Investigation into the circumstances surrounding the death of a man in hospital, whilst in the custody of HMP & YOI Norwich in December 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is the report of an investigation into the death of a prisoner at HMP & YOI Norwich. He died on Christmas Day 2008 in hospital. The man had been had been diagnosed with prostate cancer with secondary bone cancer, and transferred from the prison's healthcare centre to the hospital on 21 December.

The HM Coroner for Norwich was informed of my investigation. A post mortem was not undertaken but the man's death was noted to be from natural causes.

I extend my sincere condolences to the man's mother, partner, family and friends.

The investigation was undertaken by one of my investigators. A review of the man's healthcare whilst in custody was commissioned from the local Primary Care Trust (PCT). I am grateful for the clinical review. I would also 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 as the prison's Liaison Officer.

I make three recommendations, and one housekeeping point, for the attention of the Governor. These relate to the care of terminally ill prisoners, and their families, and to hospital appointments. There are two further recommendations for the attention of the Head of Healthcare in respect of drug stocks and transfers to hospital.

This final report notes that all the recommendations have been accepted. The man's family raised some factual inaccuracies that have been amended in the report. These related to his family history and information regarding his admission to hospital on 21 December.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

The man was sentenced to an indeterminate sentence of Imprisonment for Public Protection (IPP) in June 2006, following conviction for a number of sexual offences. He arrived at HMP & YOI Norwich and settled well into the regime on the vulnerable prisoners unit.

In December 2007, the man was seen in the prison's healthcare centre as he was complaining of pain when urinating. A sample of his urine was sent for analysis, following which he was referred to an urologist at a local hospital. In late December, he reported pain in his lower back and groin.

On 4 January 2008, the man was urgently admitted to the local hospital due to an irregular and hard prostate. Three days later, he was discharged back to Norwich with a diagnosis of prostate cancer. He was given medication to control his pain and other symptoms, whilst further treatment was being considered at the hospital. In April, a computerised tomography (CT) scan indicated that the cancer had spread to his bones and his prognosis was poor. (A CT scan takes images of the whole body.) It was noted that the man felt isolated by his illness and he intimated that he would like contact with the Macmillan nurses. (Macmillan nurses specialise in the care of terminal illnesses.)

The man applied to the Parole Board for early release after he was diagnosed, but his application for release was refused. By mid May 2008, his mobility was becoming problematic and he suffered ongoing pain in his hips and back. It was decided that he should transfer permanently to the healthcare centre for nursing care. The local community palliative care services made regular visits to offer emotional support to him, and advised healthcare staff on pain control and nursing care.

In June, the man's pain relief medication was raised to include an opiate medication. The following month he had an assessment for a possible deep vein thrombosis, which later was found to be negative. A course of chemotherapy (intravenous medication for the treatment of cancer) was discussed with him and it was agreed to start the treatment in August.

By the end of November, the chemotherapy had been discontinued as the man's condition had deteriorated and further treatment would not have been appropriate. A consultant in palliative care services saw him on several occasions in the healthcare centre to ensure his pain control was effective and that he was comfortable.

On 20 December, the man's condition deteriorated further and the following morning he was admitted to hospital with a chest infection. He died on 25 December with his mother and partner at his bedside.

The investigation found that the man was well cared for by healthcare staff and the involvement of local palliative care services was good practice. However, I have some concerns about aspects of his treatment and that of his

family and have made five recommendations and raised one housekeeping point.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened on 2 January 2009 when my investigator visited Norwich and reviewed his prison files. Copies of documents were requested and later sent to my investigator. Notices of the investigation, inviting staff and prisoners to contact the investigator if they wished to raise any issues, and the Ombudsman's terms of reference, had been sent in advance of her visit.

2. No members of the Independent Monitoring Board (IMB) or the local branch of the Prison Officers' Association (POA) asked to see my investigator. Norwich has much experience of death in custody investigations and staff and the IMB are familiar with my procedures. No prisoners or members of staff came forward as a result of the Ombudsman's notices.

3. A review of the man's medical care at Norwich was commissioned from the the local Primary Care Trust (PCT).

4. One of my family liaison officers wrote to the man's mother informing her of my investigation. The man's mother and partner asked for a visit from the family liaison officer and my investigator to talk about their concerns about the man's care, the visit took place on 20 February 2009. I address the issues they have raised in relation to the man's release from prison, visiting arrangements, and hospital admissions and appointments, in the Issues section of this report.

5. No formal interviews were undertaken for this investigation. However, enquiries were made with the Ministry of Justice's Compassionate Release section in response to family questions.

6. Another of my investigators visited HMP & YOI Norwich in March, she made further enquiries with a Principal Officer (PO) to clarify some of the issues raised by the man's family.

HMP & YOI NORWICH

7. 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.

8. 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. The unit is designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.

9. The HM Chief Inspector of Prisons last inspected Norwich in November 2006. An extract from that inspection noted:

   "Health services had improved under management by the 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."

10. The Independent Monitoring Board noted in their Annual Report for 2007:

    "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. However, there is a need for an up to date survey of the health needs of the prison population. There have been some problems with the out-of hours service. This seems to depend on the experience of the individual doctor. There is still an unresolved difficulty with the qualification of the Medical Officer. The staff office is in a poor state of decoration, with a worn carpet, broken furniture and filing cabinets that do not lock. Six of the secure cells have been refurbished and look a lot better. However, the concrete block (with a mattress on top) which is part of the bed, has been built so that there is a gap between it and the wall, where prisoners can hide and not be observed."

11. There have been 17 deaths due to natural causes at Norwich since my office took responsibility for investigating all deaths in prison custody in 2004. (The fact that the Nelson Unit holds elderly prisoners explains the relatively high number of deaths.)

KEY FINDINGS

12. In April 2006, the man was convicted at the Magistrates Court following conviction for sexual offences. It was not his first conviction for this type of offence. He was sentenced at the Crown Court in June 2006 to an indeterminate sentence for public protection (IPP), and a Sexual Offenders Prevention Order was imposed for five years. (Under an IPP sentence, the offender is not released until the Parole Board is satisfied that their risk has been reduced to such a point that they can be safely managed in the community.)

13. The man was received into Norwich following his first court appearance. During his reception health screen, he did not raise any health problems other than that he was overweight. He had not seen his doctor recently, did not have any outstanding hospital appointments, and was not taking any medication.

14. In September 2006, the man was seen by a psychologist. They discussed treatment programmes to address his offending behaviour and issues around his sentence. He was located in the vulnerable prisoners unit and settled into the prison regime. From his reception until December 2007, nothing significant was recorded in his medical notes.

15. The man was seen by a nurse in the healthcare centre on 4 December 2007. He had previously reported to the doctor that he was having pain when passing urine. A sample of his urine was sent for analysis, and a letter of referral was sent to the local hospital for an appointment with an urologist (a specialist in kidney and urine illness). Three weeks later, a full blood test was taken and sent for analysis. A request was made to test his PSA levels by taking a blood sample. (PSA is a protein released into the bloodstream by the prostate. Diseases such as prostate cancer may be detected as the levels of PSA increase.)

16. On 4 January 2008, the man was examined by the prison's medical officer. The doctor noted that he had an enlarged prostate, and he was admitted to the hospital as an urgent referral to see the urologist. On 7 January, he was discharged back to Norwich with medication, having been diagnosed with prostate cancer. A further appointment was made for a bone scan. According to medical notes written three days later, the man felt better and was pain free as a result of his medication. On 4 February, it was recorded that he did not attend the healthcare centre for a blood test, as there were no officers available on the wing to escort him to the unit. A member of the healthcare centre completed an NHS incident form for the information of the clinical manager.

17. The man returned to hospital on 3 March for his bone scan appointment. Three days later, he was seen by the doctor who noted he was experiencing pain in his lower back, and who prescribed pain relief medication of co-codamol. Later that day, he asked to see a

nurse again. He told the nurse that he felt he was not receiving treatment equitable to that in the community. An outpatient appointment for a further bone scan had been cancelled when he was inadvertently shown the date of the appointment whilst at the hospital. The next appointment was thought to be six weeks after the original appointment. The man also told the nurse that the hospital had sent him appointment letters. (For security reasons prisoners are not allowed information about the times and dates of outside hospital appointments.) The nurse spoke to the correspondence unit at the prison to alert them, and arranged for appointment letters to go to the healthcare centre and not directly to him.

18. The man also spoke to the nurse about his illness and asked to see the Macmillan nurses, as he was feeling isolated. The nurse re-assured him that if he wished to see a Macmillan nurse that could be arranged. He declined her offer.

19. On 3 April 2008, the man's medical notes record that his solicitor had asked for a medical letter outlining his illness for an application for compassionate discharge. (A compassionate discharge is a release from prison due to exceptional circumstances, which frees the prisoner from their sentence.)

20. The following day, the doctor noted that the man's bone scan indicated further cancer in his bones. Documentation from the hospital indicated that his prognosis was poor and his condition was severe. It was decided to treat him conservatively, which meant that he was pain free and his symptoms were treated with medication. Six days later, the doctor noted that the man should be issued with a soft seat as the cancer in his bones would cause him pain if he sat on a hard surface. He was given a more comfortable chair later that day.

21. The man made an application to the Governor on 11 April to receive visits from his family in the family room where the seating was more suitable and comfortable for him. (There is no indication from his prison notes that this happened and his family also said no visits took place in the family room, other than one visit in the Chapel.) On 2 May, a nurse was called to see the man on the wing in his cell. He was having difficultly with his mobility and was suffering pain, but he wished to stay on the wing with his friends. The nurse told him that she would speak to the doctor about increasing the pain relief medication.

22. Later, the man was examined by the doctor who noted his poor mobility. The doctor prescribed stronger pain relief. Following a consultation between the doctor, nurse and the Head of Healthcare, it was agreed to re-locate the man to the in patient healthcare centre where he could be nursed and cared for in a more appropriate environment. He settled into the unit and was given a morphine based medication.

23. On 6 May, a nurse specialising in palliative care visited the man and made recommendations for his nursing care including pain relief and support. The nurse also made contact with a Consultant in Palliative Care. On 18 May, it was noted that the man was still experiencing pain, despite trying to manage without additional pain relief. He was advised to seek help from nursing staff to inform them of the extent of his pain.

24. The man was visited by the palliative care nurse again on 20 May. The nurse examined him and noted his present medication and pain threshold. She also recorded that he had been concentrating on his application for a compassionate discharge.

25. The palliative care nurse again visited the man a month later. She noted that he was still managing with his current medication for pain relief. He spoke to the nurse about his compassionate release being refused, which had upset him. The nurse also suggested that some Velcro footwear should be issued as his feet were swollen and normal footwear was in appropriate. There is no record in his medical notes to say whether he received the footwear. (The man's partner told my colleagues that he was not given Velcro slippers.)

26. On 29 June, the out of hours doctor service, Medicom, was contacted by healthcare staff as the man was complaining of pain which was not relieved by his current medication. A Medicom doctor visited him and prescribed Oramorph (morphine). The medication was added to his daily medication by the Consultant in Palliative Care on 2 July. On 14 July, the man attended hospital for a scan to check for a thrombosis in his leg. It showed no sign of any further problems.

27. The palliative care nurse visited the man on 17 July and recorded that he had pain when passing urine, swelling in his legs, and constipation. He was receiving Oramorph when the pain became uncomfortable. The nurse requested a CT scan of his abdomen and pelvis, medication to relieve his constipation, and said that he should continue with the Oramorph as required.

28. The man attended an outpatient appointment at the local hospital on 29 July. On returning to the prison, he told a nurse that his cancer was progressing faster than expected and the hospital was considering chemotherapy. He also told the nurse that his solicitor would be making another application for compassionate discharge, and the hospital consultant would be sending a letter to his solicitor outlining his present medical condition. Two days later, he discussed his latest test results and future treatment with a palliative care nurse.

29. On 7 August, the man asked for Oramorph as he was in pain, but he did not see the doctor until two days later. The doctor noted that he was now in constant pain and adjusted his medication to regular Oramorph with additional pain relief. On 11 August, he was told by

healthcare staff that his CT scan did not show any significant progression of his cancer.

30. The man went back to the hospital on 14 August for a Doppler Assessment (a Doppler Assessment is a medical procedure to check blood flow to the feet). His legs were still swollen and again the risk of thrombosis was checked. There is no result of that assessment, although information held in his notes indicates that no thrombosis was detected.

31. A CT scan appointment was booked for 18 August at 2.00pm. Unfortunately, the escort officers and the man did not reach the hospital until 2.20pm, when the CT scan nurse refused to see him. The escort officers told the nurse that they were unaware of the time of the scan and had been instructed to leave the prison at 2.00pm. Healthcare staff submitted two NHS incident forms to the clinical manager reporting the missed appointment and the man was taken for the scan the following day. On 20 August, he was seen by an oncologist at the local hospital.

32. The next day, the man was visited by a palliative care nurse. He told the nurse that the oncologist had suggested to him that he only had about a year to live. The nurse noted that he was upset and tearful. He was to be given chemotherapy treatment at the local hospital, and was visited by the Consultant in Palliative Care. A week later, it was noted that the man had a painful lump on his jaw. A dental x-ray ruled out any tooth abscesses. He received his first treatment of chemotherapy on 5 September.

33. Two days later, the man experienced difficultly passing urine, and when he did there was blood present. He was also retaining urine and so a catheter was fitted. (A tube is inserted into the bladder so that urine can be collected directly from the bladder to a bag sited externally.) The palliative care nurse visited him on 10 September. The nurse noted that he had tolerated his first treatment of chemotherapy with few side effects. The catheter was still in place, and working well. He was more comfortable and the swelling in his legs had improved. The nurse noted the lump to the man’s jaw and asked healthcare staff to monitor it and note any further swelling and numbness.

34. The man had his second chemotherapy treatment on 26 September. He returned to the prison and was said to be comfortable. Four days later, the catheter was removed on advice of the oncologist. He went to the hospital for chemotherapy on 17 October and 7 November. He complained of severe pain in his lower back on 17 November, and the doctor advised him to take Oramorph more frequently as he had previously been reluctant to tell healthcare staff when he was in pain. Two days later, it was noted that he was having Oramorph regularly.

35. On 28 November, the man went to the local hospital for more chemotherapy and a CT scan. Following his treatment he saw the oncologist who told him that the chemotherapy would now stop, as it would no longer help him. He was said to be tearful when he got back to the prison.

36. Five days later, the doctor noted that the man was experiencing severe low back pain and his dosage of Oramorph was increased. On 5 December, the Consultant in Palliative Care visited the man and discussed his prognosis. A Do Not Resuscitate form was completed. (This form indicates that should the patient go into heart failure then resuscitation would not be commenced.)

37. It was noted in a letter held in the man's medical notes that he was not involved in this discussion at this stage, due to his distress. However, he told the Consultant in Palliative Care that he did not wish to have any further treatment, and towards the end of his life he fully understood what this form indicated (and at one point appeared to have emphasised it with staff). The consultant wrote in her letter that she would discuss this with the man at her next visit.

38. The palliative nurse visited the man on 17 December. She noted his mood was low, and that he had found a family visit the previous day to have been distressing. His medication was discussed, but he wished it to remain at present level until after Christmas.

39. Three days later on 20 December, the doctor noted that the man was becoming less mobile and had lost his appetite. Further medication was prescribed to help him feel more comfortable, as well as oxygen to aid his breathing. Later that day, the man's condition deteriorated and the on call nurse manager was asked to open the pharmacy to obtain Frusemide, which was prescribed for him. (Frusemide is used to reduce swelling and fluid retention.) The doctor was recalled from another part of the prison to administer the medication intravenously. He was also given oxygen to aid his breathing. At 5.30pm, the man was still very unwell and healthcare staff made contact with Medicom. Further Frusemide was required but there were no more stocks at the prison. The Medicom doctor administered the Frusemide, which he had in his possession, and diagnosed a chest infection. Antibiotic medication was also prescribed. The healthcare staff were concerned that oxygen supplies were low and notified the duty manager.

40. Medicom were contacted again at 12.30am on 21 December as the man had not improved and was now receiving continuous oxygen. The doctor made contact with the local hospital and arranged to admit him to hospital. No ambulance was available. Ambulances requested as non-emergency have a four hour slot to reach a patient. At the time the ambulance was deemed to be non-urgent. The prison's Orderly Officer was asked about transferring the man by taxi. However, the contracted taxi service did not have disabled access. As a result, he was not

transferred to the hospital until 5.20am when an ambulance did become available.

41. The man was escorted by two officers, and restrained by means of an escort chain. (An escort chain is over a metre in length with one cuff attached to the prisoner and the other to an officer.) He was admitted to the hospital and allocated a private room on a ward. Unfortunately, he was unable to receive a visit from his family as there was a virus on the ward and visiting hours were temporarily suspended. Prison staff made telephone calls to keep his family informed and give updates on his condition.

42. During the morning of 25 December, the man's condition deteriorated rapidly. The Governor gave permission for the restraints to be removed and a Release on Temporary Licence was completed. (A Release on Temporary Licence can be granted by the Governor and allows the prisoner to be released from custody with certain restrictions.) The prison arranged for his mother and partner to be collected by taxi from their homes and taken to the hospital. The prison chaplain went to the hospital and stayed with the man's relatives at his bedside until he died at 5.00pm.

43. The man's family told the investigation that they appreciated the support from the chaplain and the sensitivity of the escort officers who gave them privacy to be with the man during the last few hours of his life. The prison's family liaison officer assisted the man's family following his death by offering support and practical assistance, which they also greatly appreciated. Funeral expenses were offered to the family and a memorial service was held in the prison's chapel.

ISSUES

The man's location at Norwich

44. The man's mother and partner asked why the man had not moved on from HMP & YOI Norwich following his conviction to enable him to start offending behaviour programmes. On 13 September 2006, an entry in his personal history record noted that he was seen by a psychologist, who recorded that the man had asked to see him to discuss his IPP sentence and offending behaviour. The psychologist explained the issues around an IPP sentence and talked about Sexual Offending Treatment Programmes (interactive learning sessions addressing sexual offending behaviour).

45. The man had been sentenced to IPP and his release could only be granted by the Parole Board. He was a vulnerable prisoner and Norwich has a unit for prisoners who feel at risk within the custodial system. Whilst it is unusual for a prisoner to remain in a local prison for such a period of time, I understand that he was happy at Norwich even though courses for addressing his sexual offending behaviour were not available. He would have had to transfer to another prison when he felt ready to start treatment courses.

46. In February and April 2007, it was noted that the man was preparing for a Parole Board hearing and engaging well in this process with the psychology department. From his diagnosis in early 2008, it would not have been appropriate for him to have commenced any programmes.

Parole Board hearing in November 2007

47. The man's partner was asked by his solicitor to attend a Parole Board hearing in November 2007 at Norwich. On arrival at the prison, and following a long journey, I understand she was denied access to the prison. The man's partner produced photographic identification to the gatekeeper but, following enquiries, she was told that she could not be allowed into the prison as she had not been cleared by the security staff.

48. The man's partner told my family liaison officer that she had to wait outside the prison for 30 minutes in heavy rain whilst the gate keeper made enquiries. (It should be noted that the man's partner is disabled.) Eventually, she walked to a nearby public house and waited for his solicitor to come and tell her what had happened.

49. Parole Board hearings are often held within secure areas of the prison. The man's partner had not been to the prison before and so no security checks had been processed. It is not known whether his solicitor informed the prison of his partner's attendance for the hearing. It might have helped if the solicitor had arranged to meet her outside the prison and checked her security level prior to the day of the hearing.

50. Whether the prison was aware of the man's partner attending the parole hearing or not, the fact that she was kept waiting in heavy rain outside the prison is clearly a matter of regret. His partner uses a walking stick as she suffers from severe arthritis and standing in rain for 30 minutes was particularly uncomfortable. As she had not been to the prison before, she did not know about the prison's visitor centre. I am disappointed that a member of the gate staff did not direct her to the centre to wait in a more suitable environment whilst the enquiries were being made.

51. I would ask the Governor to remind gate staff of the facilities for visitors to the prison and to ensure that all visitors are dealt with in a sensitive and dignified manner.

The man's admission to hospital in January 2008

52. The man was transferred to hospital on 4 January 2008, and remained as an inpatient for three days over the weekend. It was during his stay in hospital that he was told that he had prostate cancer. His partner told the investigation that he always telephoned her on Fridays and Sundays. She became concerned when she did not hear from him, and was anxious until he telephoned her when he returned to the prison on 7 January. Prior to his transfer to hospital, he had asked prison staff to call his family to tell him that he was going into hospital to save them any anxiety.

53. A Principal Officer (PO) told my second investigator that prisoners' families can be told when a prisoner is admitted to hospital but that it depends on two things. First, the prison must think that it is a sufficiently serious situation to consider notifying the family. Second, if this is the case, they will then make a security risk assessment. If the medical situation is serious and there are no security matters preventing them doing so, the prison will notify the prisoners' family.

54. The man's transfer to hospital and subsequent diagnosis of cancer was a distressing time for him. The fact that his family were unaware of his admission to hospital for a potential life threatening condition caused them, and the man, great anxiety when he became aware they had not been informed.

    The Governor should remind staff that, when a prisoner is admitted to hospital for a potentially serious condition, the next of kin should be informed unless there are significant risks to security.

Cancelled hospital appointments

55. The man had told his family of a cancelled hospital appointment which caused them some anxiety. On 18 August 2008, he was escorted to

hospital for a CT scan. However, on arrival, a member of the hospital staff refused to carry out the procedure as he and his escort arrived too late for the appointment. The man's mother and partner raised concerns that he had been late for two hospital appointments. He was seen at one appointment, but at the second, thought to be on 18 August, his family believed that he was not seen and the escort officers had gone to lunch instead of taking him to hospital.

56. Information held in the man's medical notes indicate that he was late in arriving for his scan appointment and an incident form was completed by healthcare staff for the attention of prison staff. Hospital escorts are an important part of ensuring prisoners receive treatment, and arrangements for escorting officers should be made in advance of the date of appointment. (I am pleased that he did have the scan the following day.)

The Governor should review arrangements to ensure that prisoners arrive punctually for hospital appointments.

Family Visits

57. Prior to the man's admission to the healthcare centre, he did not wish to receive visits from his family. Nevertheless, following his diagnosis of cancer and his deteriorating health, he asked for family visits. His family were concerned that visits took place in an area of the visits hall where young offenders also had visits. His family said it was distressing to see him so unwell in what they thought was an unsuitable environment. They spoke about the noise and presence of young children in the visits hall being particularly difficult when trying to have sensitive and meaningful visits when he was terminally ill. On one occasion, a visit had to be ended early because the man became too unwell and the temperature of the visits area was too cold.

58. The Principal Officer (PO) told my investigator that the prisoner's health determines where the visit can take place. Ordinarily, all vulnerable prisoners' visits take place in the young offenders visits hall and the PO acknowledged it could be noisy. If a prisoner is too unwell, a visit can be arranged in the healthcare centre. In some cases of serious illness, a prisoner can have a visit in their cell. I note the PO's response but am conscious that the man's family were not offered this latter option.

59. One visit was arranged by chaplaincy which the family appreciated. The man's family were only able to visit on weekdays due to the distance from their home to Norwich and the availability of public transport. No extra or special visits were arranged for them to have quality time with the man.

60. The man made an application on11 April 2008 for visits in the family room, which would offer him greater comfort. The application was agreed by a governor with the proviso that staff could be arranged to

facilitate this. There is no indication in his prison file that family room visits ever took place.

61. Whilst understanding the pressure on allocating staff to visits areas, and the limited space available, I would hope that all terminally ill prisoners could receive visits in a sensitive and comfortable environment.

The Governor should review visiting arrangements for terminally ill prisoners.

The man’s clothing

62. The man had told his partner that he would not be able to receive from her a coat for travelling to his outpatient appointments. His partner was particularly concerned that he did not have access to a warm coat whilst travelling to hospital during the colder months, when he was receiving chemotherapy. Body temperature control is essential when patients are undergoing this form of treatment.

63. My second investigator was told by the PO that extra clothing can only be brought in for prisoners in the first fortnight of their sentence. After that time, a prisoner can apply for clothing to be brought in. The PO knew the man and thought it likely that any such application, given his circumstances, would have been approved. (There is no record that he made such an application.) Alternatively, the prison could have provided a coat for him had he asked.

Applications for release from prison

64. The man’s notes indicated in June that he had been refused a compassionate discharge (which can only be granted by the Secretary of State). In this instance I believe he made an application to the Parole Board to be released from his indeterminate sentence. .

65. He also considered a further application in September, although it is unclear whether he proceeded with the application.

66. During the course of my investigation, enquiries were made with the Compassionate Release section of the Ministry of Justice. They revealed that the man did not apply for a Compassionate Release at any time and his request to be released from prison was directed at the Parole Board.

67. I understand the disappointment felt by the man and his family that he was refused release from custody. However, his offending dated back to 1982 and he had been convicted of 47 sexual offences, in addition to other offences. His last conviction resulted in an IPP sentence. I am unable to comment on a Parole Board decision, but taking into account his previous offending behaviour, public protection issues would clearly have been a major factor.

Transfer to hospital on 21 December

68. The man’s condition deteriorated on 20 December which resulted in emergency measures taking place, with the intervention of Medicom, and the duty manager being contacted to open the pharmacy. The clinical reviewer has raised concerns that there seemed to have been a shortage of drugs and oxygen that evening. The shortage of those drugs could have affected his condition should he have needed them. I endorse the clinical reviewer’s recommendation:

The pharmacy provider should ensure that supplies of drugs and other resources, such as oxygen, are adequate to meet the needs of patients.

69. Healthcare staff contacted Medicom at 12.30am on 21 December as they were concerned that the man was not responding to medication and needed constant oxygen to aid his breathing. The Medicom doctor made contact with the local hospital and arranged to admit him. A non-emergency ambulance was unavailable due to pressure of emergency calls that morning. Healthcare staff asked the Night Orderly Officer (NOO) about the possibility of transferring him by taxi.

70. The NOO, after making enquiries with the contracted taxi firm for the prison, informed healthcare staff that the taxi firm did not have suitable transport to take the man, an escort and medical equipment. It was not until 5.20am that an ambulance arrived to take him to hospital.

71. Whilst I am not in a position to comment on the resources of the Ambulance Service and the time slot of four hours for a wait for a non-emergency ambulance, I am concerned that it took so long for an ambulance to take the man to hospital. However, he was constantly monitored by nursing staff whilst he waited for the ambulance, and I note the care offered by healthcare staff in what was a difficult few hours. I endorse the recommendation made by the clinical reviewer:

    Staff should be given guidance on the assessment of patients requiring transfer to hospital to ensure that the mode of transport is appropriate.

    Following circulation of the draft report, the man's partner commented that the family were telephoned, by a an officer, to inform them that he had been admitted to hospital, although they were not told that they could telephone the ward directly. Had they been aware of this information it would have offered them a direct link to the man in hospital.

Use of restraints

72. The man was restrained by an escort chain from his admission into hospital on 21 December until late in the morning of 25 December, the day he died. The clinical reviewer makes the following judgement:

    > "The use of restraints under these circumstances appears to have been over cautious and at odds with the treating of the patient with compassion and ensuring the preservation of his dignity."

73. I appreciate that the man was conscious until the morning of 25 December, that daily management checks were completed by senior managers, and that there was no indication from hospital staff that the

use of restraints was inappropriate. Nevertheless, I agree with the clinical reviewer. When the man went from prison to hospital, his condition had already deteriorated, he was not mobile, and he was receiving opiate medication. Notwithstanding that public protection is the priority, and his offending history was rightly taken into account, I believe that the use of restraints was excessive.

74. I am satisfied that when his condition deteriorated on the morning of 25 December, restraints were removed from the man straightaway.

Clinical care

75. The clinical reviewer comments that the man seems to have received a high level of care from both prison healthcare staff and the local hospital. She notes that the palliative care team offered an excellent service and there was good communication between the prison and the team.

RECOMMENDATIONS

The Governor of HMP &YOI Norwich

1. The Governor should remind staff that, when a prisoner is admitted to hospital for a potentially serious condition, the next of kin should be informed unless there are significant risks to security.

   Accepted – "Bedwatch log to be amended. Alert staff that should a prisoner be admitted to hospital for a serious condition to consider family contact through Duty Governor."

2. The Governor should review arrangements to ensure that prisoners arrive punctually for hospital appointments.

   Accepted – "Managed through the Prison Health operations Forum meeting. Issues raised to make sure staff arrive earlier to allow for hospital escorts."

3. The Governor should review visiting arrangements for terminally ill prisoners.

   Accepted – This will be raised through the Prisoner Health operations Forum meeting."

The Head of Healthcare HMP & YOI Norwich

1. The pharmacy provider should ensure that supplies of drugs and other resources, such as oxygen, are adequate to meet the needs of patients.

   Accepted – "Review of emergency medication/Oxygen supplies has taken place, new systems in place for maintaining levels in the prison at all time."

2. Staff should be given guidance on the assessment of patients requiring transfer to hospital to ensure that the mode of transport is appropriate.

   Accepted – "All healthcare staff will be trained to be aware of the Ambulance priority requests and processes for upgrading priority should the condition of the patient change."

Housekeeping point

I would ask the Governor to remind gate staff of the facilities for visitors to the prison and to ensure that all visitors are dealt with in a sensitive and dignified manner.

Accepted – "New facilities in place outside the adult prison for visitors to wait."