Investigation into the circumstances surrounding the death of a man at a hospice, while a prisoner at HMP Norwich, on 8 September 2006

Report by the Prisons and Probation Ombudsman for England and Wales

March 2007

This is the report of an investigation into the death of a man who died at in a hospice, on 8 September 2006 whilst in the custody of HMP Norwich. The man who is the subject of this report was only 26 years old when he died. He had been diagnosed with aplastic anaemia in October 2004.

I offer my sincere condolences to the man's family and friends for their sad loss.

A member of my team carried out the investigation. I am grateful for the assistance that she received from the Governor of Norwich and his staff. Particular thanks are due to the safer custody manager, who acted as the establishment's liaison officer.

During the course of the investigation, I asked for a clinical review of the care and treatment received by the man to be carried out. As on previous occasions, I am grateful to the Assistant Director of Quality and Nursing from Norwich Primary Care Trust, for her assistance.

This is a report that reflects very well on the care that Norwich prison offered to a young man with a terminal illness. I wish to commend the good practice and co-operation between the prison, its healthcare team, local hospitals and the hospice which allowed this young man to die with dignity. I will be forwarding a copy of this report to the hospice to enable managers there to share my appreciation of the work of a committed palliative care team.

Stephen Shaw CBE
Prisons and Probation Ombudsman **March 2007**

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SUMMARY

The man who is the subject of this report was diagnosed with aplastic anaemia in October 2004 and underwent a bone marrow transplant. Six months later, in April 2005, he was remanded to HMP Norwich and located on the healthcare unit.

Healthcare staff acted quickly. They contacted the man's hospital specialist for his records, confirmed his medication and established his care plan. He continued to be treated at the Hospital where he had regular appointments.

After being released on bail in May 2005, the man returned to Norwich in October having been sentenced to seven years imprisonment for a serious sexual offence. He told staff his bone marrow transplant had failed and he was awaiting a second. Again the appropriate medical and care plans were put in place and he was well supported.

In October, healthcare staff became concerned by man's low mood, and he was placed on the self-harm monitoring procedures for a short time. However, a few weeks later his disposition had improved sufficiently to discontinue the observations.

Between October and March 2006, he remained essentially stable, attended his hospital appointments and received regular reviews of his medication and care plans. In April 2006, he underwent his second transplant with cells donated by his sister. When he was discharged back to Norwich prison at the end of April, a discharge letter set out the instructions for his care and the action to be taken in the event of a high temperature.

In late May**,** the man was re-admitted to hospital with a high temperature. After treatment with anti-viral medication, he improved and returned to the prison. However, a recurrence in early July meant he again returned to hospital.

There was concern about the man's falling blood count, and in late July he was told that transplant of further cells was not an option. He was also told that any further infection could be fatal. At this point he was referred to the Macmillan nurses for palliative care and psychological support.

At the beginning of September, the man moved to a hospice offering specialist palliative care for the terminally ill. A multi-disciplinary decision was taken that, in the event that he should suffer a cardio pulmonary arrest, he would not be resuscitated.

A week earlier, following a difficult night, the man collapsed twice as he walked to the bathroom. The hospice contacted his sister, who was due to visit and informed her that he did not have long to live. She arrived to visit at 2.00pm that afternoon, and talked with her brother. At 3.35pm, the man died in his sleep.

INVESTIGATION PROCESS

1. The investigation was opened in September 2006, when my investigator issued notices to staff and prisoners telling them of the investigation and offering them an opportunity of contributing. There were no responses to these notices. She also reviewed relevant documents and established a chronology of events.

2. She later visited HMP Norwich and was given a tour of the healthcare unit where the man had lived. She also met the appointed liaison officer, the healthcare manager and the clinical care manager. All had been closely involved with the man's care.

3. A clinical review was commissioned from Norwich Primary Care Trust to assess the care and treatment received by the man during his time in custody.

4. A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team met with the man's sister. She had no concerns about the way her brother had been treated, and felt the prison and the hospice did all they could for him. She was also grateful for the way she had been treated by staff from Norwich prison and described them as very supportive.

HMP NORWICH

5. HMP Norwich is a multi-functional adult prison and young offender institution (YOI) on two separate but adjacent sites. It is designated as a local prison and serves the courts of East Anglia. It accepts adult men and young offenders, whether convicted or on remand. In total, the prison can accommodate 823 prisoners.

6. The healthcare unit covers two floors. It provides accommodation for 28 prisoners with physical and mental health needs on level 2, while a dedicated unit for elderly life sentenced prisoners occupies level 1.

7. The last full inspection by Her Majesty's Chief Inspector of Prisons, Ms Anne Owers, took place in July 2004. In her report, Ms Owers commented that key recommendations from earlier deaths in custody investigations had not been implemented. However, I have been reassured to learn that the prison has now implemented a procedure for following up such recommendations and has reviewed all those that were outstanding.

8. There have been 11 other deaths at Norwich since April 2004. Of those, four have been due to natural causes, one of which is still under investigation. The other three natural cause investigations have commended the care and treatment offered by the prison's healthcare unit.

KEY FINDINGS

9. The man was remanded to HMP Norwich in April 2005. He was seen by a nurse on reception and went through the routine healthcare screening. He reported that he had been diagnosed with aplastic anaemia in October 2004. He said he was being treated at a specialist hospital and had undergone a bone marrow transplant in late February. He had been discharged from hospital the end of March, but was still receiving treatment as an out-patient.

10. The nurse who conducted the screening contacted the hospital, and confirmed both the diagnosis and the man's current medication. A detailed care plan was prepared which referred to the recent bone marrow transplant and the risk of bleeding and infection. The care plan stated that the area surrounding the man's cell should be kept clean, a healthy diet was to be encouraged, and his dressings would be dealt with by the clinic. Additionally, if he reported bleeding, bruising, lethargy or shortness of breath, or if his temperature rose above 38 degrees on two successive occasions, the healthcare manager was to be contacted immediately. It was also noted that he would need to attend the transplant clinic at hospital twice a week.

11. During the consultation, the man was also asked about his mental health. He confirmed that he had not been in prison before and denied any thoughts of suicide or self-harm.

12. The man was admitted to the healthcare unit. The on-call doctor was contacted to prescribe his medication. With the man's consent, healthcare staff requested details of his treatment plan and arrangements for follow up appointments from the hospital's haematology department. The information was received, along with his clinical history, a few days later.

13. In early May, the man was seen at the transplant clinic by a consultant haematologist. The notes from the appointment say that he would require another blood transfusion, despite the intermittent blood transfusions he had already received. However, the results of his bone marrow tests the previous month were reasonable, and there was no evidence that it was being rejected.

14. The man was released on bail later that day. He told prison staff that he was going to London, a condition of his bail. He was told that he should rearrange his future hospital appointments, and contact numbers were provided. Additionally, the risks associated with his condition were explained to him and his medication was provided.

15. In October, the man was sentenced to seven years imprisonment and returned to Norwich prison. He was seen by another nurse working in reception, and reported that the bone marrow transplant had failed and he was awaiting a second. He also confirmed that he was still under

the care of the specialist hospital, and was receiving platelet transfusions regularly, although he had missed his last appointment. He also required a blood transfusion every three weeks.

16. The man's gums were bleeding, and the reception nurse contacted the haematology registrar at the hospital for advice. An appointment was made for the clinic the next day. The man was again located in the in-patients wing in the healthcare unit.

17. In late October, a Self-Harm at Risk Form (F2052SH) was opened by the clinical care manager. She was concerned that since the man's return to prison he had been extremely quiet, and at times was tearful. She also noted that, given the nature of his medical condition, any attempt at self-harm or suicide could be severe and thus more likely to successful. When she approached the man, he would not engage in conversation with her. However, a healthcare officer was able to get a response and the man denied any thoughts of suicide or self-harm.

18. Discreet observations were recommended, as it was recognised that the man was a person who valued his space and privacy. It was also planned to offer support through the chaplaincy and staff, and encourage him to maintain contact with his family and friends.

19. A few days later, a review of the man's situation was undertaken. It was noted that he was still very low in mood and was not engaging with staff. However, he said he did not think he should be subject to the self-harm observations. He explained that most of his friends and family were in Portugal, and they were the people he wished to talk with, not the prison or healthcare staff. It was decided that the observations should continue and every effort made to engage with him.

20. The man was reviewed again in November. On this occasion he presented as much happier, smiling and engaging in conversation. He said he would like to take part in education. As his medical condition prevented him from attending classes, it was agreed that in-cell education should be arranged. At the end of the meeting, both the man and the healthcare staff were happy to close the self-harm observation document.

21. Between October 2005 and April 2006, the man remained in the healthcare unit. He was treated with blood and platelet transfusions and his medication and blood levels were carefully monitored. This was achieved through partnership work between the prison's healthcare department, Norfolk and Norwich local and specialist hospitals. Future treatment plans were also agreed, and the associated risks were explained to the man.

22. In 10 March 2006, the man was admitted to the haematology ward at a specialist hospital where he underwent his second bone marrow

transplant from his sister, in April. At the end of the month, he was discharged from hospital and returned to the healthcare unit at the prison. A discharge letter provided clear instructions to contact the hospital urgently should his temperature rise above 38 degrees on two separate occasions one hour apart.

23. Following the transplant, the man continued to received care and treatment in accordance with the instructions from the haematologist, together with regular follow up appointments and monitoring. In May, it was documented that his blood counts were falling, and he returned to hospital. He was found to have a virus, and was treated with a course of anti-viral medication. Although there was still concern about his falling blood counts, he recovered sufficiently to return to the prison in mid-June where he continued to be carefully monitored.

24. In early July, the man's temperature rose, and he was re-admitted to the haematology ward at the hospital. On this occasion he was treated for a fungal chest infection, but it failed to respond to treatment and led to pneumonia.

25. The man was seen by the Macmillan Clinical Nurse Specialists at the end of July, following a referral for symptom management and psychological support. He was also told that transfusion of further cells from his sister was not an option. The seriousness of his situation was explained, including the fact that any further infection could be fatal.

26. In September, the man was moved to a hospice in Norwich which offers specialist palliative care for people with terminal illness. He was assessed by a senior house officer and nursing staff who found that his fever was stable and constant. Care and risk plans were established to meet his needs.

27. The man had the normal escort arrangements for a prisoner staying out of the prison overnight. Two officers would be with him at all times. However, following a risk assessment, it was agreed that he did not need to be handcuffed while in his room. Additionally, a note was made within the bed watch log emphasising that the officers should wait outside the room when he was seen by nurses.

28. In accordance with Norwich Primary Care Trust policies**,** a multi-disciplinary decision was taken that in the event that the man should suffer a cardio pulmonary arrest he was not to be resuscitated. The "Do Not Resuscitate" form was completed, recording the reason for the decision. It was believed that his condition indicated that effective cardio pulmonary resuscitation (CPR) would not be successful. If CPR did succeed, "it was unlikely to be followed by a lengthy, good quality of life". It was recognised that the man was in the terminal phase of his illness, and that he was struggling to believe that he was going to die.

29. The bed watch log also notes that the man was tearful, having been told of his poor prognosis. He talked to the nurses about his situation and about family issues, particularly concerning his daughter. He was also able to call his sister and talk to her.

30. The man's medical notes show that his condition deteriorated over the next few days. He became weaker, and experienced more pain and increased bleeding from his gums. Throughout, his needs were repeatedly reassessed and his support adjusted accordingly, including the provision of a pressure relieving mattress.

31. The bed watch logs include several entries showing that the man telephoned his grandmother in Portugal. He also received regular calls and visits from his sister who lived in Leicester. He was visited by the prison's Roman Catholic chaplain, and was able to receive Holy Communion. In early September, the prison's Governor gave permission for the handcuffs to be removed.

32. A few days later, the man coughed up blood clots overnight, and continued to become weaker. He insisted on walking to the shower and bathroom, but collapsed twice while doing so and had to be helped back to bed. Staff at the hospice then contacted his sister, who was due to visit that day and she arrived just before 2.00pm. She was met by the staff nurse who told her that her brother had deteriorated and did not have long to live. A governor and the healthcare manager from the prison also arrived to check his condition. The hospice doctor talked to the man and his sister about his symptoms.

33. At 3.00pm, the bed watch log shows that the man was asleep. At 3.35pm, he passed away.

34. Norwich prison has comprehensive contingency plans for dealing with a death in custody. They were followed properly, including informing all who needed to know of the man's death. A debrief was conducted with staff, and those involved were properly supported by the management and care teams. Thorough records were also compiled and retained. Additionally, in accordance with Prison Service Order 2710, the prison offered financial assistance to the family and financed the repatriation of the man's body to Portugal.

ISSUES

35. The man was diagnosed with aplastic anaemia before coming into custody. He was receiving on-going specialist care in relation to his diagnosis from a specialist hospital, and this continued throughout his imprisonment. There was no evidence of any other poor physical health, mental health, or substance misuse history prior to custody.

36. Having been released on bail, the man returned to Norwich following sentencing in October 2005. Healthcare staff noticed that his mood appeared low, and placed him on the self-harm monitoring procedures for a short time. However, after some weeks he appeared to become more cheerful and talked to staff about his illness. He became vulnerable as his health declined, and talked openly about his fears.

37. Staff on the healthcare unit described him as a pleasant and easy going young man who was very likeable. It is clear from my own investigation that the man was sensitively and professionally cared for by healthcare staff. Equally, the prison staff who conducted the bed watch were responsive and compassionate in their treatment of him.

38. Whilst in custody, the man was required to attend the Bone Marrow Transplant Clinic at a specialist hospital twice a week. The prison arranged for the appointments to continue, and provided good quality care and assessment. It is clear that he did not miss any of his appointments. In August, the man was told there were no further treatment options available, and was referred to a specialist palliative care service.

39. Both the man and his sister were fully involved in the decisions made in relation to his care, this included open discussions on his prognosis when he was not responding to treatment, and the decision not to resuscitate him when his condition deteriorated further and he entered the terminal phase of his illness. He found it difficult to come to terms with the fact that he was about to die, and the palliative care team provided psychological support to help him cope.

40. In accordance with Norwich Primary Care Trust policy on resuscitation, a multi-disciplinary team met to discuss the man's situation and agree a way forward. The decision not to resuscitate was clearly documented in both the prison and clinical records, ensuring that healthcare and prison staff were aware of the instruction.

41. The clinical reviewer also judges that the man's medical care was appropriately and effectively managed. She concludes that comprehensive risk assessments and care plans were in place to monitor, assess and treat his needs. There is clear evidence that his needs were met at all stages by the healthcare team at the prison, the haematology specialist services and specialist palliative care services of the specialist hospital, local hospitals and the hospice.

The prison healthcare team, prison staff and local specialist services should be commended for their collaborative approach to his care, enabling the man to die with dignity.

RECOMMENDATION

The prison healthcare team, prison staff and local specialist services should be commended for their collaborative approach to his care, enabling the man to die with dignity.