INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING

THE DEATH OF A MAN AT HMP NORWICH

ON 6 NOVEMBER 2005

Report by the Prisons and Probation Ombudsman for England and Wales

May 2006

The man who died was serving a life sentence, having been convicted of war crimes. He died from heart failure on 6 November 2005, in the elderly prisoner unit in the healthcare centre at HMP Norwich, at the age of 84. This is a report into the circumstances surrounding his death.

The man had been suffering from a terminal illness, and was being treated with palliative care. He had expressed his wish to die in the healthcare centre with people who knew him, rather than in a hospital with strangers. My investigator and I offer our condolences to his family on their loss.

A member of my team, carried out the investigation. I wish to thank the Governor of Norwich for making the necessary facilities available to my investigator, and for the assistance of the Liaison Officers. During the course of the investigation, I also asked for a clinical review of the care and treatment received by the deceased to be carried out. I am extremely grateful to the Assistant Director of Quality and Nursing, Norwich Primary Care Trust, for her assistance.

Whist I am concerned by some matters surrounding the issuing of medication, this should not detract from the overall findings. The way that Norwich planned for the man's death, and the care he should receive, is an example from which other prisons can learn. The collaborative working between specialists, Macmillan nurses, the Primary Care Trust, the healthcare staff and prison management, meant that every aspect of the man's care had been carefully considered and prepared for. This included arrangements for his son to visit his father in his cell at any time - day or night - as necessary.

This is a report that highlights exceptional levels of care affording the man a peaceful and dignified end to his life. All of this reflects very well upon the individuals concerned, their prison, their Service, and upon our society as a whole.

Stephen Shaw CBE
Prisons and Probation Ombudsman **May 2006**

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Summary

The man was born in Poland in 1921. Following the Second World War, he came to England where he found work with British Rail, settled and had a son.

When he was 78, he was charged with war crimes committed in 1942. In 1999, he was found guilty and sentenced to life imprisonment. This was set at a whole life tariff. He had pleaded not guilty and maintained his innocence.

After spending time in four different prisons, he arrived at Norwich in February 2005, where he was cared for on L wing - the elderly prisoner unit.

The man suffered from many conditions, largely related to his age. These included: chronic constipation, type 2 diabetes mellitus, hypertension, macular degenerative glaucoma, impaired hearing due to tinnitus, angina, congestive cardiac failure, obesity, depression, and trans ischaemic attacks (TIAs, mini-strokes that cut off the blood from the brain). The clinical reviewer concludes these were all dealt with appropriately within the prison, and there was a good use of external specialists.

During his time at Norwich, his health steadily deteriorated. At times, he found this difficult to deal with, and felt depressed and stated that he wanted to die. On these occasions, an F2052SH was opened (a form used to monitor and support those thought to be at risk of suicide or self harm).

On two occasions, he was able to accumulate medication. He also was found to be putting medication in his pocket instead of taking it at the time it was issued. This may have been because he wanted to be in charge of his own medication. However, it means that he was not taking medication at the time he should have, and it could have been saved with the potential for causing significant harm. I make recommendations relating to this matter.

By September 2005, the man had developed heart failure secondary to ischaemic heart disease, and had renal impairment. At this stage, doctors at the Norfolk and Norwich Hospital felt there was nothing else they could do to treat the conditions and the he was prescribed symptomatic relief only.

Collaborative decisions were made amongst a range of professionals regarding his care. This included a decision not to resuscitate should he stop breathing. The Liverpool Care Pathway for the dying patient (LCP) - which provides an evidence-based framework for end of life care - was fully implemented

The prison contacted the man's son and discussed his father's condition and care. Towards the end of the man's life, procedures were put in place to facilitate visits from his son at any time of day or night. This was compassionate and an example of good practice.

The medical records were exceptionally well kept and demonstrated the level of interaction with the man and the care he received. The treatment for the conditions from which he suffered was appropriate, and staff demonstrated patience and sensitivity. The palliative care that the man received was exceptional, allowing him to die with dignity, in a familiar environment, and with people who knew him.

I make three recommendations in this report, and highlight two areas of good practice.

Investigation process

To begin the investigation, my investigator visited HMP Norwich where she was given a tour of the unit and the cell where the man died. My investigator met the Governor, the Liaison Officer, the Healthcare Manager and the Clinical Care Manager.

The safer custody team were organised, helpful and expedient in arranging documents relating to the deceased to be sent to my investigator. The police also made available statements they obtained from staff.

A clinical review was commissioned from Norwich PCT in which they were asked to review the care and treatment received by the man during his time in custody.

One of my family liaison officers contacted the man's son. The son explained that he had visited his father several days before his death, and felt he was being treated very well by the prison. He said he was full of gratitude for the treatment his father received.

HMP Norwich

HMP Norwich is located within the city boundaries and holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The certified normal accommodation is 591 and the prison has an operational capacity (maximum crowded capacity) of 823.

A car park and road divides the prison. One section of the prison accommodates young offenders and the Healthcare Centre, which also includes the elderly prisoner unit. The remainder of the population is accommodated in the main prison complex.

L wing is the older prisoner unit. It opened in 2004 and provides nursing home care for the elderly and infirm.

The man's time in Norwich

When he transferred to Norwich in February 2005, the man was suffering many ailments related to his age. He was appropriately referred to specialists for treatment for these conditions, including cardiology and a diabetic clinic.

In his medical record and wing record there are frequent and good quality entries regarding him and his care. Sometimes he would engage with staff, but at other times he could present challenging behaviour. In the main, he appears to have settled well at Norwich.

In April 2005, the man was found with a razor blade. When asked, he admitted thoughts of self harm. It was also reported that he had asked another prisoner how much medication he would need to take to overdose. Subsequently, an F2052SH document was opened. The following week, medication was found in his cell which was not permitted. After increased monitoring, it was felt he was much better and the F2052SH form was closed on 26 April 2005.

From June, his health began to deteriorate, and his visits to the Norfolk and Norwich Hospital became more frequent. In June, it was found that he had an atypical atrial flutter and his medication was adjusted.

In July, the man was readmitted to hospital for several days suffering heart disease and renal impairment. He was seen regularly by the prison doctor, or on call doctors, and was monitored by nurses throughout the day. On 19 July, he was found collapsed in his cell but suffered no injuries. From then, he began to collapse on a more regular basis.

The man's deteriorating health sometimes made him particularly depressed and he would express thoughts that he wanted to die. Consequently, another F2052SH was opened on 24 July.

At the end of August, the man was collapsing on a regular basis. He was taken to hospital but refused treatment. He was then admitted on 1 September with a peripheral oedema, and was diagnosed as developing heart failure secondary to ischaemic heart disease. He also had renal impairment. At this stage, doctors at the Norfolk and Norwich Hospital felt there was nothing else they could do to treat the conditions, and he received symptomatic relief only.

The man found this difficult, and decided that he did not want to die in prison. He also felt that, if he was going to die in prison, then he wanted to finish his life. Again and F2052SH was opened. He was in hospital until 13 September. During his absence from the prison, staff found large quantities of medication in his cell.

Once he had come to terms with the terminal nature of his illness, he expressed his wish to die in HMP Norwich being cared for by staff who knew him well, rather than amongst strangers.

A multidisciplinary decision was made in accordance with Norwich Primary Care Trust's resuscitation policy that the man would not be resuscitated should he stop breathing. The consultant physician, concluded that *"the likelihood of returning the heart to sinus rhythm following cardiac arrest would be less than 2% and during the resuscitation process it would be likely that cardiac output and blood flow to the brain would be compromised leading to brain damage".* A management plan was developed to ensure his care needs were met to allow him to die with dignity.

From this time, the man sometimes expressed his wish to die. Although he often refused medication, at other times he would complain he did not have enough.

The head of healthcare contacted the man's son and discussed his father's condition. The son said that he would like to see his father. The manager discussed this at length with the man who found the subject particularly difficult. He wanted to see his son, but was proud and initially did not want his son to see him in prison. After careful consideration, he agreed it would be a good idea. The first visit was arranged for 28 October. The man seemed happier after the visit, and said it had been good to see his son.

On 31 October, the man's condition deteriorated further. The nursing staff contacted Medicom (the number for an on call doctor). At first, the doctor did not want to attend and suggested that he should be transferred to hospital. Nursing staff then contacted the healthcare manager who attended the prison and conducted a further assessment of the man's condition. The manager again contacted the doctor on duty through Medicom and this time the doctor agreed to come. The man was prescribed antibiotics and given an intravenous diuretic and oxygen. The doctor agreed that an acute hospital was not appropriate and that the man should be made as comfortable as possible. The healthcare manager spent a long time with him. He told her he was ready to die and stated clearly to the doctor and to the healthcare manager that he did not want to go to hospital. As his condition had severely deteriorated, the healthcare manager contacted his son and offered him the opportunity to sit with his father overnight if he wished.

The doctor reviewed the man's condition throughout the following day. Nurses helped him to wash and shave. His son visited for most of the day, and sat with him in his cell on L wing. Arrangements were made to allow the cell door to remain open throughout the day and night.

By 2 November, the man could no longer tolerate oral fluids or food. His situation was reviewed by the prison medical team and Macmillan nurse, and discussed with the consultant physician. She advised that the man was in the terminal phase of heart failure. As he was unable to take medication orally, arrangements were made for the use of a syringe driver to administer pain

relief medication. The multi-disciplinary Liverpool Care Pathway for the care of the dying was implemented.

The healthcare manager issued a risk assessment notice to all staff. This said the aim was to keep him comfortable and to allow access to his cell 24 hours a day. Arrangements were made for his cell door to be left open at all times including night and patrol state; this meant redistributing discipline staff to be based on L wing rather than in the main Healthcare Centre. A nurse also always had to be present on L wing. All L wing staff were instructed to carry radios for extra security. The notice contained information on whom to contact to arrange visits for his son, and specified that he was allowed to visit in cell even outside normal hours.

Between 2 and 5 November, the man received palliative care.

On 6 November, the staff nurse started work at 7.45am. Along with the senior nurse, she checked the man at about 7.50am. The staff nurse reported that she checked on him a further four or five times, and he remained unconscious. Between 10 and 10.40am, the staff nurse gave him a bed bath with a B grade nurse.

At about 11.10am, the staff nurse went to check him again. She noticed there were no vital signs, so closed the door and went to tell the senior nurse. At 11.15am, both nurses attended the man’s cell. The senior nurse held his hand and stroked his hair. He took a couple of last shallow breaths. After about five minutes, they checked his vital signs. There were none. The senior nurse removed the battery from the syringe driver, and they left and closed the door.

The senior nurse immediately began to inform those who needed to be told beginning with the healthcare manager and the duty governor.

The healthcare manager arrived at the prison, and contacted the man’s son. She also contacted Medicom, and the duty governor arrived at the prison at approximately 2.15pm. The doctor then went to the man’s cell and confirmed his death.

Norwich prison has comprehensive contingency plans in the event of a death in custody. All plans were instigated and thorough records were kept. A debrief was conducted with the staff, and the care team offered staff support. Prisoners on the elderly prisoner unit were told the news individually and offered support. The chaplaincy also attended and supported prisoners and staff.

Findings

Medical care provided prior to November

The man was suffering from multiple medical conditions whilst at Norwich. These included: chronic constipation, type 2 diabetes mellitus, hypertension, macular degenerative glaucoma, impaired hearing due to tinnitus, angina, congestive cardiac failure, obesity, depression and trans ischaemic attacks (TIAs). The clinical reviewer concludes these were all dealt with appropriately and there was a good use of external specialists.

Other professionals visited Norwich to provide services. These included a chiropodist and a physiotherapist.

The medical notes are extremely comprehensive, and the care afforded to the man is clear from them. When an issue of concern is raised, there is evidence of follow up and consultation with other professionals. When results of tests have not been received, these are chased up and then acted upon. Regrettably, poor quality entries in medical notes are regularly found in my investigations. It is therefore all the more praiseworthy that evidence of such comprehensive care was found in the man's case. The governor and healthcare manager may wish to share this observation with relevant staff.

There were many occasions when the man refused treatment. He declined to be assessed by the physiotherapist; he often refused medication, and sometimes refused his food. There is evidence that staff persevered, and tried at different times to persuade him to cooperate in his treatment. When they were unsuccessful, they informed the doctor and appropriate action was taken.

Medication in cell

The man was not allowed to keep his medication in his cell. In July, a healthcare officer realised that the man was putting tablets in his pocket instead of swallowing them when they were being issued. He challenged him about this (he was defensive), and made a note of it.

When the man was in hospital on 8 September, staff found large quantities of aspirin, bisacodyl (a laxative) and a jam jar full of Lactuluse (for constipation, and used to reduce the amount of ammonia in the blood of patients with liver complaints) hidden in dirty washing during a routine cell search. They also found paracetamol and other pain relief in his trouser pockets. This was noted in the wing record and medical record, but does not appear in his F2052SH and was not considered in his care plans. This may have been because the F2052sh document would have been with him at hospital. However, this information should have been entered in F2052sh at some point. This was a serious omission because of the potential self harm implications of hoarded medication. It could also have meant that the man

was not receiving the correct dosage of medication for his ailments which might have worsened his condition.

Throughout September and October, the man expressed his wish to die. Although at times he said this would happen when it was his time, he had good days, and bad days. Staff were sufficiently concerned to keep the F2052SH document open.

On 26 October, the man was seen by staff with pot of liquid medication before morning medication had been issued. A note was put in the medical record reminding staff that they must watch him take medication at its time of issue.

At times, it seems he struggled to cope with his condition and to understand the restraints imprisonment necessarily placed upon him. In particular, he found it difficult to understand why he could not keep medication in his cell. The man may have wanted to take control of his own medication, but there is a possibility that he was trying to accumulate medication with thoughts of self harm. In either event, the consequence was that he was not taking the medication at the correct times and in the correct dosages that he needed.

I am concerned that the man managed to accumulate medication in his cell on several occasions. I therefore make the following recommendations:

I recommend that all staff issuing medication be reminded to observe patients swallowing their medication.

I recommend that staff involved in the daily cell fabric searches on the Healthcare Centre are advised to pay particular attention to any medication found in the cell.

Record keeping

The entries in the F2052SHs tended to be observational, and did not demonstrate the significant interaction staff were clearly having with him. However, given that his wing record and medical records were so comprehensively completed, I do not feel his care suffered in any way.

Palliative care

The Liverpool Care Pathway for the dying patient (LCP) has been developed to transfer the hospice model of care into other settings. It is a multi-professional document which provides an evidence-based framework for end of life care. The LCP provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions. The LCP is a key recommendation in the NICE guidelines for supportive and palliative care. It is a NHS Beacon project.

At Norwich, the LCP was implemented fully and respectfully. I commend those responsible. I am also satisfied that the decision taken to allow the man

to remain in the elderly prisoner unit rather than transferring him to an external hospital was compassionate and correct.

Resuscitation decisions

In September 2005, the man was diagnosed as developing heart failure secondary to ischaemic heart disease. He also had renal impairment and was being treated for symptomatic relief only. A multidisciplinary decision was made in accordance with Norwich PCT resuscitation policy that he would not be resuscitated. This was clearly documented and staff were made aware.

Collaborative working

After the man accepted he was dying, and decided he wanted to die in Norwich prison amongst staff who knew him well, the prison healthcare team, prison staff and external specialists worked together to enable this. This included:

- support from the Macmillan nurse, Central Norfolk Palliative Care Service
- discussions and advice given on care plans by the consultant physician
- the governor risk assessing and authorising the man's cell to be left open in patrol hours and through the night
- the prison facilitating flexible visiting hours and visits within the man's cell for his son.

Clear instructions were given and documented on the process staff should follow in the event of the man's death. The clinical reviewer confirms these were in line with the Norwich PCT's confirmation of expected death policy. Furthermore, all Prison Service death in custody contingency plans were followed.

The collaborative working in managing the palliative care needs is an example of good practice

Contact with the man's son

The healthcare manager made contact with the man's son once it was clear that the man was not going to recover in September. The healthcare manager remained in contact until the man's death. Visits were facilitated, and the son was able to sit with his father in his cell. There are times in a prison when few staff are on duty and therefore cell doors are closed for security. Procedures were put in place so this would not prevent his son's access, and staff would be deployed to facilitate a visit whatever time of day or night.

The healthcare manager informed the son of his father's death, in a timely manner, by phone. This was appropriate given the fact that the son was expecting to hear the news.

The son told my family liaison officer that he was grateful for the care his father had received.

The maintaining of contact with the family, and facilitation of visits in cell, at any time of day and night, was respectful and compassionate. This is an example of good practice, and should be shared across the Prison Service estate.

On call doctor cover

Healthcare staff called Medicom, the on call doctor service, on several occasions when the man was unwell. On one occasion on 31 October, a doctor refused to attend and suggested the man be transferred to hospital.

When the healthcare manager called, the doctor agreed to attend, and on examination agreed admission to hospital was not appropriate. The clinical reviewer makes a recommendation in relation to this incident which I endorse:

I recommend that any issues regarding the "on call doctor" service should be reported to the PCT using the incident forms.

Conclusion

Overall, I judge that the man received exceptional care from Norwich prison, and from external agencies, and this afforded him a dignified end to his life.

Recommendations

For the Governor and Healthcare Manager

I recommend that all staff issuing medication be reminded to observe patients swallowing their medication.

I recommend that staff involved in the daily cell fabric searches on the Healthcare Centre are advised to pay particular attention for any medication found in the cell.

I recommend that any issues regarding the “on call doctor” service should be reported to the PCT using the incident forms.

Good practice

The collaborative working in managing the palliative care needs is an example of good practice

The maintaining of contact with the family, and facilitation of visits in cell, at any time of day and night, was respectful and compassionate. This is an example of good practice, and should be shared across the Prison Service estate.