme for prisons in the near future which will set out national standards.

65. The clinical reviewer identifies recommendations relating to end of life care for terminally ill prisoners at Littlehey. Those recommendations include training of staff in the GSF, medication charts, and the timely use of the GSF, pain management and nutritional status. We therefore endorse the following overarching recommendation for the head of healthcare of Littlehey:

The head of healthcare at HMP Littlehey should work with commissioners to develop an end of life pathway for prisoners in line with the Gold Standard Framework.

66. On his transfer to the Nelson Unit, a new palliative care plan was developed by healthcare staff. The plan was appropriately followed by nursing staff and updated to monitor the man's pain control and medication.

18 June 2011

67. A Healthcare Officer (HCO) was on duty in the Nelson Unit on 18 June. Around 8.30am, she was unlocking the cells for prisoners to take their breakfast. She unlocked the man's cell and saw he was in bed. She spoke to him and he nodded his head in response to the officer. The HCO continued with her duties and within ten minutes, she heard a personal alarm sound and ran down the landing checking all the cells.

68. On her arrival at the man's cell, she found him on the edge of his bed with blood pouring from his mouth into a bucket. The HCO assisted the man by supporting him under his arms and asked a passing prisoner to fetch a nurse immediately. A nurse was alerted and made her way to the man's cell. The nurse saw the distressing situation and raised the emergency alarm. At 8.53am, an emergency ambulance was summoned.

69. A Healthcare Senior Officer (HCSO) arrived at the man's cell and assisted the first HCO. With the nurse and the two HCOs they moved the man onto his bed and laid him in the recovery position. (This is the best position for a casualty who is unconscious and breathing. It keeps their airway open.) The HCSO then told the HCO to leave the cell as her uniform, hand and arms were heavily blood-stained. Furthermore, she had injured her shoulder whilst supporting the man.

70. Other healthcare staff then assisted with caring for the man and checked his medical observations. A nurse told the HCSO that the man had signed a DNR. At 9.00am, a paramedic arrived at the man's cell and attached a mobile defibrillator to his chest to check for signs of electrical activity in his

heart. Staff informed the paramedic that the man had signed a DNR. At 9.05am, the paramedic confirmed that the man had died.

71. Haemorrhage in the lungs is an unusual symptom associated with lung cancer and is distressing for the patient and for those trying to assist them. we acknowledge the professional standard in which the HCO and her colleagues supported the man. The clinical reviewer also reflects that staff acted well in the circumstances and more generally comments on the assessment and quality care planning by healthcare staff at Norwich.

Family Issues

Informing the man's family of his diagnosis

72. The man was not in touch with his family during his time at Littlehey. His offender manager (OM) told the investigator that the man contacted him because he was concerned that, despite writing to his mother on several occasions, he had not received a reply. He asked the OM if he could contact his mother on his behalf to find out how she was and if she had received his letters.

73. The OM wrote to the man's mother raising her son's concerns and asking if he could assist in her having contact with him. The man's mother replied to the OM and he told the investigator that she had said, "that she sometimes forgets to write to the man but that he could write to her more often."

74. On 26 May, a prisoner wrote to the man's sister, on his behalf, to tell the family that he had cancer. The friend included the man's prison number and added that the family could reply through him, as a friend, if that is what they wanted.

75. Prison staff contacted the OM on 6 June, to inform him of the man's prognosis relating to his terminal illness. The man was keen to know if a visit could be arranged so that his mother could see him. He told prison staff that despite writing to his family he had not heard anything and that his family may not want contact. However, he wanted to see them to say his "goodbyes". The OM told the prison staff that he had the man's mother's address. It was agreed that the OM would visit her at her home address which was in the same town as his office. (This town is some distance from Littlehey.)

76. On 8 June, the OM and a female civilian worker from Suffolk Constabulary visited the man's mother. The OM was accompanied by the civilian worker for support and for her experience as a public protection worker. On arrival at her home, the man's mother said she had been made aware that her son was very unwell through the letter that had been sent to her daughter on 26 May. The family agreed the man's brother would visit him in Littlehey.

77. The OM informed the prison of the outcome of his visit and if the man wanted to see his brother, then he should send him a visiting order. The deputy governor, emailed the OM to thank him for his assistance but explained that

the man would be transferring to Norwich on 9 June. The Governor of Norwich was copied into the email exchange to keep him informed of the situation regarding the man's family.

78. The family told the Ombudsman's family liaison officer that they were concerned that they had not been told of the man's illness. The man took the initiative to inform his family, by asking a friend to write to his sister on his behalf. It is good practice for the prison to ensure families are kept in touch in the event of a prisoner's serious illness. Although it was not normal practice to involve the offender manager in such a situation, the OM had supervised him for some time and knew his family arrangements.

79. The investigator spoke to the Deputy Governor, about appointing a family liaison officer to work with the man's family as soon as they were aware he was terminally ill. She told the investigator that the man was moved to Norwich the day after the OM visited the man's mother and there had not been enough time to appoint a family liaison officer to maintain that contact. She emailed the Governor at Norwich to make him aware of the man's family situation.

80. We are satisfied that Littlehey supported the man in renewing contact with his family. He had no communication with his family during his prison sentence and was concerned that they would therefore not know the seriousness of his health problems. Arrangements were made for the family to be told of his diagnosis and the man was made aware that his family were actively looking for ways in which to visit him. We acknowledge the professional manner in which the OM carried out his duties and the sensitive approach he took, which is beyond his remit as an offender manager.

Visiting arrangements

81. The man's family told the Ombudsman's family liaison officer, that they had tried on many occasions to speak to the chaplaincy staff at Littlehey to arrange a visit without success. The investigator spoke to Littlehey's chaplain, to ask if he, or any of the chaplains had spoken to the family to arrange for them to see the man. The chaplain told the investigator that neither he, nor his colleagues on the chaplaincy team, could recall any contact with the man's family.

82. After he died, the man's family were told that there was an 'open door policy' on the Nelson Unit in Norwich, whereby cells are unlocked so that nursing staff have 24 hour access to the patient. It also means that visits can be facilitated at short notice. The man's family were concerned that they were not advised of the policy while he was still alive, and therefore could not take advantage of it. The policy only applies when a prisoner is assessed as being in the final days of his life. Such visits are pre-arranged and authorised by the Governor. The man was deteriorating and a visit from his family was brought forward. Although his condition was serious, his death was sudden and unexpected, and therefore the open door policy had not been put in place. Sadly, the man died unexpectedly before his family could visit.

83. The man's son told the family liaison officer that he tried to visit his father at Norwich. However, he had been told that he would need the permission of the Governor having previously been on remand in the prison. (The man as an ex-prisoner, would be required to write to the Governor to ask for his permission for a visiting order so that he could visit his father.) The investigator wrote to the Governor asking if he recalled visit arrangements for the man's son.

84. On 23 September, a member of staff of Norwich's secretariat replied to the investigator's letter. According to security records, the man's son telephoned the prison on 15 June to discuss visits. As a matter of medical confidentially, the visits booking staff would not have been aware of the man's terminal illness.

85. The letter further adds:

> "It is deeply regrettable that [the man's son] was not able to visit his father before his death and our visits manager has tendered her personal apologies for the distress caused. We would have certainly tried to hasten the required security checks had we known of the impending circumstances and a system is in place to this effect."

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86. A governor spoke to the man's brother via a telephone call during the afternoon of 17 June. Despite having booked a visit the following week, the man's brother wanted to see him sooner given his deteriorating medical condition. The governor telephoned the Nelson Unit and was briefed about the man's medical condition. It was agreed that a visit from his family the following day would be beneficial for him.

87. The governor arranged for the man's brother and sister to visit the Nelson Unit on 18 June. During the early morning of 18 June, the governor was in the healthcare unit when the man was taken ill. He attended the Nelson Unit and assisted with the emergency response. Following the man's death, the governor implemented the contingency plans for a death in custody and arranged for family liaison officer (FLO), who was off duty, to come into the prison.

88. In line with the death in custody Prison Service Order (PSO) 2710, the governor and the FLO visited the man's nominated next of kin, his son, to inform him of his father's death face to face. Around 11.30am, the governor and the FLO left Norwich to travel to the man's son's home to tell him of his father's death. At the end of the visit, the man's son agreed that the FLO and the governor should return to Norwich and tell the man's brother and sister of the death, rather than a family member contacting them on the telephone.

89. Visits centre manager, was contacted during the morning, by prison staff and asked if she could receive the man's family members, sign them in as visitors

and make them comfortable. The manager was told not to inform the family of their brother's death and contact the duty governor when they arrived.

90. The duty governor, was told that the man's brother and sister had arrived at the visits centre. However, as the governor and the FLO had not yet returned from visiting his son, the duty governor made the decision to wait for their return before meeting with the family. In a memorandum to the FLO submitted after the man's death, the duty governor was noted to have said , "I felt that it was more appropriate for a FLO to break the news to the family if possible rather than an untrained person such as myself."

91. At around 1.15pm, the visits manager met the man's brother and sister in the visits centre. Following a telephone call from a family member, they knew their brother had died and were distressed. They left the visits centre and the manager rang the communications room so that a message could be sent to the duty governor to update her on the situation. When she got that message, the duty governor went to the visitor's car park where she found the man's family in a distressed state.

92. Around 1.25pm, the man's brother and sister returned to the visits centre with the duty governor and were offered refreshments. The visits manager showed them into a small room and stayed with the family while the duty governor explained the process of dealing with a death in custody. The manager said in her statement that the man's family were distressed that they had found out about their brother's death via another family member.

93. The FLO and the governor arrived back at Norwich and immediately went to the visits centre. The FLO spent around two hours talking and comforting the man's family during this sad time.

94. The man's brother told the Ombudsman's family liaison officer that he telephoned the prison at 10.00am and was told to be at the visits centre at 1.00pm. The man's brother and his sister arrived at Norwich at 1.15pm and were asked to wait in the reception area. They were told that 'the governor' was on dinner break. Whilst waiting the man received a telephone call from his brother who told him that his brother had passed away. At the visits centre they spoke to the visits manager and left the visits centre to 'get some fresh air' in the car park. The duty governor came to them in the car park and took them into visit centre manager's office until the governor and the FLO arrived.

95. The family were distressed that they were not told of their brother's death when they telephoned the prison at 10.00am. Furthermore, they said that the subsequent delay until a member of the prison staff made contact with them was disrespectful.

96. The man was terminally ill and extremely frail, but the circumstances of his death were unexpected. The man died on a Saturday when there are minimal staff on duty. The FLO, was off duty but was called into the prison to take on

that role and visit The man's son. Prison Service Order (PSO) 2710, (follow up to death in custody), says:

> "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened".

97. The investigator was told that arrangements were made for the man's family in anticipation of their arrival at the prison to try to break the news to them in person. However, despite those plans, his brother and sister were telephoned and told of the death.

98. The man's brother and sister were understandably distressed, they arrived at the prison expecting to visit their brother, they were left waiting and then eventually told he had died earlier that day. The duty governor could have been waiting at the visits hall in anticipation of their arrival, but chose to wait for a trained FLO to break the news in person. We acknowledge the family's concerns and empathise with their unfortunate experience that afternoon.

99. The visits centre is supervised by a voluntary organisation and their staff are not trained to deal with deaths of prisoners, in accordance with PSO2710. When the family first arrived at Norwich, they should have been met by a senior member of the prison staff. This is situation cannot be repeated and that all family members are afforded appropriate care and respect on the death of a prisoner. We therefore make the following recommendation for the attention of the Governor.

The Governor must ensure that the senior management team take responsibility for liaising with family members on the death of a prisoner, in the absence of a trained family liaison officer.

CONCLUSION

100. The man was diagnosed with lung cancer on 26 May 2011 and died three weeks later from a haemorrhage caused through the tumour on his lung. He had been unwell for several months prior to his diagnosis. Despite a month in hospital in April, it was a further ten days after he was discharged before the man's cancer was confirmed. The clinical reviewer commented that the man was looked after by caring staff and his care appeared to be equitable to that which would be provided in the community.

101. Issues raised by the man's family have been investigated. While the suddenness of the man's death could not reasonably have been foreseen, staff could have supported the family better despite the tragic turn of events. A senior member of prison staff should have met the man's family when they first arrived at Norwich, unaware as they were of their brother's death earlier in the day. Instead, plans put in place in anticipation of the man's brother and sister's arrival at the prison were not changed. Unfortunately, before the prison FLO was able to break the news of the death to the man's family, they were telephoned with the sad news whilst waiting at the prison to visit their brother. This was perhaps a unique set of circumstances but one from which the prison can still learn..

RECOMMENDATION

For the head of healthcare HMP & YOI Littlehey

The head of healthcare at HMP Littlehey should work with commissioners to develop an end of life pathway for prisoners in line with the Gold Standard Framework.

Accepted – "The Head of Healthcare in collaboration with NHS Cambridgeshire will conduct a "root and branch" review of the end of life pathway in line with the Gold Standard Framework."

For the Governor at Norwich

The Governor must ensure that the senior management team take responsibility for liaising with family members on the death of a prisoner, in the absence of a trained family liaison officer.

Accepted – "Guidance will be given to all Duty Managers should the situation arise again. FLO's will always inform the Next of Kin first, and a back-up plan will be put in place should family members arrive at the prison in the meantime."