

**Investigation into the death of a man
whilst in the custody of HMP Norwich in November 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

September 2010

This is the report of an investigation into the death of a man, a prisoner at HMP Norwich. He died on 25 November 2009, in the healthcare centre. He was 64 years old. I offer my condolences to his family and friends for their loss.

He had a significant medical history of chronic disease, including hypertensive disease, gastric problems, heart disease and angina. In 2007, he was diagnosed with a malignant tumour of his rectum and prostate, which later spread to his bones, liver and lungs. He failed to respond to chemotherapy and the disease eventually led to his death.

This investigation was carried out by one of my investigators. I would like to thank the governor of HMP Norwich and the family liaison officer for their participation and invaluable assistance in the investigation. The clinical reviewer who undertook a review of the man's clinical care, on behalf of Norfolk Primary Care Trust, and I appreciate her assistance.

I am satisfied that the level of care delivered by the healthcare team was adequate and I am pleased to note the level of decency and dignity that terminally ill prisoners receive at Norwich. The clinical review makes eight recommendations regarding clinical matters, which I endorse. I make two recommendations regarding the provision of escorts for hospital appointments and the need to consult offender managers and complete risk assessments when prisoners transfer to a hospice.

The version of my report, published on my website, has been amended to remove the names of the woman/man who died and those of staff and prisoners involved in my investigation.

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SUMMARY

The man was born in March 1945 and died in November 2009, at HMP Norwich. He was 64 years old and had been diagnosed with rectal and prostate cancer, which had spread to his bones, liver and lungs.

He was sentenced to life imprisonment in 1988 with a tariff of seven years. He spent the majority of his sentence at HMP Wakefield, where he suffered significant ill health. However, he completed a number of offending behaviour programmes and eventually was re-categorised to category C.

When the man's cancer was first diagnosed, he had a six month course of chemotherapy in 2008. After a short period of remission, the cancer recurred and he had a further course of chemotherapy in the first few months of 2009. In May of that year, he decided to stop his treatment. His consultant later agreed to the man's decision as the treatment had not been effective and his condition had deteriorated. In August 2009, he transferred to HMP Norwich to be nearer to his family and receive palliative care at their elderly persons unit.

A number of requests for compassionate release were made on his behalf. Initially, he did not meet the criteria regarding life expectancy. Unfortunately, when a later application was made, appropriate accommodation could not be obtained to ensure that a robust release plan could be implemented. The man settled in at Norwich, where his symptoms were treated. Towards the end of October, the community specialist palliative care doctor, who also works at the prison, arranged for him to be admitted to a local hospice to adjust his pain control medication. After a few days, the man asked to return to Norwich so that he could smoke.

After another six weeks at Norwich, the man died peacefully in the healthcare centre. His family had been told of his deterioration and had the opportunity to visit him before he died.

The clinical reviewer makes eight recommendations regarding clinical matters. She also identified some good practice in respect of the man's healthcare at both Wakefield and Norwich. I make a further two recommendations suggesting a review of the arrangements for escorting prisoners to hospital and ensuring that offender managers are part of the decision-making process when prisoners are transferred to a hospice.

THE INVESTIGATION PROCESS

1. The man died in November 2009, aged 64. My investigator opened the investigation when she visited HMP Norwich on 8 December. She received copies of the man's personal and medical records.
2. HMP Norwich issued notices to staff and prisoners informing them of the investigation and inviting anyone who had relevant information to contact the investigator. No one responded.
3. As the man had only been at Norwich for approximately four months before he died, my investigator contacted staff at HMP Wakefield and West Yorkshire Probation area. She also spoke to his offender manager, at Greater Manchester Probation area.
4. Norfolk Primary Care Trust commissioned a clinical review of the healthcare provided to the man. I am grateful to the clinical reviewer for her review which is attached as an annex to this report. The clinical reviewer comments on good practice at both Wakefield and Norwich and highlights issues for consideration in healthcare and palliative care services at Norwich.
5. One of my Ombudsman's family liaison officers spoke to the man's sister to ask if there were any matters that she wanted to be addressed in the report. Her only concerns were that the man had told her there had been a short gap in his medication during his stay at HMP Norwich and that he had asked to be released to a hospital. She felt that her brother had been well cared for and had settled in well. She also wanted it to be known that she had been treated excellently by the family liaison officer at Norwich.

HMP NORWICH

6. HMP Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 700, having opened a new wing in September 2009. It holds both remand and sentenced male adults and young offenders. The prison is divided into two sections, one accommodating young offenders and the healthcare centre and the other for the remainder of prisoners.
7. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 23 inpatients. On the ground floor of the centre is a specialist elderly persons unit, the Nelson Unit. It has been designed and equipped to enable older and less able prisoners to be supported and cared for.
8. Previous reports by the Ombudsman highlight areas of good practice. Both clinical and disciplinary staff are experienced at providing care for the elderly and for those, like the man, who are terminally ill. When a prisoner is coming to the end of his life at the prison, there is an 'open door policy'. (Cell doors are left open to facilitate quick support or assistance and the prisoner is free to move around as he feels able.)
9. There are established links with community palliative care services, including Priscilla Bacon Lodge, the local hospice, where the man spent some time towards the end of his life. The relationship between the prison and such community services provide good continuity of treatment and a multi-disciplinary approach to the treatment of terminally ill prisoners.
10. HM Chief Inspector of prisons last inspected HMP Norwich in November 2006. The inspection found there were good links with palliative services and good use of the Liverpool Care Pathway.

Liverpool Care Pathway

11. The Liverpool Care Pathway (LCP) is a key recommendation in the National Institute for Health and Clinical Excellence (NICE) guidelines for support and palliative care. It is a continuous quality improvement programme for the care of terminally ill patients. It has been developed to transfer the hospice model of care into other settings, such as prisons.
12. The LCP is a multi-disciplinary process which provides an evidence based framework for end of life care. It provides guidance on different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions. Additionally, psychological and spiritual care and family support can be included.

HMP WAKEFIELD

13. HMP Wakefield is a high security prison for those serving four years or over, including life sentenced prisoners. The prison provides workshops and an education department offering both full and part-time education. The programmes department offers a range of offending behaviour courses including the Sex Offender Treatment Programme and a range of extended sex offender programmes.
14. The prison's healthcare centre is separate from the main residential areas. All the cells have integral sanitation and the prison has recently been refurbished. The most recent inspection report on Wakefield by HM Chief Inspector of Prisons was issued in April 2008
15. In relation to the healthcare at Wakefield HM Chief Inspector of Prisons reported:

“Good attention was paid to palliative care, which was appropriate to the population profile at Wakefield.”

“There had been some recent investment of resources by the primary care trust, a physical health needs assessment had been completed and joint working was apparent. Some improvements were being made, but some of the accommodation was not fit for purpose. Prisoners had to wait too long to see a GP. There were a number of problems with pharmacy and medicines management. Dentist services were good. Mental health services were inadequate. Too many outside hospital appointments were cancelled with little monitoring of the reasons.”
16. The Independent Monitoring Board (IMB) at Wakefield published their most recent annual report in April 2008. They said of healthcare provision, which had undergone a number of changes:

“The commissioning process of services by the PCT is now providing an increase in resources and investment, this along with the appointment of a new Head of Function and a new healthcare manager, both of whom have embarked upon a proactive management style, has resulted in the provision of better services and an increase in morale among staff.”

KEY FINDINGS

17. The man was convicted of a violent offence on 22 September 1988 and sentenced to life imprisonment with a tariff (minimum time to serve) of seven years. He spent most of his sentence at HMP Wakefield, in West Yorkshire but transferred to HMP Norwich in August 2009, as he had terminal cancer and wanted to be nearer to his family.
18. Throughout his sentence, the man had significant health related problems. He had heart and circulatory disease during the early 1990s leading to a coronary artery bypass, whilst he was at HMP Wakefield. During this time, he also had stomach and back problems resulting in a laminectomy. (A laminectomy is an operation to remove the bony coverings of the spine to widen the spinal canal, in order to relieve pressure on nerves and reduce pain.)
19. The man's most recent health problems started in 2007. In March, he was diagnosed with a malignant tumour of his rectum. It had spread to his bones in August and a further diagnosis of prostate cancer was made at this time. The man was taken to St James's Hospital, Leeds, for surgery to remove the tumours, which subsequently led to a short remission of his rectal cancer.
20. During the first half of 2008, he had chemotherapy. He remained in pain throughout the year, but refused to be admitted to the healthcare centre. Unfortunately, his prostate and bone cancer continued to spread and, in January 2009, he was again diagnosed with rectal cancer. In March, he was told the cancer had spread to his liver and lungs.
21. Doctors gave him a life expectancy of six months at this time, although his consultant said that if he had chemotherapy, it might be extended to more than a year. The man's consultant arranged palliative care for the man and he was introduced to a Macmillan nurse. (Palliative care is the active holistic care of patients with a terminal illness, taking account of their spiritual, family and medical needs. It is sometimes provided by Macmillan nurses.) The hospital started chemotherapy, with a view to extending the man's life.
22. The man continued to take part in his sentence plan and completed the Better Lives Booster course in which he was reported to have done well. (The aim of a sentence plan is to enable a prisoner to use their time constructively, reduce the risks posed and avoid further offending.) During this time he occasionally felt very emotional and asked to move to a prison nearer to his family. It is clear from the records that he was able to discuss his concerns with prison and nursing staff at HMP Wakefield and felt well supported.
23. On 11 May, the man asked to be considered for compassionate release. However, at this stage he was still considered to be a high risk and his consultant had commented "is receiving chemotherapy and remains independent". His prognosis at this time was six to 12 months. There was no evidence to suggest that it would be detrimental to his life expectancy or general health to remain in prison at that time. On the same day, the man

decided to stop his chemotherapy and he pulled out his Hickman Line. This is an intravenous line from his chest to a vein, to enable chemotherapy drugs to be pumped into his system.

24. The man's offender manager considered the request for compassionate release but did not support it as he thought that the man still posed risks, particularly to female nursing staff. Furthermore, the prison considered that the man did not meet the criteria for compassionate release. Prison Service Order 4700, advises that the prisoner should have a prognosis of three months or less, to be considered for release.
25. At a hospital review on 26 May, the man discussed his decision to stop chemotherapy with his consultant who agreed, as he had deteriorated. The man's health then started to deteriorate further. It is recorded in medical reports that he lost weight, had a loss of energy and was starting to feel increasingly ill. His life expectancy was reduced to two months.
26. At this stage, the man decided to stop taking his other medication. Staff suggested that he move to the healthcare centre but he refused and so a carer was arranged to help him around the wing. His carer, prison and medical staff supported and counselled him and he subsequently resumed his medication. Towards the end of May, he agreed to move to the healthcare centre, where he could be better cared for. According to medical records and wing history sheets, he received many visitors from other prisoners. Healthcare staff said they "would do everything in their power to make him comfortable". The prison appointed a family liaison officer as a link between staff and the man's family.
27. A further request for compassionate release was made on 27 June by the first prison doctor at Wakefield, who said that the man had "much less than 6 months to live".
28. The man's offender manager responded to this request immediately. However, in his report of 12 June, he says that he had problems finding appropriate accommodation. The man wanted to be released into the care of his sister but this was not possible. His sister said she did not feel able to care for him adequately and that the local authority would not allow her brother to live with her. The man's offender manager made enquiries of Southend on Sea Adult Social Services Department, regarding release to a nursing home and was told that they needed a nursing needs assessment by the prison healthcare.
29. The man's offender manager was also told that the man would need to be registered with a general practitioner (GP) in the community, before the medical report could be submitted to the panel, for consideration of release. Attempts were made to register him with his sister's GP, but this was declined. It is not clear why, although the man's offender manager states in his report that GPs are not obliged to take patients. The local Primary Care Trust was then contacted with a view to ensuring that the man was provided with a GP. The relevant professionals from both the prison and probation

service continued in their efforts to ensure that all of the available options for release on compassionate grounds, were fully explored. However, because a specific release address could not be approved, it was not possible to construct a complete and robust risk management plan, and so the request could not be supported. This decision was upheld by the Parole Board and the Secretary of State in October 2009.

30. At the same time as the man's offender manager enquiries, staff at Wakefield explored the possibility of the man transferring to a prison nearer to his sister's home. HMP Norwich is known for its elderly prisoners unit and its links with community care for those who are coming to the end of their lives. It was also closer to his sister's home.
31. In preparation for this, the man was re-categorised to category C in August, based on the fact that he had completed his Better Lives Booster programme. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with Category A prisoners being the most dangerous.) The man had started as a category A prisoner. His risk was further reduced by the physical restrictions caused by his ill health. He was happy to transfer to Norwich but concerned about continuity of treatment and, having spent many years at Wakefield, felt he would miss his friends and staff.
32. His Macmillan Nurse, supported and counselled him through this period and, on 5 August, the man agreed to the transfer. The prison staff organised it swiftly and on 11 August, he was assisted to go to the wing to say goodbye to his friends. Healthcare staff at Wakefield passed medical information to Norwich, so that they were prepared for the man's arrival.
33. The man travelled to Norwich on 12 August where he was given a single cell, with integral sanitation. No medical notes were completed on his arrival at Norwich, although notes were made retrospectively at 1.44pm on 13 August. These notes showed that he arrived "tired but alert and oriented. He enjoyed a meal in the dining area". The record gave further information about the man's existing physical abilities and noted that he would be assessed by the palliative care team later that day.
34. The man's pain relief medication consisted of a long term acting morphine preparation (MST), which was topped up every four hours with Oramorph, (short term relief for break through pain). There is no record of a full, holistic assessment on arrival at Norwich, but the locum doctor reviewed him at 12.24pm on 13 August. He prescribed 28 days of the general medications but only two days of MST. The doctor said that this would be reviewed by the specialist palliative care staff later that afternoon.
35. At 6.03pm, the specialist palliative care nurse, assessed the man. According to the records, he had not been given Oramorph all day and was suffering from pain in his lower abdomen. The specialist palliative care nurse contacted the Macmillan nurse at Wakefield and was told that no matter what

the MST dose, the man still required Oramorph every four hours. The locum doctor prescribed it on 14 August. The man also expressed his wish not to be resuscitated in the event of his collapse and signed the appropriate documents after discussing it with staff.

36. There is another entry in the medical history on 19 August, where the man said he had not had Oramorph as regularly as he did in Wakefield. He complained of increased pain over the next few days and staff recorded that this was disturbing his sleep. On 2 September, the man said his pain was no longer under control. Staff contacted the specialist palliative care nurse who instructed that his MST should be increased and said that she would review him.
37. On 5 September, the man ran out of cyclizine tablets (sickness relief) which he had brought with him from Wakefield. Although the locum doctor had prescribed a further supply on 12 August, they had not been dispensed. As there were no cyclizine tablets in the pharmacy, the doctor gave another form of anti sickness tablet, metoclopramide, as a substitute.
38. Over the next few weeks, the man complained of increasing pain, swollen testicles and a mucous like discharge and bleeding from his rectum. A second prison doctor, arranged an emergency computed tomography (CT) scan (a detailed x-ray which can show three dimensional images inside the body) on 13 October, with a view to having radiotherapy to help with his pain relief. However, the prison was unable to provide an escort to accompany him to hospital.
39. The investigator asked the head of healthcare about the procedure for taking prisoners to hospital appointments. Only four appointments per day were allowed, two in the morning and two in the afternoon because of the staff resources required to escort prisoners. She was told that healthcare staff were not consulted about which prisoners attend their appointment. Staff were not informed that the man could not attend until after the appointment time. The second prison doctor arranged a further scan for 23 October, which the man attended.
40. Meanwhile, according to medical records, the man's pain increased and he became confused and emotional. The governor agreed that there should be an open door policy, so that staff could attend to the man immediately, if necessary. As a result of the man's increased pain, the second prison doctor made arrangements for him to be transferred to Priscilla Bacon Lodge, a local hospice, with a view to improving pain control. The governor agreed and, on 26 October, the man moved into the hospice. (The man's offender manager told the investigator that he was unaware of this move at the time.)
41. The investigator was told that whilst the man was resident in the hospice, he only had one prison escort officer. No restraints were used and he had a single room. At his own request, the man returned to the healthcare centre at the prison on 2 November. He asked to return so that he could smoke freely.

Medical records showed that he was more settled and his pain was more controlled on his return.

42. On 5 November, the man refused to take his medication and told staff that he wanted to “give up and die”. The second prison doctor and a nurse spoke to the man and he started to take his medication again the following day, 6 November.
43. The man’s friend, who was his nominated next of kin visited him on 13 November. She contacted his sister and alerted her to her brother’s deterioration. After a telephone call from the man’s friend, the head of healthcare arranged for the man’s sister to be permitted to visit whenever she could, so she was not tied to prison visiting times. His sister subsequently visited him.
44. Over the next ten days, the man deteriorated further and was unable to swallow his medication without vomiting. The second prison doctor said that at this stage it would be best practice to administer medication via a syringe driver. (A syringe driver is small portable battery operated pump, which administers medication over a 24 hour period.) However, when the investigator asked about this she was told that none of the nursing staff felt adequately trained to use this method. Many of the staff were agency nurses. Instead the man’s medication was injected subcutaneously (under the skin) at regular intervals. Although it was agreed this was not the best method, it was adequate to ensure that he was pain and symptom free.
45. In interview the head of healthcare and the second prison doctor said that a recent recruitment drive for permanent staff had taken place. Now that the prison had more stable staffing they were able to roll out training for syringe driver use. Furthermore, continuity of assessment and care would be much better.
46. On 25 November, at 7.25, a first prison nurse, one of the full-time, permanent nurses at the prison went in to check the man. She told my investigator that she knew he was “very poorly” and she wanted to see him before she finished her shift because she knew he was near to the end of his life. She noted that his breathing was very shallow. She held his hand and “he took one more breath and then stopped breathing”. She said that she stayed with the man for another five minutes and then left to tell relevant staff. He had continuously stressed that in the event of his death, he was not to be resuscitated. The most recent review took place when he arrived at Norwich.
47. The prison doctor pronounced the man dead at 9.25am. The prison’s family liaison officer and the head of healthcare visited the man’s nominated next of kin, to inform her of his death. She asked them to contact his sister to tell them, which they did by telephone. The prison family liaison officer telephoned one of his sisters’ and she said that she would then telephone her other sister. From that time the prison liaison officer treated both the man’s friend and the man’s sisters, as next of kin and arranged the funeral with them both. The prison liaison officer said that the prison would meet funeral costs.

When the Ombudsman's family liaison officer spoke to the man's sister, she had nothing but praise for the way the prison staff had informed her of the news of the man's death. She asked that we commend the prison family liaison officer in this report and was satisfied that her brother had been treated with dignity.

ISSUES

Clinical care

48. The clinical reviewer conducted a review of the clinical care given to the man, on behalf of Norfolk PCT, and her report is attached at annex 1. The review looks broadly at the provision and management of healthcare services generally within the prison and more specifically at the particular standard of care the man received.
49. The clinical reviewer focussed on the following areas – assessment, medical support, staffing, coordination and consistency of care and medication. Her conclusions are summarised below:
 - There were inconsistencies in assessments due to staffing difficulties and entries in the electronic medical records system were not always appropriate.
 - In terms of medical support, more input was provided by the specialist palliative care team than in the community, partly because locum GPs had insufficient knowledge of the man.
 - Owing to high levels of nursing staff absences and the consequent use of agency staff, there was a lack of coordination of care as well as a breakdown in communication and forward planning in obtaining medication. Staff were also inexperienced in the use of syringe drivers for pain control. However, an alternative method was used which was adequate for the man's needs.

In the light of her findings, the clinical reviewer makes eight recommendations relating to clinical matters, which I endorse.

50. The clinical reviewer also identified a number of areas of good practice. At Wakefield, there was good palliative care with support networks both inside and outside of prison. There was also good coordination and communication, particularly the consistency of having assessments made by the same GP which provided good follow-up and reassessment. Norwich worked collaboratively with the specialist palliative care service and gave attention to the man's dignity. Steps have been taken to provide a dedicated person in the healthcare centre to handle the process for releasing prisoners, in consultation with the specialist services.

Escort arrangements for hospital appointments

51. On 13 October 2009, an emergency CT scan was arranged for the man. He was unable to attend as no prison staff were available to escort him. Staff explained to the investigator that only two people per day could attend hospital appointments because of the staff needed to escort them. The decisions about who could attend such appointments were not routinely discussed with healthcare staff and they were not told that the man could not go until after the appointment time had elapsed.

The Governor and head of healthcare should review the system for arranging escorts for hospital appointments to ensure that healthcare staff are consulted and appointments for terminally ill prisoners are given appropriate priority.

Applications for compassionate release

52. The man made three requests for compassionate release. The first one was refused because it was not within the criteria stated in PSO 4700. The second was not supported because adequate risk assessed accommodation could not be secured for the man. The third was still in the administrative processes when he died. I am satisfied that staff at Wakefield dealt appropriately with the requests.

Transfer to hospice

53. In order to provide better management for the man's increasing pain, he transferred to Priscilla Bacon Lodge, a local hospice. While resident there, he was in a single room, escorted by one officer in plain clothes and was not placed in restraints. I am pleased to note the sensitivity of these arrangements. However the offender manager was not aware that the man had moved to the hospice until after the event and there was no record of a risk assessment having taken place. Whilst the decision was made by the governor and the palliative care specialist and was in the man's best interests, a comprehensive risk assessment, taking account of the offender manager's views, should have been completed.

The Governor should ensure that the decision to transfer a prisoner to a hospice is taken in consultation with the offender manager and a full risk assessment is completed.

Conclusion

54. The man went into prison with a number of chronic illnesses. He was then diagnosed with cancer, but failed to respond to treatment. He transferred to the elderly prisoners unit at Norwich where he was given palliative care for his symptoms. Although he spent a short time in a local hospice for pain control, he chose to return to the prison. He did not meet the criteria for compassionate release and a final application made towards the end of his life was still being considered when he died. The investigation has found that

the man was given appropriate care and treatment and his family and peers were able to visit him throughout his illness. His family were told of his deterioration, so were able to see him before he died.

RECOMMENDATIONS

1. The Governor and head of healthcare should review the system for arranging escorts for hospital appointments to ensure that healthcare staff are consulted and appointments for terminally ill prisoners are given appropriate priority.

Accepted – In future prison escorts will liaise with healthcare when they are unable to fulfil agreed escort duties. Healthcare staff will prioritise escorts based on clinical need. The Governor will inform staff of this procedure by means of a GNTS. This has now been completed.

2. The Governor should ensure that the decision to transfer a prisoner to a hospice is taken in consultation with the offender manager and a full risk assessment is completed.

Partially accepted – the man was admitted to the Priscilla Bacon Lodge for symptom control rather than 'end of life care'. The offender manager would have been consulted as part of the decision making process as to where the man's 'end of life care' was to take place, if this was to be outside the establishment.