Investigation into the circumstances surrounding the death of a man in November 2010 at HMP&YOI Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

October 2011

This is the report of an investigation into the circumstances surrounding the death of a 75 year old man at HMP&YOI Norwich. He had been diagnosed with a number of medical conditions including diabetes, chronic kidney disease and chronic obstructive pulmonary disease. He died in November 2010 from pancreatic cancer.

He had lost contact with his family and they have not played any part in my investigation. Nevertheless I give them and his friends my condolences on his passing.

The investigation was carried out on my behalf by two of my investigators. A clinical review of the man's healthcare was undertaken by the clinical reviewer on behalf of the local PCT. I am grateful for her report. I would also like to thank the Governor of Norwich and his staff for their co-operation and assistance with this investigation.

The man was elderly and had spent the majority of his adult life within a custodial environment. The last two years of his life were spent at Norwich on the older prisoners' unit, where he suffered from multiple health problems.

I judge that his condition was diagnosed promptly and that he was given appropriate medical care, including palliative treatment. However, I make four recommendations about healthcare issues. They concern ensuring that sufficient staff are trained in the use of syringe drivers to give medication, providing training in the opening of Liverpool Care Pathways, and the certification of death as well as ensuring that a patient's capacity is considered in relation to discussions and decisions about resuscitation.

I would also like to acknowledge the high standard of clinical care by nursing staff and commend a member of chaplaincy for the companionship, care and attention shown to the man during his final days.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2011**

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SUMMARY

1. The man was a life sentenced prisoner. He began his sentence at HMP Wakefield but transferred to HMP Whitemoor on 24 February 1988, where he spent the majority of his years in custody. He was not released when his tariff expired in June 2004, as the Parole Board considered he still posed a risk of serious harm. He remained at Whitemoor until 29 January 2008 when he transferred to HMP Norwich.

2. He was a wheelchair user, had been diagnosed with type 2 diabetes, chronic kidney disease, chronic obstructive pulmonary Disease (COPD), arthritis in his hands and a below knee amputation. He was given a cell in Norwich's dedicated unit for older prisoners.

3. On 14 October 2010, he looked jaundiced and complained of abdominal pain. After examination by a doctor at the prison, he was referred to hospital. He was admitted to the hospital on 19 October 2010, where he was diagnosed with pancreatic cancer.

4. At his request, he returned to Norwich Prison on 28 October for palliative care. Staff from the chaplaincy team, a volunteer prison visitor and fellow prisoners visited him during his final days. He died five days later. He had no family and so the prison chaplaincy arranged a funeral, taking account of his wishes.

5. The investigation has found that, after reporting his symptoms, his condition was diagnosed promptly, he was given appropriate palliative care and both clinical and spiritual staff complied with his wishes. However, I make four recommendations relating to clinical matters. I recommend development of a policy to allow doctors to give permission for nurses to certify deaths and for those nurses to be trained to do so. Nurses should also be reminded to take account of and record mental capacity in relation to decisions on resuscitation. I also recommend training for nurses in both the use of syringe drivers and the Liverpool Care Pathway for dying patients.

6. I am satisfied that clinical staff provided a high level of care. I also commend a member of the chaplaincy who spent a great deal of time with him towards the end of his life when he was severely incapacitated.

THE INVESTIGATION PROCESS

7. The investigation was opened 8 November 2010 when two investigators visited Norwich prison. Notices announcing the investigation were issued. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigators. One prisoner came forward as a result. However, he declined to talk to my investigators when they later visited to conduct interviews. During their visit to Norwich on 8 November, staff gave the investigators copies of documentation relating to him and they saw his cell.

8. Both investigators visited Norwich Prison on 17 January 2011, and interviewed two members of staff. The interviews were carried out with the clinical reviewer, who had been appointed to conduct a review of the man's clinical care.

9. My investigators originally intended to also interview a Healthcare Assistant. However, at the time of their visit she was on long term sick leave. They subsequently decided not to interview her as the staff nurse who was interviewed was able to provide full details.

10. My investigators also contacted Her Majesty's Coroner on 3 November to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist his enquiries into the man's death.

11. The man had no family. However, one of the prison's family liaison officers contacted his probation officer to report his death.

12. My investigation assesses the following aspects of his care and treatment:

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

HMP NORWICH

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

Healthcare

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

    - primary medical and nursing services
    - out of hours and 24 hour nursing cover
    - mental health in reach services
    - community services
    - dentistry
    - in patient care unit
    - life sentence prisoner inpatient unit.

15. Norwich prison healthcare staff use a computerised documentation system, known as SystmOne.

Older prisoners' unit

16. A staff nurse also spoke to my investigators about the older prisoners' wing in general. She said that the wing caters for 15 patients all of whom were over 65 years old. During the day, a registered nurse is always on duty, while the nights are staffed by a registered nurse from the healthcare centre. She said there is also a healthcare assistant on duty and a prison officer trained in healthcare duties.

17. During the interview she said that all the cells in the unit are adapted for wheelchairs and have en-suite facilities. The patients have a specialist hospital bed if they need one.

Her Majesty's Inspectorate of Prisons

18. Her Majesty's Inspectorate of Prisons reports on all Prison Service establishments. In February 2010, the Inspectorate carried out an unannounced inspection at Norwich and the resulting report was published in April 2010. The inspection found that the managers had tried to focus on the prison's local role and organise the accommodation in a more effective way. The environment had

been greatly improved by rebuilding A Wing. The report concluded that Norwich was an improved and safer prison compared to the last time they had visited in 2007.

19. The Inspectorate report also refers to the dedicated older prisoners' unit on the ground floor for prisoners over 65 with specific health problems. The unit is staffed by one qualified nurse and either one or two healthcare assistants, supported by a hospital officer. Inspectors found that many of the patients required full nursing care and staff struggled to provide the required level of care. The staff had not received specific training in dementia. However, patients who were spoken to were satisfied with their care.

20. The inspection found that the healthcare provision was improving but the inpatient regime was insufficient. The report made the following comments about the older prisoners' unit in particular:

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

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) whose role is to monitor the prison and to report any concerns that they have regarding the prison, or how prisoners are treated. Board members visit any area of the prison at any time and have direct access to any prisoner who they wish to see, or who asks to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report to the Secretary of State for Justice.

22. In their annual report, covering the period 1 March 2008 to 28 February 2009, the Board, when referring to healthcare, said:

> "The most serious risk to the provision of healthcare within HMP Norwich is that after a number of years, there is still no dedicated GP [general practitioner] service. The locum service has been shown to have serious deficiencies."

23. The latest annual report, for the period 1 March 2009 to 28 February 2010, said:

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

24. The report said also that the position for elderly prisoners had not improved over the last year in relation to social care. It said the prisoners on the older

prisoners' unit had very little with which to occupy themselves and that providing specialist diets can be problematic.

Previous deaths at Norwich

25. Norwich has specialised in recent years in caring for older prisoners whose lives may well end whilst still serving a prison sentence. The prison has established links with a palliative care provider in the local community. The Ombudsman assumed responsibility for investigating deaths in custody in 2004. Since then, the office has investigated a significant number of deaths at Norwich resulting from illness, primarily diseases such as cancer. One of the issues raised by the clinical reviewer is the timeliness of the opening of the Liverpool Pathway for the care of the dying. A previous report into the death of a man in 2007 also raised the issue and recommended all staff should be trained.

Prison Service Orders (PSO)

26. Prison Service Orders are long term instructions which are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

Prison family liaison officer (FLO)

27. Following any death in prison, the prison Governor is required to appoint a family liaison officer to be the first contact in the prison for the deceased person's family. PSO 2710 contains advice and guidance on dealing with families that supplements the mandatory instructions in the PSO.

Night procedures

28. During the night, only the orderly officer carries a full set of keys to unlock all gates and cells. Officers are issued with a cell key in a sealed pouch for use in emergencies.

ISSUES

The diagnosis of the man's terminal illness

29. The man was born in October 1935 in Poplar, East London. In 1962, he was convicted and committed to Broadmoor. This was not his first conviction. Eighteen years later, he was sentenced to life imprisonment, with a minimum tariff of 25 years, at Crown Court on 23 May 1980, following conviction for murder while on leave from Broadmoor. His tariff expired in June 2004. However, he was not released as the Parole Board did not consider that the risk of serious harm that he posed had been reduced.

30. He was held on remand at HMP Bristol from 19 June 1979 and on conviction was initially allocated to HMP Wakefield. He remained at Wakefield from 22 January 1981 until 24 February 1998, when he transferred to HMP Whitemoor. He moved to HMP Norwich on 29 January 2008. A week before his transfer, on 21 January 2008, he fell in his cell. The x-ray taken at the time showed a broken left hip. However, the hospital local to Whitemoor said they would not operate but would keep the pain under control with pain killers.

31. On arrival at Norwich, he immediately went into the older prisoners' unit. Nurse A carried out a medical assessment. He noted that the man was in poor health with several chronic conditions. He had:

    - type 2 diabetes (this occurs when the body produces insufficient insulin)
    - an impaired femoral and popliteal (behind the knee) pulse in his left leg
    - a left leg below knee amputation
    - chronic obstructive pulmonary disorder (COPD) which is a respiratory disease
    - an enlarged prostate
    - arthritis
    - the broken hip he had sustained the week before.

    He also suffered from heart, kidney and breathing problems and high blood pressure. During his time at Norwich, staff put in place care plans for his diabetes, care of wounds and prevention of pressure sores.

32. The investigators spoke to Nurse B about him. She said that he used a wheelchair and had recently been given an electric wheelchair as he had difficulty with a manual chair due to his arthritis. When he first had the electric wheelchair, he had complained that it did not move quickly enough so she had arranged for it to be altered.

33. On 14 October 2010, Prison Doctor A examined him. In an entry made on 15 October in his medical record, the doctor noted that he looked jaundiced (his skin had a yellow tinge) and complained of central abdominal pain. The doctor reviewed him on 15 October and noted that the abdominal pain had persisted overnight and he looked increasingly jaundiced. The doctor diagnosed

abdominal pain and noted that he planned to arrange blood tests and review if his symptoms worsened. The clinical reviewer could find no information in the records that he had been jaundiced prior to this date.

34. Four days later, on 19 October at 2.12pm, he had an appointment with Prison Doctor B, who noted that he was still jaundiced and his urine was a dark colour. On examination, his liver was possibly slightly enlarged but there were no obvious hard masses (meaning cancerous growths). The doctor considered that he required urgent further tests under the two week wait pathway and sent a referral to hospital. (If cancer is suspected, the NHS Cancer plan says that a patient must be seen by a cancer specialist within two weeks.)

35. The next day at 5.02pm, Prison Doctor C reviewed him. The medical notes indicate that he had been increasingly jaundiced for the previous five days and was not drinking. The doctor's examination highlighted the jaundice, that his central abdomen was tender and bowel sounds were inaudible. She diagnosed suspected cancer of the pancreas and recommended an urgent referral for inpatient treatment. Less than three hours later, he was taken to hospital, where cancer of the pancreas was subsequently diagnosed.

36. Nurse C at Norwich noted on 24 October that he was on the Acute Medical Unit (AMU) at hospital waiting for assessment. She said she had been told he was comfortable and receiving intravenous (IV) fluids and antibiotics. (IV means administered directly into the vein.) The notes said that he was expected to be discharged the following week.

37. Nurse D at Norwich spoke to the staff nurse on the Gately Ward at the hospital on 27 October. She was told he was very frail with a poor oral intake. The IV antibiotics had been stopped but IV fluids continued for hydration. The medical notes show that he was due to have a bilary stent inserted to help bile drainage but he had been too frail for the procedure to take place. He had also been given a Fentanyl patch to relieve his pain. She noted that, due to his frail state and poor prognosis, the likely outcome of the consultant's review would be that he would return to Norwich prison for palliative care. She informed the hospital nurse that if he was no longer on IV therapy and stable then he could return to the prison. Prison Doctor B noted that when he returned to Norwich on 28 October there was no letter or diagnosis, but that a member of healthcare would request this information.

38. When interviewed, Nurse B said a Healthcare Assistant (HCA) had noticed that he was still jaundiced. She said the HCA had referred this to the nurse on duty. She was not on duty when he went into hospital and, when he returned, was shocked to see how rapidly he had declined.

39. The clinical reviewer raised no concerns about the timeliness of the diagnosis.

Informing the man about his condition and treatment

40. The discharge letter from the consultant at the hospital said that staff at the hospital had lengthy discussions with the man about his condition. He felt he did not want to remain in hospital but would rather spend his remaining days in familiar surroundings. The consultant considered that this would be the best option as he was slowly worsening. The doctor thought that he had not been seen by the palliative care team on admission to hospital but that it would be worth obtaining advice for symptom control if there was a problem. A copy of the discharge letter was not given to the man but it clearly showed that he was aware of the diagnosis.

41. On 28 October, after he returned to the prison, a Do Not Resuscitate (DNR) form was completed on his behalf, signed by a doctor and a registered nurse. The DNR shows that he was unable to sign due to arthritis in his hands but there was no indication from the record that he lacked capacity to make this decision. I think that staff should have explicitly recorded his mental capacity. The clinical reviewer has made a recommendation on this point, which I endorse and slightly recast below:

    The Head of Healthcare should remind staff to ensure that the patient's mental capacity is considered in relation to discussions about resuscitation and that this is explicitly recorded in the clinical record.

42. The Liverpool Care Pathway (LCP) is an outline of care which a dying patient can expect to receive in the final days and hours of their life. The pathway was developed to try to provide the same level of nursing expertise at the end of life as during other treatments, regardless of the patients' environment. The pathway was opened on 30 October by Nurse B. Goal 1.3 of the LCP record shows that the man was aware of his diagnosis and he had made the decision to return to Norwich.

43. Having reviewed the records, the clinical reviewer concludes that he was informed of his diagnosis and that the only possible treatment was palliative care. I agree with her views.

The man's medical appointments and treatment

44. When he arrived at Norwich, he was already suffering from multiple health problems and various care plans were put in place. He had regular blood tests, which from January 2010, sometimes showed abnormal results but no further action was taken. The clinical reviewer concludes that these abnormal results could be attributed to the medication he was receiving for his various health problems.

45. Following a computerised tomography (CT) scan, doctors confirmed the diagnosis of pancreatic cancer which had spread to the liver and possibly the lungs. (A CT scan uses X-rays and a computer to create detailed images of the inside of the body.) The records show that the hospital considered further

investigations and treatment. However, on the basis of the result of the CT scan hospital staff decided that this would be of no benefit to him.

46. He was discharged from hospital on 28 October and returned to Norwich. Details of his medication requirements were sent with him. The home discharge letter said that there was to be no further follow-up by the hospital.

47. His medical records show that referrals were made in an appropriate and timely manner.

The man's pain relief and medication

48. The records show that while he was in hospital, a prison nurse spoke to hospital staff who told her of his worsening condition and that palliative care was advised.

49. On his return to Norwich, he was assessed by the specialist palliative care team from the Priscilla Bacon Lodge, a community based specialist palliative care service. The team prescribed medication for pain relief and sedation, offering to visit again if required. Prison Doctor B also reviewed him and agreed that his medication should remain the same.

50. During the night of 28 October, a practice nurse observed him through the observation hatch. Cells are locked during the night and the orderly officer, who is in charge of the prison, must give permission before the door can be opened. The entry in his medical record indicated that he was sleeping and his breathing appeared to be regular and quiet. The nurse noted he did not appear to be in pain and was comfortable at that time.

51. At approximately 1.30am on 29 October, the same nurse saw him trying to get out of bed. The nurse called the orderly officer to obtain permission to go into the cell. When asked, he said that he had a pain rating of 9/10, meaning that he was in severe pain. The nurse noted that he had bubbly breathing and might have water on his lungs. He gave him pain relief and pressure area care, to prevent bedsores.

52. During the afternoon of 29 October, he was out of bed having received assistance from staff. An entry in his medical notes by a member of the Community Health Service said that an officer saw him huddled over his chair in pain. Staff helped him back into bed and gave him more pain relief medication.

53. An entry in his medical records shows that on 30 October he appeared to have slept well, expressing few signs of pain. He had attempted to get out of bed to use the toilet at around 2.00am and staff helped him into fresh pads and administered pain relief.

54. On 1 November, Nurse B discussed the use of syringe drivers, to administer pain relief, with a worker from the Priscilla Bacon Lodge Hospice. She considered this to be the best way to give him his pain medication. She noted that the prison doctor was reluctant to prescribe a syringe driver as there were no staff available at the prison who were competent to set one up and no training had been given.

She suggested liaising with the district nurse to find someone who could set up the syringe driver. However, the doctor said this was an issue for management as funding would need to be made available. She discussed this with the Matron who said she would discuss the best course of action with the Head of Healthcare. In the interim, medication was administered through a tube inserted in the back of his hand.

55. Staff prescribed medication for his nausea and the treatment of excess oral secretions. During interview, the nurse said that as she was concerned about his secretions she had telephoned the Pricilla Bacon Lodge to ask for advice. Based on the advice she was given, his medication was changed and the new drugs successfully reduced the secretions.

56. In spite of the fact that he appeared to have been given appropriate pain relief, the clinical reviewer concludes that he would have benefited from using a syringe driver which provides a continuous supply of the drug instead of an intermittent supply from taking it orally. However, providing a syringe driver was not possible as staff were not appropriately trained to manage it. During her interview, the nurse said when she was carrying out personal care for him at times he seemed to be in pain. When she was on duty she always made sure that he had the correct pain relief but she would have liked him to be able to have a syringe driver. She recorded in the care plan that the doctor had been unwilling to prescribe a syringe driver even though this had been identified as best for him.

    The Head of Healthcare should ensure that sufficient numbers of registered nurses are trained to administer medication via a syringe driver and can provide this care when it is needed by terminally ill and dying patients.

Liaison with the man's family

57. The man's contact with his family had stopped many years previously. Therefore, the prison staff did not contact them when he passed away. As he had no next of kin recorded, staff informed his probation officer of his death.

58. He was seen regularly by a member of the chaplaincy team and also by the IMB. Other prisoners from the wing also visited him in his cell regularly and staff sat with him when they were able to.

59. I judge that all actions taken were appropriate.

Compassionate release

60. PSO 6000 – Parole, Release and Recall, Chapter 12, advises that early release on compassionate grounds may be considered on the basis of a prisoner's medical condition or as a result of tragic family circumstances. It is only granted in exceptional circumstances.

61. The fundamental principles underlying the approach to early release on compassionate grounds are:

- The release of the prisoner will not put the safety of the public at risk.

- A decision to approve release would not normally be made on the basis of fats of which the sentencing or appeal court was aware.

- There is some specific purpose to be served by early release.

62. Early release may be considered on medical grounds where a prisoner is suffering from a terminal illness and death is likely to occur soon. There are no set time limits but three months is considered to be an appropriate period. A clear medical opinion on the likely life expectancy is required. The Secretary of State will also need to be satisfied that the risk of re-offending is past and that there are adequate arrangements for the prisoner's care and treatment outside prison. There is also a requirement that the early release of a prisoner will bring some significant benefit to the prisoner or his family. The decision to release a prisoner on compassionate grounds is made by the Secretary of State taking into account information provided by Prison Service staff and medical opinions.

63. Early release on compassionate grounds would not have been considered appropriate for the man. At the time of his diagnosis it was apparent that his life expectancy was very short and the processes to secure his release would not be completed in time. He had no family contact and there would have been no benefit in releasing him. While in hospital, he had expressed a desire to return to Norwich prison, where his friends were. He had built up relationships with both prisoners and staff. If released, this support network would not have been available and he would have been amongst strangers at the time of his death. I am satisfied that the care and treatment that he received on an emotional level was likely to be far greater if he remained in prison.

The man's location

64. At his request, following the diagnosis of his illness, he returned from hospital to the prison. He had previously been living on the older prisoners' wing and returned there where he remained amongst his friends.

65. As he wanted to return to the prison, the option of a hospice was not considered. In reality, it is unlikely that given the short time span between the diagnosis of his illness and his death that a place in a hospice would have been secured. However, he had expressed an understandable desire to return to the unit which had been his home for the previous two years.

Palliative care plans

66. On 30 October, Nurse B put in place the Liverpool Care Pathway. She reported at 11.44am that he was no longer able to tolerate sips of water and was semi-conscious. She said he was unable to talk at this point.

67. She explained during her interview that she had opened the pathway on 30 October as this was the first time she was on duty following his return from hospital. If she had been on duty, she would have opened the plan sooner. She

went on to suggest that it may not have been opened at an earlier stage if a registered mental nurse had been on duty as they would not have received training in opening and using the plan. At the time, there was no case manager in charge of opening the plans.

68. The initial assessment of him carried out by Nurse B and a doctor indicated that he was not in pain or agitated, nauseated, vomiting and neither did he have trouble breathing. The assessment showed that he was unable to swallow and was incontinent. He was experiencing respiratory tract secretions, was confused and only semi-conscious. A further barrier to communication was that he had poor hearing.

69. Other entries show that a priest had visited him on 29 and 30 October and that prayers had been said. A chaplain had also spent three hours sitting with him.

70. In accordance with the care plan, the nurses checked on him four times every hour. As he was unable to swallow, mouth care was given at regular intervals. As already discussed, Nurse B observed that secretions were a problem. She contacted the Priscilla Bacon Lodge for advice about his medication.

71. In her interview, the chaplain said on 2 November she had been aware of nursing staff attending to him every 15 minutes to begin with. Then, nearer the time of his death, they remained with him constantly. This is a considerable use of staff time and I recognise the resources which the healthcare manager put into looking after him to ensure that he was not alone when he died.

72. Although the Liverpool Care Pathway was used, some staff expressed the view that, given his condition, it should have been opened sooner. The clinical reviewer makes a recommendation regarding training staff to use the pathway, which I endorse and slightly recast. Given the nature of the prisoners living in the older prisoners unit and the number of terminally ill prisoners who have been looked after there, I am disappointed that this recommendation has become necessary.

    The Head of Healthcare should arrange for staff to be trained in the opening of the Liverpool Care Pathway, to ensure that it can be opened when it is required.

Other care and support

73. The member of chaplaincy is a Church of England Accredited Lay Worker (ALW). She told my investigators that she visited the man regularly. She said that the Methodist preachers also went to see him when they were on duty as this was his denomination. However, she said he was also happy to receive visits from her. While he was in hospital she visited him twice and then visited him every day once he returned to the prison. She also recalled that on his return, he had been visited by the head of the Prison Visitors (volunteers who befriend prisoners) and at least two prisoners.

74. She told the investigators that she was aware that he was frightened of dying although, by the time he returned from hospital, he only communicated through hand grasps. She said the staff did everything they could to make sure he was comfortable and were always very compassionate towards him. She had talked with him about the type of funeral service he wanted. He had made it clear to her by his hand gestures and eye movement that he would like a Methodist service which she arranged.

75. In the 24 hours prior to his death, she spent a considerable period of time with him. On the morning of his death she arrived at Norwich at approximately 7.45am and remained with him until he died at lunchtime. Nurse B confirmed that the chaplain spent significant periods of time with him in the final few days before his death and appeared to have made him her priority. She was full of praise for her.

    The Governor of Norwich should commend the chaplain for the considerable time and companionship she gave to the man during his time in hospital and the final stages of his illness.

Staff debrief

76. Following the death of the man, the duty governor, on 2 November, carried out a hot de-brief for staff. He told my investigator that staff were agitated and upset that, despite several telephone calls, the doctor had not seen him until nearly 45 minutes after the first telephone call had been made.

77. He also explained to her that, although the prison's care team had seen members of Prison Service staff, the healthcare professionals felt unsupported by their management. The clinical reviewer asked the Head of Healthcare to comment on the current procedures and/or policies for debriefs and support of staff following a death in custody. At the time of writing this report no response had been received.

78. Given the number of older prisoners at Norwich, often serving very long sentences and the consequential incidence of deaths in custody, it may be appropriate for properly trained nursing staff to certify deaths. This might help to prevent delays in pronouncing deaths if a doctor is not immediately available. Again, I endorse and recast a recommendation by the clinical reviewer.

    The Head of Healthcare should consider whether medical staff can give written permission for registered nurses to certify deaths when the death is expected. Relevant training should then be given to the nursing staff and appropriate support put in place for staff undertaking this role.

CONCLUSION

79. The man was an elderly man who had multiple health conditions when he transferred to Norwich prison. I have found that his terminal condition was diagnosed in a timely manner and, following a week in outside hospital, he returned to Norwich for his final days, as he wished.

80. The prison worked closely with the community palliative care team to ensure that his last days were as comfortable as possible. However, the lack of staff with the training and experience to administer syringe drivers concerns me, especially considering the population of the unit for older prisoners.

81. I would like to take this opportunity to highlight the high level of care and treatment given to him. The chaplain told my investigators that Nurse B had, in her opinion, given him an excellent level of care. The nurse told my investigators that she had been impressed with the amount of time the chaplain spent with him, particularly in the few days before he died.

RECOMMENDATIONS

1. The Head of Healthcare should remind staff to ensure that the patient's mental capacity is considered in relation to discussions about resuscitation and that this is explicitly recorded in the clinical record.

   This recommendation was accepted. The response was,

   "This is done as part of the patients care plan and care plan review; it is also picked up in the joint working with PBL on the GSF.
   Modern Matron to review this practice and ensure compliance- Suggest Audit."

2. The Head of Healthcare should ensure that sufficient numbers of registered nurses are trained to administer medication via a syringe driver and can provide this care when it is needed by terminally ill and dying patients.

   This recommendation was partially accepted. The response was,

   "Agreement with District Nurses under City2 to provide immediate access to syringe drivers when requested from Doctor."

3. The Head of Healthcare should arrange for staff to be trained in the opening of the Liverpool Care Pathway, to ensure that it can be opened when it is required.

   This recommendation was accepted. The response was,

   "To be included in the L wing competencies framework and ensure all staff are competent and trained for this."

4. The Head of Healthcare should consider whether medical staff can give written permission for registered nurses to certify deaths when the death is expected. Relevant training should then be given to the nursing staff and appropriate support put in place for staff undertaking this role.

   This recommendation was partially accepted. The response was,

   "Nurses cannot certify death and in this environment only Doctors or paramedics can do this. We have a Doctor on site 6 days a week and access to Medicom outside these hours."

COMMENDATION

The Governor of Norwich should commend the chaplain for the considerable time and companionship she gave to the man during his time in hospital and the final stages of his illness.