Investigation into the circumstances surrounding the death of a man at HMP & YOI Norwich in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the death of a man who died on 18 December 2008, in the Nelson Unit at HMP Norwich. The man had cancer and transferred to Norwich from HMP Littlehey on 10 November. He was 49 years old and an American citizen.

Her Majesty's Coroner for Norwich was informed of our investigation. A post mortem has not been carried out. I extend my sincere condolences to the man's family, and his friends in this country.

The investigation was undertaken by one of my colleagues. A review of the man's healthcare, whilst at Norwich, was commissioned with Norfolk Primary Care Trust (PCT). I am grateful to a senior oncology nurse for the clinical review. I would like to thank the Governor of Norwich and his staff for their help and assistance. I am particularly grateful to the Safer Custody Co-ordinator who acted at liaison officer.

I make one recommendation to the heads of healthcare at Norwich and Bedford in relation to recordkeeping and one to the heads of healthcare at Bedford and Littlehey for updating agencies of prisoner's transfer. I repeat the recommendation to the Department of Health regarding the delivery of local palliative care services for terminally ill prisoners.

I acknowledge two areas of good practice, to the Governors of Littlehey and Norwich for the high standard of care afforded to the man. I acknowledge the good practice of the Governor of Littlehey in releasing the man on a temporary licence whilst he was an in patient in hospital and the hospital visit arranged for the man's friend. Lastly, I note two recommendations held in the clinical review.

Up to the circulation of this final report the prison service have not responded to the recommendations, furthermore, the man's family have no comments to add to this report.

Jane Webb
Deputy Prisons and Probation Ombudsman **November 2009**

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SUMMARY

The man was sentenced to six years imprisonment in October 2006 at Crown Court. He was an American citizen and a deportation order was imposed on completion of his sentence. The man arrived at HMP Bedford and a first reception health screen document noted that he had a chest infection. He was referred to the Oral and Maxillofacial Unit at Bedford Hospital for treatment to lesions on his mouth.

On 23 February 2007, he transferred to Littlehey. The man's medical notes said that he received treatment for his ongoing mouth lesions, chest infections and anxiety. He was seen regularly in the healthcare unit to monitor his medical conditions and treated with physiotherapy for shoulder pain.

In July 2008, the man was losing weight and suffering from chest pain. A doctor requested a blood sample and advised the man to have a blood screening to test his HIV status. (HIV stands for Human Immunodeficiency Virus**.** HIV is a virus that takes over certain immune system cells to make many copies of itself. It causes slow but constant damage to the immune system.) The man agreed to the HIV blood test, which later proved to be positive. Following a referral to a specialist and an x-ray, the man was diagnosed with lung cancer on 4 August.

He started a course of radiotherapy (a treatment for cancer). On 12 September, The man was admitted to hospital for chemotherapy (intravenous medication) treatment. He was accompanied by two officers and restraints (hand cuffs) were used. On 3 October, he returned to Littlehey and an application for a compassionate discharge was started. However, he became unwell with a high temperature on 18 October and returned to hospital. Two officers acted as escort and he was again restrained. The man was visited regularly by healthcare staff from Littlehey and his application for a compassionate discharge was progressed.

The man's family in America were kept informed about his condition and it was agreed that he could return to America if the compassionate discharge was approved. On 30 October, the Governor of Littlehey agreed to release the man on a temporary licence and the restraints were removed.

The man was told of his poor prognosis on 4 November and that he had only weeks to live. He was visited by healthcare staff and arrangements were made for his transfer to a more suitable care facility. On 10 November, the man was transferred to the Nelson Unit at HMP Norwich and his application for a compassionate discharge was withdrawn. The following week his sisters travelled from America to Norwich, to visit their brother and stayed locally for seven days. They were allowed to see him every day in the Nelson Unit. The man's condition continued to deteriorate and at 1.20pm on 18 December, a doctor confirmed the man had died.

The Nelson Unit continues to provide excellent care for terminally ill patients, although this was not what the unit was originally resourced to do so. I

recognise the high standard of care afforded to the man and the continued problem of providing local terminal care for prisoners.

THE INVESTIGATION PROCESS

1. A review of the man's medical care was requested by Norfolk PCT on 20 December 2008. A senior oncology nurse and modern matron, specialising in cancer related illnesses, conducted the review on behalf of the PCT.

2. The investigation into the man's death was opened on 2 January 2009, when my colleague visited Norwich. She reviewed the man's prison file and ordered copies of the documents to be sent to her. Notices and terms of reference of the Ombudsman's investigation were sent in advance of my colleague's visit. There were no responses to the notices of investigation.

3. The Independent Monitoring Board (IMB) and the Prison Officer's Association (POA) did not ask to meet with my colleague. Norwich has previous experiences of death in custody investigations and is familiar with all the procedures.

4. On 15 January, a family liaison officer wrote to the man's sister in America informing her of the investigation. At the time of the circulation of this report the man's family have not raised any issues they wish the investigation to consider.

5. My colleague went to a clinical panel review meeting on 27 February at Norwich Primary Care Trust to discuss clinical issues pertinent to the man's medical care. Evidence for the investigation was taken from the man's prison file and medical notes.

HMP & YOI NORWICH

6. Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 824, holding remand and sentenced adult men and young offenders. The prison is divided into two sections. One area accommodates young offenders and the healthcare centre

7. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 32 in-patients. On the ground floor of the centre is a specialist elderly patients unit, Nelson Unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.

8. Her Majesty's Chief Inspector of Prisons last inspected HMP Norwich in November 2006. An extract from that inspection noted,

> "Health services had improved under management by Norfolk PCT. There had been considerable investment in an electronic clinical management system, and clinical governance arrangements were linked with the PCT's clinical governance strategy."

9. Two extracts from The Independent Monitoring Board (IMB) Annual Report for 2007, noted that:

> "Over the last year there has been no difficulty recruiting nurses with the right experiences. Lessons have been learnt from death in custody reviews, which have been included in protocols, risk assessments and action plans. Risk assessments have been completed on a range of issues from infection control, the misuse of medication and bullying to 'flu outbreaks and staff shortages. There is a good working relationship with the PCT with the sharing of emergency on-call."

> "The Nelson Unit for elderly prisoners has introduced an innovative 'open door' policy to deal with deaths, of which there have been four this year. It has also used the voluntary sector to develop various social activities, which are being developed. A handrail has now been fixed and the prisoners will at last be able to use a specially made garden."

10. There have been 17 deaths due to natural causes since my office took responsibility for investigating deaths in custody. This is because the Nelson Unit situated in Norwich, caring for elderly prisoners, has a high number of natural cause deaths. The man was located to the unit for palliative care, even though he was not elderly.

HMP LITTLEHEY

11. HMP Littlehey is a category C prison. It has the capacity to hold 706 male offenders, but has a typical occupancy around 690. It first opened in 1988 and has eight residential wings. Three additional units have been added since the prison was originally built, and all the rooms on these units have privacy locks and en suite showers.

12. Approximately 10 per cent of the prisoners are serving life sentences. A small proportion of the prisoners are category D that enables them to work outside the prison. The prison offers sex offender treatment programmes, as well as extensive industrial work and education opportunities.

13. Provision of healthcare is the responsibility of Cambridgeshire Primary Care Trust with the General Practitioner service being provided by a local GP practice. A wide range of health promotion clinics are available, with Mental Health Nurses available on a daily basis. A psychiatrist also visits. Healthcare staff run nurse-led chronic disease clinics. There are no in patient facilities at Littlehey or 24 hour healthcare.

14. Medication is administered on a weekly and/or monthly basis to those prisoners who have been risk assessed as suitable for holding it in their own possession. It is administered on a daily basis to other prisoners, when either they are judged to be at risk or the medication is considered unsuitable to be held in their possession.

KEY FINDINGS

15. The man was born in America in May 1959, and came to England in 1991. He was single, following the death of his partner in 2005. The man was a hairdresser and lived in the Cambridgeshire area.

16. On 11 October 2006, The man was convicted of sexual offences at Crown Court and sentenced to six years imprisonment. The judge also recommended that he should be deported to America on completion of his custodial sentence. The man had one previous conviction for driving offences and this was his first time in prison.

17. Following his court appearance, The man was received into HMP Bedford. His medical records note that he was in reasonably good health, but had a chest infection. The man told the doctor he smoked 20 cigarettes a day and drank around '14 pints a week'. It was also noted that he had received treatment for a psychological illness 15 to 20 years ago. The man said he had no thoughts of self harm or suicidal tendencies.

18. The following day the man saw the doctor who diagnosed bronchitis and prescribed an anti-biotic. The man told the doctor that he was not HIV positive. On 15 November, he fell from his cell bunk and lacerated his left foot. The wound was dressed with steri strips and the man said that he was okay. The following day he saw the doctor with soreness to his mouth, so an oral medication was prescribed. A referral was made for The man to be seen as an outpatient in the Oral and Maxillofacial Unit at a hospital.

19. On 20 November, the man developed cellulitis (a form of infection) from the wound in his foot. On examination, the doctor prescribed an anti biotic and pain relief and advised the man to elevate his leg. On 18 January 2007, the man was seen in the healthcare unit with lesions in his mouth and it was noted that he had been referred to hospital for further tests to this ongoing problem.

20. The man transferred to Littlehey on 23 February 2007. He was assessed by a nurse and his medication was recorded. He was deemed fit to work and was allocated a job in the kitchen. Later, he became a barber on his wing.

21. On 21 March 2007, the man was seen by the doctor. He had a swelling to his face and lip and was prescribed an antibiotic. The man's notes also refer to a post operative swelling to his face, indicating that he had recently undergone minor surgery of a biopsy on the corner of his mouth. A month later, the man was treated for sinusitis and prescribed a nasal spray. He also complained of insomnia and was given a short course of Nytol (a remedy to aid sleep).

22. The man was reviewed by a doctor on 8 May. The mouth lesions were improving, but there was no letter from the hospital indicating the source of the lesion. Oral medication and gel were prescribed to help relieve his symptoms. On 14 June, the man was still experiencing insomnia and Amitriytiline, a stronger medication for relaxation and aiding sleep, was prescribed.

23. A week later, the man saw a community psychiatric nurse. The nurse wrote that he was experiencing bouts of depression, caused by bereavement issues, his sentence, and the threat of deportation. The man was receiving support and counselling through the chaplaincy department, which he said was helping. The nurse advised him to continue the counselling and, if he felt that was not enough, make an appointment to see the doctor.

24. On 5 July, the man saw the doctor and was prescribed an anti-depressant. He also told the doctor that he had some itching around his penis. An antibiotic was prescribed and it was later diagnosed that The man had a urine infection.

25. The man saw the doctor again on 6 August, following laser excisions in hospital to his tongue and lips. His mouth area was still swollen and now oozing fluid and penicillin was prescribed. He continued to have a regular prescription of Amitriytiline until 13 November, when he felt well enough to stop using it.

26. On 23 January 2008, the man was diagnosed with a chest infection. As he was already receiving antibiotics, it was decided to carry on with the medication and review the symptoms if there was no improvement. A week later, he was given some cough medicine. The man saw the doctor on 7 February, as he still had a chesty cough, and further antibiotic medication was prescribed.

27. The man saw the physiotherapist for treatment to his neck and shoulder from February through to May. He was prescribed anti-inflammatory cream on 21 February, to help with the shoulder pain as well as paracetamol and ibuprofen. The man was also advised to stop smoking.

28. The man saw a nurse on 3 March and told her that he felt very lethargic and was still experiencing shoulder pain. The nurse arranged for him to have a comfortable chair in his cell and took a blood sample for analysis. Three days later, the man was prescribed Naproxen, (a pain relief medication for inflammation). The man was reviewed by the doctor on 30 April, following further excisions to his lip. He had extensive warts on his tongue and lips and suffered from them for sometime. A mouth wash was prescribed to soothe the symptoms. the man's other medication and pain relief remained the same.

29. On 8 July, the man was seen by a doctor who wrote that his lips were still sore. He also complained of a chesty cough, and cough mixture was prescribed. On 17 July, the doctor noted that the man was losing weight. They discussed taking a sample of blood to check for HIV but the man declined the test. The doctor decided that the man should return to see him in a week.

30. The man agreed to a blood test for general screening on 21 July, because of his weight loss. Three days later, the blood test results showed an abnormality and the doctor advised the man to have more extensive blood tests to check for any HIV infection.

31. On 31 July, a blood test result showed that the man was HIV positive. Later that day, The man was informed of the result by the clinical nurse manager and a nurse. The man was given advice and informed that he would be seen by a Genito-Urinary Medicine (GUM) consultant. (GUM is the treatment of sexual related diseases.) He was also offered support and reassurance from the clinical nurse manager, and told that he could access healthcare staff when he felt the need to talk. The following day, the man returned to the healthcare unit and had further discussions with the clinical nurse manager.

32. The man had more blood tests on 4 August. Four days later, he saw a nurse again, and another blood and a sputum sample was taken for analysis. On 13 August, the man was seen by the GUM consultant and had an x-ray.

33. The next day, the man was seen in the healthcare unit and an urgent appointment made with the doctor. The man was given the results of the x-ray, which showed a lump on the right side of his chest. Later, he saw the doctor who prescribed a pain control medication and Fortisips (a food supplement drink) as he was now under weight. The doctor had been told by the hospital that the man's x-ray indicated two tumours, one of which was growing on to the rib bone. A computerised tomography (CT) scan was urgently arranged. (A CT scan is an x-ray procedure that takes images of the whole body.)

34. The man asked for stronger pain control medication on 16 August. The pharmacist advised against opiate base pain relief, which could have an adverse effect on his blood plasma levels because of the other medication he was taking. On 18 August, it was noted that the man was waiting for a magnetic resonance imaging (MRI) scan. (An MRI scan takes images of body tissues.) He was referred to a chest physician at a hospital.

35. On 21 August, the man went to the hospital for an appointment with a consultant. He also under went a lung biopsy. A week later, he was seen by a prison doctor and nurse who noted that his pain was under control. He was prescribed more food supplements.

36. The result of the man's biopsy was discussed with him on 4 September when he went to the healthcare unit and saw the clinical nurse manager. He was now under the care of an oncologist at hospital. (An oncologist specialises in cancer related illnesses.) The diagnosis of lung cancer was confirmed, and a course of radiotherapy was advised. (Radiotherapy is another treatment for cancer related illnesses.)

37. Further discussion took place about the man's HIV status and the long term care of both illnesses. He said he did not want to die in prison and one of his wishes was to return to America to be nearer to his family. However, he had no medical insurance in America and was unsure of how he could fund his treatment. The man was reassured that the staff at Littlehey would support him and he could access healthcare at anytime.

38. The man went to an appointment with the GUM consultant. They discussed a plan of care and the radiotherapy course that would start soon. On 9 September, the man went to hospital for his first session of radiotherapy. On return to Littlehey, he was seen by a nurse who noted that he was tired after his treatment. Extra food was ordered from the kitchen, so that he could supplement his diet whilst under going his treatment. Consent was obtained from the man for wing staff to be informed of his medical condition so they to could offer support. It was also noted that his pain was controlled, but if he needed any assistance with breakthrough pain he should contact healthcare staff.

39. On 10 September, the man went to hospital for another radiotherapy session. He was seen by a hospital social worker specialising in HIV. The social worker telephoned the clinical nurse manager to discuss concerns that the man had for his future, although he had told the social worker that he felt safe and fully supported at Littlehey. The clinical nurse manager advised the social worker that the man would remain at Littlehey, but should his condition deteriorate, the situation would be reviewed.

40. The man was admitted to hospital on 12 September. He was escorted by two officers and restrained by an escort chain. (An escort chain is a 1.8 metre length of chain with one cuff attached to the prisoner and the other to an officer.) He started a course of chemotherapy (intravenous medication for the treatment of cancer). On 19 September, the man was visited in hospital by the clinical nurse manager. She wrote that he had contracted pneumonia, which was being treated with antibiotics nevertheless, but was in good spirits.

41. Whilst at the hospital, the clinical nurse manager telephoned the man's sister in America. She thanked her for the support and care that the staff at Littlehey had shown to her brother. She said his family were keen for him to return home to continue his treatment and wondered whether a release on compassionate grounds would be considered so that he could be deported. The clinical nurse manager said she would

42. On 23 September, the clinical nurse manager discussed the man's long terms plans with the HIV social worker. She was aware of his wish to return to America. However, his treatment was a priority and a multi disciplinary meeting would be arranged to discuss his future plans. The following day, the clinical nurse manager spoke directly to the man by telephone. He seemed cheerful despite a high temperature and chemotherapy sessions were ongoing.

43. The clinical nurse manager telephoned the man again on 25 and 29 September and on 1 October. On each occasion he updated her on his condition and the treatments he was receiving. On 2 October, the clinical nurse manager discussed an application for a compassionate release with the deputy governor. They agreed to pursue the application and she would pass on the relevant forms for the prison doctor and hospital consultant to complete.

44. The following day, the man was discharged from hospital back to Littlehey. The clinical nurse manager liaised beforehand with the hospital consultant to plan a contingency for the man's care. The man returned to the wing and allocated a single cell. Wing staff and the healthcare staff were made aware of his medical needs and the support he might require.

45. On 7 October, the clinical nurse manager visited the man. She noted that his cell was warm, he appeared to be comfortable and was well supported by wing staff. The clinical nurse manager and the man discussed his future care plans. He asked to stay at Littlehey until his chemotherapy was completed and was hopeful that his compassionate release would be granted. She told the man he could stay at Littlehey but, should his condition deteriorate, he might have to transfer to a prison with 24 hour healthcare.

46. The man said he was reluctant to leave his friends at Littlehey and felt that his health would deteriorate if he was transferred. The clinical nurse manager told him that he would be involved in any decision making. The man was able to take his own temperature, along with regular checks by healthcare staff. He was aware that, should it rise above a normal reading (37 degrees), he should immediately inform the healthcare staff. (A rise in temperature, during and following chemotherapy requires medical intervention.)

47. The following day, the clinical nurse manager saw the man and he told her that he was experiencing nausea and had little appetite. On 9 October, the man saw the doctor and told him that he felt unwell and had been sick. The doctor reviewed his medication and prescribed a higher dose of pain relief.

48. On 13 October, the man went to the hospital for a chemotherapy session. Two days later, the clinical nurse manager and a pharmacist saw the man in his cell. He became distressed during the conversation as he felt his pain was not under control. She contacted the doctor, who raised the dosage of his pain relief medication. The following day, the clinical nurse manager visited the man who told her he was now pain free.

49. The clinical nurse manager saw the man on 17 October, and he told her that his pain remained under control. He was going to have a bath which he found soothing. However the walk from his cell to the bathroom was some distance and he became breathless. She told him that he could use a wheelchair and one of his friends could push him to the bathroom. Later, the clinical nurse manager telephoned the hospital consultant regarding the letter to progress the application for compassionate release. A copy of the letter was faxed to Littlehey.

50. The following day, the man went back to hospital as his temperature was high and he felt unwell. He was escorted by two officers and an escort chain restraint was used. He was given intravenous anti biotic medication. Two days later, the clinical nurse manager visited the man in hospital where they discussed his future care plans. She told him that Littlehey might not be able to provide the level of nursing care he needed and a transfer to another prison was likely. The man became distressed and said he wanted to remain at Littlehey with his friends. The clinical nurse manager said she would not pursue a transfer at that stage but wanting him to be aware of the care he might need in the future.

51. On 22 October, the clinical nurse manager met the deputy governor, security principal officer and the residential governor. A discussion took place over the man's deteriorating condition and the use of restraints. It was agreed that the residential governor would visit the hospital and complete a risk assessment. It was noted the following day, that the man was poorly and a sleep most of the time. A week later, he was visited by a nurse. She wrote that the man remained very weak, although his pain seemed to be under control.

52. The nurse telephoned the hospital on 30 October, and was told that the man's condition was deteriorating and his prognosis was now weeks rather than months. She asked the registrar to fax details of this prognosis for the attention of the deputy governor and head of healthcare. A release on temporary licence was granted and the restraints were removed although, two bed watch officers stayed at the man's bedside. The man was able to move around the ward and visit the grounds of the hospital to get some fresh air.

53. Later, the head of healthcare visited the man in hospital. They discussed the latest prognosis and the man said he wanted to return to Littlehey, on his discharge from hospital, to say goodbye to his friends.

54. Whilst there were no immediate arrangements to discharge the man from hospital, the head of healthcare began a plan of action in preparation for his care. The application for a compassionate discharge had been submitted to the Home Office for their consideration. The head of healthcare made contact with the head of healthcare at Norwich for a vacancy on the Nelson Unit. Littlehey's head of healthcare also made enquiries about local hospice care. (A hospice provides in patient care and support for terminal illness.)

55. On 31 October, whilst a nurse continued to make enquiries into hospice care, the hospital undertook an assessment of the man's palliative care needs. Three days later, the nurse visited the man in hospital. She noted that he was weak and only able to walk a few steps. He was open minded about the suggestion of a hospice, especially if was local.

56. The clinical nurse manager wrote on 3 November that the palliative care assessment had not been completed by the hospital as they were under the impression that the man might return to America. She spoke to a doctor who told her that an assessment would be carried out that afternoon to see if he could be referred for a hospice place. The bed watch escort was reduced to one officer.

57. On 4 November, the head of healthcare and the clinical manager visited the man in hospital and spoke to him and his consultant together. The man was told of his poor prognosis and a compassionate discharge, although submitted to the Home Office, would be inappropriate, as he was too ill to travel to America. A hospice had declined to offer a place and there were no other local options. The Nelson Unit at Norwich was the most favourable place for the man and discussions were underway. The man said he needed to time to understand what he had been told and would like to telephone his family in America.

58. The following day, the head of healthcare made arrangements with the residential governor for a prisoner, who was a close friend of the man, to be escorted to hospital to visit him. Later, Littlehey's family liaison officer telephoned the man's sister. He had been in regular contact to update her on her brother's situation. The liaison officer explained that a compassionate release would not be possible as his poor prognosis meant that he would not be able to travel to America. The liaison officer suggested that his family came to England and spent some time with their brother. He said that arrangements should be made swiftly and that he would contact her the next day.

59. The clinical nurse manager telephoned the head of healthcare at Norwich and arrangements were made to transfer the man to the

60. On 7 November, the clinical nurse manager and family liaison officer visited the man. Although weak he was positive abut his move to Norwich and had received the news that his sisters would be coming to England the following week to spend time with him. An ambulance was arranged for the man to transfer to Norwich.

61. Three days later, the man transferred to the Nelson Unit accompanied by the clinical nurse manage. He was seen by the head of healthcare and a specialist palliative care nurse. The head of healthcare gave the man an introduction to the unit. His pain control was discussed and Oromorph (a morphine based medication) was prescribed as well as Fentanyl patches (an opiate based drug) used to control pain.

62. The application for a compassionate release had been forwarded to the Parole Board. The Parole Board asked for further information about the man's palliative care arrangements. Discussion with Norwich healthcare indicated that the man was too weak to move and his illness could be managed by staff in the Nelson Unit. The application was therefore pursued.

63. The head of healthcare also spoke to the man about resuscitation should he go into heart failure. He said that he did not wish to be resuscitated. A Do Not Resuscitate Form was signed by the man and the Liverpool Care Pathway (a plan for the daily care of patients with terminal illnesses to provide medical, emotional and spiritual support), was put into place.

64. On 15 November, Littlehey's family liaison officer met the man's sisters at the airport and took them to the Nelson Unit. The head of healthcare introduced herself and outlined their brother's medical condition, treatment and care. The sisters asked about the possibility of a compassionate release so he could return to America. The head of healthcare explained that their brother was in the end stage of his life and it would be impossible due to his poor health. Emergency contact telephone numbers were obtained for the man' sisters whilst they stayed in a hotel. The head of healthcare assured them they could visit their brother daily and she could be contacted at any time.

65. The man asked for more pain control on 17 November and his appetite declined. His sisters visited for several hours which boosted his spirits. The following day, he appeared to be disorientated and nursing staff encouraged him to take his pain relief. It was noted on 18 November,

66. The man was visited again by his sisters and seemed comforted by their presence. Later he was assessed by a palliative care consultant. She asked for blood tests to be taken and prescribed medication to make the man more comfortable. Her details were left with nursing staff should they need to contact her if the man's condition deteriorated.

67. The head of healthcare authorised that the man's room door could be left open (to allow easy access of staff during the night when there are fewer staff on duty). That evening, at the request of his sisters he was visited by the chaplain. Later, he became alert although uncoordinated and was reminded to speak to staff if he was in pain. He was given a sleeping tablet.

68. On 19 November, it was noted that the man slept all morning and his sisters visited. The next day, his blood results showed an abnormality and the head of healthcare was informed. A visit by palliative care consultant was arranged for the following day who assessed the blood results. On 21 November, the man's condition deteriorated further. He asked for his sisters to be contacted so they could sit with him. The palliative care consultant visited the man and prescribed a syringe driver (subcutaneous medication) to give continuous pain relief. Meanwhile, he would carry on with oral pain control of Oromorph and Fentanyl patches.

69. Two days later, the man seemed to be in a brighter mood. He managed to visit another prisoner and ate some lunch. On 25 November, the doctor noted that the man was feeling very sleepy on the higher dose of Oromorph. Diamorphine injections were prescribed to help him stay alert. Nevertheless, later that day, The man declined an injection of Diamorphine preferring to have the Oromorph. The head of healthcare spoke to his sisters who were returning to America two days later and were understandably upset to leave whilst their brother was so poorly. She reassured them that he would be nursed and cared for by staff on the Nelson Unit.

70. On 27 November, the man asked for less Oromorph as he wished to be alert when his sisters visited him. He became tearful, when his sisters left to return to America. The head of healthcare sat with him until he fell asleep and a healthcare assistant then sat with the man to offer support. Later, the palliative care consultant visited the man and reviewed his care plan. She noted that he was not feeding himself but had accepted some food at tea time when it was fed to him.

71. The next day, his medical notes record a pressure sore which was treated and dressed. An air cushion was requested to aid his comfort

72. The palliative care consultant reviewed the man's medication on 8 December and increased his dosage of Oromorph and Fentanyl patches as he was asking for more Oromorph. Two days later it was noted that, although very frail, he remained in good spirits. The head of healthcare spoke to the man's sister and informed her that her brother's condition continued to deteriorate. She reassured her that she would keep close contact and they could telephone at any time.

73. The man's condition was weak on 15 December. Later that day, he fell to the floor in his room but there were no apparent injuries or tenderness. Two days later, a palliative care nurse assessed him. His condition had deteriorated rapidly, he was barely responsive, had vomited and was unable to take the oral medication. A syringe driver with Diamorphine was put in place to aid his pain control.

74. At 3.25am on 18 December, the man spoke to staff and the syringe driver was keeping him pain free. He was washed and made comfortable by the night nursing staff. His nursing care continued through out the day until 1.20pm when a doctor was called to see The man who was unresponsive. The doctor noted that the man had no pulse and his pupils were fixed and dilated. At 1.55pm it was confirmed that the man had died.

75. The head of healthcare, who was off duty, was informed of the man's death. At 3.50pm she came into the Nelson Unit and telephoned his sister to inform her of her brother's death. Although distressed, she thanked the head of healthcare for the care of all the staff at the Nelson Unit. She told her that a family liaison officer from Norwich would contact her in a few days time. The head of healthcare contacted the American Embassy and a friend of the man.

76. The man's body was flown back to his family America for his funeral service and a memorial service was held in the prison's chapel. The prison offered financial assistance towards the funeral arrangements.

ISSUES

Clinical Care

77. A review of the man's clinical care was commissioned from Norfolk PCT. A senior oncology nurse carried out the review. He reviewed the man's medical records, care plans, hospital documents and letters, health service policies and palliative care protocols. He also spoke to the clinical nurse manager at Littlehey and the head of healthcare at Norwich. A clinical panel met on 16 April to consider and endorse the review.

78. Whilst the panel raised several points for consideration and made recommendations, they agreed that the man received care of a consistently good standard from both Littlehey and Norwich.

Smoking Cessation Advice

79. The clinical reviewer noted that no smoking cessation advice was offered to the man on his reception into Bedford. The man had told the doctor he smoked 20 cigarettes a day. It was not until February 2008 that the man was advised to give up smoking. The clinical reviewer acknowledged that within the prison environment it may be difficult to promote smoking cessation. Nevertheless, healthcare staff should develop a strategy for health promotion and be active in using all the services and treatments available.

80. I note the clinical reviewer's recommendation in relation to the promotion of smoking cessation. A copy of this report will be sent to the Governor of Bedford.

Record Keeping

81. As part of his report the clinical reviewer considered the Nursing and Midwifery Council guidance on record keeping. The guidance says that:

> "entries in clinical records are accurately dated, timed and signed with the signature printed alongside the first entry where this is a written record, and attributed to a named person in an identifiable role for electronic records."

82. Although most of the records were completed to the guidelines, there were entries that did not. Some entries had a name but no role. Electronic records from Littlehey adhered to the guidelines, whilst the records from Norwich and Bedford did not note the role of the person making the entry. I endorse the recommendation made by the clinical reviewer to the Heads of Healthcare of Bedford and Norwich:

All prison staff whether registered not, should be reminded about the standards of record keeping and the regular audits undertaken to ensure these standards are achieved.

Correspondence from the hospital

83. The clinical reviewer wrote that letters from the Oral and Maxillofacial Unit at Bedford Hospital were still being sent to Bedford following the man's transfer to Littlehey. It was noted that on several occasions doctors at Littlehey were waiting for updated information on the man's treatments for the lesions to his mouth. He said:

> " Based on the number of occasions that clinic letters from Bedford Hospital were sent to HMP Bedford following the man's transfer to Littlehey, there is no evidence to suggest that any attempts were made to contact the hospital to update the man's details on their IT (information technology) system."

84. I agree with the clinical reviewer's recommendation that National Health Service (NHS) should have systems that patient's addresses are checked and updated at each visit.

The Heads of Healthcare for Bedford and Littlehey should ensure that relevant organisations are updated when prisoners are transferred.

Pharmacy advice

85. The clinical reviewer commented on the good practice of the pharmacist being actively involved in reviewing the man's medication and offering advice. The pharmacist visited the man in his cell to discuss the effects of certain medications. I endorse that good practice.

Release on Temporary Licence

86. On 22 October, a discussion took place between the clinical nurse manager and senior prison management at Littlehey regarding the use of restraints whilst the man was in hospital. His condition had deteriorated and he was extremely weak and frail. The residential governor visited the hospital and carried out a risk assessment. Following that assessment and a further deterioration in the man's health, I am pleased that the Governor authorised a release on temporary licence for the man. His restraints were removed on 30 October, although the escort of two officers remained and was reduced to one officer four days later.

I commend the Governor of Littlehey's decision to release the man on a temporary licence, giving dignity as his health deteriorated.

Palliative care

87. Littlehey does not have 24 hour nursing care or in patient facilities. When it became clear that the man needed continuous nursing care at an in patient unit, enquiries were made to find a suitable place. A local hospice was unable to accept the man and continued hospital care was inappropriate. The Nelson Unit was approached, as they have facilities to care for the man's medical condition, although he did not meet their criteria of being an elderly or life sentenced prisoner. Nevertheless, the Head of Healthcare at Norwich agreed to accept the man into the unit, despite him not meeting their conditions of a placement.

88. The clinical reviewer wrote, "Where possible, services should be provided locally so that there is minimum impact on prisoner's family/carers due to transfer to other prisons."

89. The Ombudsman continues to comment on the lack of local palliative care services for prisoners. Transferring prisoners to healthcare services away from their families and locality causes emotional and practical problems for all involved. There is also greater demand on the healthcare units that are able to provide specialist nursing care, such as the Nelson Unit. Those demands, in addition to the need for expert nursing care, causes difficulties as the original purpose of the units was the care of elderly life sentenced prisoners. I endorse the recommendation made by the clinical reviewer:

    Prison healthcare teams, in collaboration with Primary Care Trusts, should endeavour to care for terminally ill prisoners within their own locality.

Healthcare staff

90. The man received quality nursing and medical care, especially after he was diagnosed with HIV and cancer. Following his admission to hospital, healthcare staff kept in daily contact with the hospital for updates on his condition, and made direct contact with the man, ensuring that he received emotional support.

91. The man was very much alone as his family lived in America. The clinical nurse manager and the healthcare staff offered professional and personal support. He was given opportunities to be consulted about his care and future plans. The man was visited most days during his hospital stay from October to November, by senior healthcare staff. His medical notes recorded, in good detail, all the medical interventions and his current daily condition. The clinical nurse manager was proactive in maintaining this contact and giving the man personal support and advice.

77. A close friend of the man, another prisoner at Littlehey, was given the opportunity to go to hospital for a visit. The man was grateful to the prison for arranging the visit and it gave him some comfort to say goodbye to his friend.

I note the good practice of the Governor of Littlehey in arranging for the man to receive a hospital visit from his friend. This was especially sensitive as the man had no relatives living in this country.

92. Littlehey's family liaison officer kept in regular contact with the man's family, making sure they were aware of his treatment and condition. When his sisters flew to England to visit him, he met them at the airport and drove them directly to Norwich to visit their brother. The family liaison officer ensured that his sisters were fully supported following the transfer of their brother to Norwich. He demonstrated a sensitive and high standard of family liaison.

I commend Littlehey's clinical nurse manager and family liaison officer for the high standard of care offered to the man and his family, and further acknowledge the professionalism of healthcare staff involved in the man's clinical care and emotional support.

The Nelson Unit

93. Following the man's transfer from hospital to the Nelson Unit, the care afforded to him was of the highest standard. Links with palliative care services are well established. A palliative care consultant and nurses have ready access to patients in the unit and provide care equitable to that in the community.

94. The clinical reviewer wrote that the healthcare team at Norwich implemented the Liverpool Care Pathway. He said of the healthcare team on the Nelson Unit:

> "Arrangements had been put in place to ensure that the healthcare staff at Norwich had open access to the man's cell during the terminal stage of his life which allowed him to receive appropriate care when required. They [the healthcare team] should be congratulated on the standard of care given. In particular, documentation was detailed and provided evidence of good collaborative working alongside members of the specialist palliative care team to ensure that the man's care needs were met and that he was allowed to die peacefully and with dignity. "

95. Norwich's head of healthcare supported the man's family during their stay and made herself available to them whenever they felt the need to speak to her. He received daily visits from his family during their stay in Norwich and they were supported by both healthcare staff and chaplaincy.

I commend the healthcare team of the Nelson Unit for the high standard of care afforded to the man and his family.

CONCLUSION

96. The man received a high standard of emotional support and care from both Littlehey and Norwich. Managers ensured that he was to be involved in the discussions about his nursing care and was kept up to date about these arrangements. I believe that the care afforded to the man's family by both prisons was exemplary.

97. The facilities at Littlehey were not sufficient to allow the man to be cared for at the end of his life. I recommend that local facilities are developed. However, as far as the man is concerned, I am pleased that a place in the Nelson Unit at HMP Norwich was arranged where he, and his sisters, received excellent care and support.

RECOMMENDATIONS

For the Heads of Healthcare at Bedford and Norwich

All prison staff whether registered or not, should be reminded about the standards of record keeping and regular audits should be undertaken to ensure these standards are achieved.

No response from the Heads of Healthcare at Bedford and Norwich

For the Heads of Healthcare at Bedford and Littlehey

1. The Heads of Healthcare for Bedford and Littlehey should ensure that relevant organisations are updated when prisoners are transferred.

2. Prison healthcare teams, in collaboration with Primary Care Trusts, should endeavour to care for terminally ill prisoners within their own locality.

No response from the Heads of Healthcare at Bedford and Littlehey

Good Practice

1. I commend the Governor of Littlehey's decision to release the man on a temporary licence, giving dignity as his health deteriorated.

2. I note the good practice of the Governor of Littlehey in arranging for The man to receive a hospital visit from his friend. This was especially sensitive as The man had no relatives living in this country.

3. I commend Littlehey's clinical nurse manager and family liaison officer for the high standard of care offered to the man and his family, and further acknowledge the professionalism of healthcare staff involved in the man's clinical care and emotional support.

4. I commend the healthcare team of the Nelson Unit for the high standard of care afforded to the man and his family.