Investigation into the circumstances surrounding the death of a man at HMP Norwich on 30 November 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2006

This is the report of an investigation into the death of a man at HMP Norwich on 30 November 2004. The man, who was 57, died from heart disease.

I offer sincere condolences to the man's family and friends in their sad loss.

The investigation was completed by one of my colleagues. I am grateful for the assistance that she received from the then Governor of Norwich, and his staff, including the establishment's Liaison Officer. My thanks are also due to Norwich Primary Care Trust who arranged for the clinical review. I regret the delay in the issuing of this report.

A key objective of all my investigations is to make sure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. In this case, the investigation team was able to meet with the man's family. I am most grateful to them for agreeing to this meeting at what must have been a very difficult and distressing time.

No-one should under-estimate the difficulties of caring in a custodial environment for a patient like the man who came into prison with a complex range of medical and psychological problems. This long report documents how HMP Norwich rose to those challenges. Perhaps inevitably, some things were not done as well as they could have been. However, I would like to draw particular attention to the views of the clinical reviewer recorded in the penultimate paragraph of p.27 of this report. These are that the man's health actually improved in certain respects while was in prison.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **September 2006**

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SUMMARY

1. The man was first remanded into custody at HMP Norwich in April 2002, charged with various offences alleged to have been committed over a period of approximately 20 years. On arrival at Norwich, his substantive health problems of diabetes, heart disease, significant visual problems, below-knee amputation and hand contractures were identified during the initial reception healthscreen by the nurse. The man required the use of a wheelchair. Medical information was obtained from his GP which confirmed that, in the year or so previously, he had been neglecting his own health needs. There was evidence that the man had missed out-patients appointments. In a letter dated 24 April 2002 addressed to the prison's Medical Officer, the man's GP recommended that the prison should keep a close eye on his mental health as he had previously shown symptoms of depression.

2. While in Norwich, the man was an in-patient in the healthcare centre on a number of occasions. Otherwise he remained on a residential wing, mostly E Wing or A1 landing which were specifically for vulnerable prisoners. Concern was expressed on more than one occasion by healthcare staff and others that the physical environment on the wing was difficult for him because of his mobility problems. Some consideration was given to transferring the man to another prison but he was put on medical hold on three separate occasions. This meant that he could not be transferred due to ongoing medical treatment.

3. It seems that the man's location in healthcare was able to help him meet both his physical and emotional needs, but that long term placement in healthcare was not appropriate. It was considered by healthcare staff that it would hinder his chances of transferring to another prison if he was seen as having health problems which prevented him from leaving healthcare. When the man's medical needs increased, he was appropriately transferred to the healthcare centre and was not treated as an in-patient for social reasons alone.

4. During his time in Norwich, the man was referred to specialist consultants at Norwich and Norfolk University Hospital in the areas of ophthalmology, genito-urinary medicine, rehabilitation medicine and diabetes. Before arriving at Norwich, the man had never previously seen a specialist for his diabetes. Initial tests at Norwich showed a good level of diabetic control and the man was followed up in specialist clinics, including seeing a diabetic specialist podiatrist. He had cataract surgery on 17 November 2003, and an operation for swollen testicles on 25 November 2003.

5. Records show that the man attended a number of planned out-patient appointments during the 2 ½ years he spent at Norwich. He missed one out-patients appointment when a taxi did not collect him on time. He also spent two nights in hospital between 19 April and 21 April 2002 following his reporting chest pain.

6. According to his medical record, the man initially suffered a number of hypoglycaemic attacks (low blood sugar) when he arrived at Norwich. He appears to have been treated successfully for these. He also suffered a number of episodes of chest pain, which also appear to have been managed well by healthcare staff with medication for angina and reassurances for stress-related symptoms. The man also suffered from chest infections which were successfully treated. He complained in his own handwritten notes of physical symptoms associated with vascular disease, which appear to be related to his existing physical complaints.

7. The man also experienced episodes of low mood during his time in Norwich. Staff appear to have identified these and provided appropriate support. He was the subject of suicide prevention procedures for short periods in May and August 2002 and February 2004. He also spoke to Listeners on several occasions. (Listeners are prisoners specially trained by the Samaritans to assist other prisoners.)

8. After the man's surgery for swollen testicles on 25 November 2004, he was initially located on E Wing. Shortly after, on 27 November, he was admitted as an in-patient to the healthcare centre as he was in some discomfort following the operation. He was monitored by healthcare staff and the wound was dressed and cleaned on 28 November. He was seen by a doctor on 29 November. At 8.10pm on 30 November, a Healthcare Officer was alerted by other prisoners that the man was in distress in the healthcare ward. Staff responded promptly. Cardiopulmonary resuscitation was undertaken but sadly was not successful. The man was pronounced dead at 8.45pm. The cause of death, following the post mortem has been given as hypertensive and ischaemic heart disease.

9. This report concludes that the man received a good standard of healthcare while in Norwich, but identifies some record keeping shortcomings. I make two recommendations.

CONDUCT OF THE INVESTIGATION

10. The investigation was completed by a senior investigator for the Prisons and Probation Ombudsman (PPO).

11. During the course of initial inquiries, the investigator was shown around HMP Norwich and visited the cell where the man died. She reviewed all the relevant documentation and established a chronology of events. Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity of contributing. There were no responses to these notices.

12. One of my Family Liaison Officers contacted the man's family and offered them the opportunity to meet with her and the investigator to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. They subsequently met with the man's family. The family raised a number of concerns, mainly about the management of the man's healthcare while at Norwich, particularly his location on a normal residential wing following an operation. The man had told his family that, when he was in hospital for the operation, the hospital had criticised action taken within the prison by a prison doctor. The man's wife indicated that he had kept records of occasions where his healthcare needs were not met in Norwich, that he kept a diary and recorded dates when he did not receive his medication, and that he had made a number of formal complaints of this nature. Our records show that none of these complaints was referred to the PPO, and all were answered locally. The man's wife showed my investigator copies of some of these complaints and a 2003 diary, but said that the 2004 diary was missing. She also said that her husband made verbal complaints about his healthcare during telephone contacts and visits with family members. He also complained to her about other prisoners helping him with his insulin as opposed to medical staff which led to him suffering a 'HIV scare' which his wife said was fully investigated. The family also compared assessments carried out by the man's GP, before and after he was admitted to prison, which they believe show a decline in his health.

13. More generally, the family felt that Norwich did not cater well for the man's basic health and social care needs as he was in a wheelchair and needed better facilities to accommodate him. The man's wife said that she had urged him to demand to see a doctor when he felt unwell, but that he told her he was afraid of repercussions if he did. She said she asked if he could see his own GP, but was told by the prison that was not possible.

14. Finally, the family was also upset that they were not informed of the man's death until lunchtime the day after and are concerned about this delay. They said that contact with the prison since his death had not always been helpful, and they had not received some of his personal possessions back at the time of our meeting. The concerns and questions raised by the family are examined further in this report.

15. The investigator wrote to the chair of the local branch of the Prison Officers' Association (POA), and to the chair of the Independent Monitoring Board (IMB), to tell them about the investigation process, and to invite them to meet with her should they wish to discuss any concerns or issues. They did not wish to arrange a meeting.

16. The investigator contacted Her Majesty's Coroner to tell him of the nature and scope of the investigation. The Coroner provided a copy of the post mortem report of 3 December 2004. The post mortem report recorded the cause of death as hypertensive and ischaemic heart disease (narrowing or obstruction of the arteries causing insufficient blood supply to the heart). There were no signs of any injuries.

17. Norwich Primary Care Trust (PCT), arranged for a clinical review of the healthcare provided to the man while at Norwich.

BACKGROUND INFORMATION

The man

18. The man was born in 1947, and was 57 years old when he died. He had first been remanded into custody at Norwich in April 2002 charged with a number of offences alleged to have occurred over a period of 20 years. He was found guilty in July 2002 and sentenced to seven years imprisonment.

19. The man had regular contact with his family (wife and children) while he was in Norwich prison. He was committed to an appeal against conviction and sentence which he felt was unduly harsh. He was waiting a further appeal hearing decision when he died, having had earlier appeals dismissed.

HMP Norwich

20. Norwich is a multi-functional adult prison and young offender institution (YOI) on two separate but adjacent sites. E wing and A1 landing are vulnerable prisoner units. Healthcare provides accommodation for 28 prisoners with physical and mental health needs.

21. Norwich had an operational capacity of 823 as of 1 March 2005. The prison accepts adult men and young offenders, Category B and Category C, whether convicted or on remand.

22. The last full inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) took place in July 2004, and concluded: 'Norwich is not so much a prison as a collection of prisons. Mostly it is a local category B prison, holding adult men on remand or serving short sentences. It also has a Category C training wing, for longer sentences, a separate unit for young adults (18-21), an open Category D house for resettling low-risk prisoners and one of the country's only two dedicated units for older life-sentenced prisoners. At the time of the inspection, apart from the small specialised resettlement and older prisoners' units, Norwich was performing none of these tasks effectively. There were unacceptable deficits in safety and key recommendations from seven recent deaths in custody had not been implemented. Parts of the prison, notably in the healthcare centre and on A Wing, were simply unfit for habitation. Custody planning for short-term prisoners was non-existent and training for longer-term prisoners inadequate.'

THE MAN'S TIME AT NORWICH

23. In April 2002, the man had suffered a minor angina attack at the Magistrates' Court, but recovered by the time paramedics arrived. On remand into custody at HMP Norwich, a first reception healthscreen was undertaken by a Nurse.

24. The healthscreen noted that the man had suffered a minor angina attack, that he was blind in his right eye, had a family history of diabetes and heart disease, and had been prescribed medication for depression. There were letters from his GP to his solicitors dated 26 April 2001, 23 July 2001, 21 December 2001 and 15 January 2002. The letter dated 26 April 2001 confirmed that the man was an insulin dependent diabetic, had diabetic retinopathy (blindness), ischaemic heart disease (narrowing or obstruction of the arteries causing insufficient blood supply to the heart) and congestive (chronic) cardiac failure. He had suffered heart attacks in 1993 and 1994 and a back injury in 1995. He had a right below knee amputation, which had left a displaced stump so he could not wear a prosthesis and was therefore dependent on a wheelchair. The letter dated 23 July 2001 confirmed that the doctor had not seen the man since 1 February 2001 and he had failed to attend a follow-up appointment on 10 May. Regarding the man's general health, the doctor concluded that it was difficult to be precise. He noted, 'He has diabetes and has demonstrated several of the complications of the condition. I am quite unable to advise whether the man's health is going to depreciate in the near future nor am I really able to give you any idea of his life expectancy. In broad terms, he is very unlikely to reach the national average age of death.' The letter dated 21 December 2001 confirmed that since 26 July the man had attended the surgery four times complaining of chest pain, probably stress-induced angina. On one occasion, he had called an ambulance to go to hospital because of the severe pain. He had a problem with the prosthesis and deteriorating vision because of the diabetes. The doctor said, 'His general health is deteriorating quite rapidly and I feel the stress of a court appearance may well induce further episodes of chest pain. He is under several consultants but is rather erratic with attending appointments, that is a consultant ophthalmologist regarding diabetic retinopathy, a consultant physician regarding diabetes and a consultant surgeon regarding his amputation.' Finally, the letter dated 15 January 2002 concluded that the man was fit to attend court, but needed access to toilet facilities every hour and rest breaks every two hours.

25. During his initial reception healthscreen, the man said that he was not suicidal and did not have any thoughts of deliberate self harm. He was admitted to the healthcare centre for observation, assessment and treatment. There it was noted that the man's diabetes had not been regularly monitored, and so was to be monitored from 12 April. It was also noted that he had been prescribed antibiotics by his GP for a leg infection but had not taken them on a regular basis. He was to have a complete and thorough assessment and an adjustment of his medication regime.

26. A cell sharing risk assessment was completed and he was considered as a medium risk prisoner (that is, the risk to other prisoners would be assessed if they were to be located in a shared cell with him).

27. On 12 April, the man had a thorough medical assessment by a doctor. He was noted to be tearful, but he spoke to his relatives on the telephone and was seen by a prison Listener.

28. On 15 April, the prison received a telephone call from the man's solicitors expressing his daughter's concerns that he was complaining of chest pains but that nobody had seen him. He had not complained to any member of the healthcare staff about the chest pains. He was seen and examined by a member of the healthcare team and said the pain had happened on 13 April but had soon passed. There is a note in his medical record that he was to be reviewed by a medical officer. He was subsequently seen on 18 April.

29. On 19 April, the man suffered severe chest pain and was admitted to Hospital. He was discharged on 21 April. On 23 April, he was referred to a consultant in Rehabilitation at the hospital, concerning his prosthesis. He attended an appointment at the hospital on 29 April. The man was unable to use his artificial leg as he could not extend his knee properly. The man had been through a physiotherapy programme after the amputation and the consultant reminded him of the exercises he needed to do to improve the flexibility of his knee. A follow up appointment was to be arranged for six weeks time to see if there had been any improvement.

30. On 24 April, the man's GP sent a patient summary printout for him to the prison doctor with an accompanying letter. The letter confirmed that the man suffered from ongoing health problems: ischaemic heart disease, diabetes, severe peripheral vascular disease (narrowing of blood vessels), Dupuytren's contracture (fingers fixed in a bent position) and congestive (chronic) cardiac failure.

31. On 1 May, the man was tearful and said he might end it all. An F2052SH was opened by a probation officer at the prison. (An F2052SH is a suicide/self harm at risk form.) The man was moved to the healthcare centre and located in a shared ward under close supervision and prescribed antidepressants. It is not possible to establish when the man returned to the main residential units due to an absence of completed records. The F2052SH was closed on 4 May after a case review undertaken by healthcare staff. The man was considered to be in a 'natural state of anxiety regarding his alleged charges.' He said that he would not harm himself as he had too much to lose: his wife, children and grandchildren. The support plan was for healthcare staff to continue to observe his mood and behaviour and give him the opportunity to discuss his feelings.

32. On 17 July, the man was sentenced to seven years imprisonment. He returned to Norwich and was located on an ordinary residential wing. Unfortunately, prison computer records only confirm his cell location from February 2004. From July 2003 to February 2004, the man's location has

been pieced together from paper records as far as possible. Because of the nature of his offence, when on ordinary location the man was placed in either A1 wing or E wing which are the wings for vulnerable prisoners.

33. On 18 July, there is a note in his medical record which states 'fit for ordinary location.' On 19 July, a plan was drawn up for his care on normal location. He was collected by healthcare staff for his insulin injection that morning and it was noted that, because he was partially sighted, testing and insulin injections needed to be carried out by staff. It was also noted that the man needed to try to use his crutches. He also felt the heat, and panicked if he felt he did not have enough air. This in turn caused chest pain for which he needed his anti-angina medication, GTN spray. Due to fact that he had low blood sugars at times, staff were to ensure that he had glucose or biscuits to hand. An assessment was to be carried out over the weekend to ascertain the best management plan with particular reference to his mobility and diabetic needs.

34. On 20 July, the man had hot water poured on him by an unidentified prisoner when spending a short time on E Wing. He refused to take his insulin and said he would not take it again. There is a note in his medical record that staff should keep a discreet but close eye on him. A nurse explained to him that if he did not take his insulin and went into a diabetic coma, he would go back to A1 landing not healthcare as he wanted. The nurse noted, 'The man was, in my opinion, trying to manipulate the situation saying he would behave himself if he got back to healthcare. At this I explained it was his choice to take or refuse the insulin, which he accepted.'

35. On 22 July, the then Head of Healthcare, expressed concerns about how the incident with hot water had been managed. He wrote a letter to the Governor, and said that the man had told him that he had obtained little help from wing staff who just directed him to the cold tap. The then Head of Healthcare indicated that he had previously given instructions to staff that any scalds should be doused for 15 minutes under cold water. The man told him that he was not sure if he wanted the police involved, and was asked by staff to sign some paper which he could not read. He also expressed his concerns about the man's treatment generally on A1/E Wing and said in his opinion that the man needed a prison with a minimum of type 2 healthcare. That is he required an establishment with 24-hour healthcare on site, and was not considered suitable to be moved to a prison where healthcare was only provided on a part time basis.

36. The then Head of Healthcare also documented that he discussed the issues with wing staff and the man was on medical hold, which meant he could not be transferred to another prison due to ongoing medical treatment. This is the first mention of the man being on medical hold and the then head of healthcare subsequently removed him. He concluded that the healthcare team would need to discuss the man's health needs with the healthcare team of the next establishment before any transfer could be considered.

37. On 24 July, the man was moved to a larger cell on A Wing and noted to be reasonably mobile. There is a note in his medical record that a landing officer and the Observation Classification and Allocation Unit (OCA) were dealing with a possible transfer for him. There is no mention of where he was to be transferred to. A doctor (signature illegible) said that a case conference did not appear appropriate but that any further problems would be discussed.

38. On 26 July, the chaplain wrote a letter to the Governor about the man's location and treatment on A Wing. She copied the letter to the then Head of Healthcare. She said, 'I am very disturbed and distressed at the conditions in which this man is having to live. He has one leg amputated and consequently he depends on a wheelchair. In the healthcare centre he had adequate room to manoeuvre and facilities for showering etc. In A Wing he is in a cell with no room to manoeuvre his wheelchair, to get to the lavatory or to get out of the cell, there is a step. Because of newspaper coverage about his case he ... has received abusive behaviour from others on Rule 45 and he has also been attacked with boiling water. He is unable to shower. It seems now to be the case that in light of the attack, he is locked up all the time.'

39. That same day, the man submitted a complaint because he had missed a clinic appointment for his leg because the taxi did not turn up. There is no record of the prison's response to this complaint. There is a written note on the application which states, 'healthcare staff please inform inmate of situation', and another entry states, 'For attention of landing staff.'

40. On 1 August, it was decided that the man needed to have his testicles drained of excess fluid and referral to hospital for surgical treatment. This was subsequently done.

41. On 5 August, the man swallowed a number of painkillers which had been prescribed for him and which he had stored up. He told staff that he had subsequently been sick. An F2052SH was re-opened by an Officer. The man was seen by healthcare staff and his observations were noted to be normal. He remained on normal location in a shared cell. On 6 August, he spoke to two different Listeners. He said he was content on normal location and had no intention of harming himself.

42. On 7 August, an F2052SH review was undertaken and a detailed support plan was implemented for the man. He said that he felt isolated and lonely and had nobody to talk to. He added that he could not accept that he was guilty and had lost his family. He wanted to be transferred to HMP Littlehey. The support plan was for the man to have regular contact with a prison visitor and to use a radio as a source of escapism. Wing staff and Listeners/Samaritans were to offer support, and the OCA was to look at transferring the man to Littlehey. A Senior Officer wrote a letter to the Deputy Governor. He said that the man's health had deteriorated since being released from healthcare and he asked whether the man could be re-admitted, not for health reasons but to talk to other prisoners. He noted that

the OCA was having trouble allocating him to another prison due to his disability and diabetes. The man also made a complaint about his location on A wing, saying it was not suitable for a disabled prisoner and that he was not allowed to have his GTN spray for angina in his possession. The complaint was referred to healthcare and the Governor for consideration. It has not been possible to establish if there was a written reply to the complaint.

43. On 8 August, the then Head of Healthcare wrote to the chaplain agreeing with her memo to the Governor (26 July). The then head of healthcare agreed with the chaplain's concerns about the facilities for disabled prisoners at Norwich, particularly those on Rule 45. The man spoke to a Listener that day. On 9 August, there is a note in the man's medical record that it was hoped he would be transferred to a more appropriate prison. He was also relocated to healthcare.

44. On 11 August, there was a plan to encourage the man's mobility and independence. He was still waiting for his new prosthesis and was therefore re-referred to the clinic for assessment. There is also a note that he was unable to see well enough to test his blood sugars or draw up his own insulin. A care-plan was drawn up for the man to use his crutches on a daily basis - gradually increasing the length of time - and to be referred for remedial physiotherapy. Staff were to perform blood sugar tests and set his insulin pen at the correct setting for him to self-administer. Staff were also to encourage him to care for his own hygiene needs, make his own bed, and to keep his environment clean without over-exerting himself.

45. The man attended the limb clinic on 12 August. There is a letter from the then head of healthcare to the Deputy Governor, 'Important that the man is moved to a more appropriate prison. Confining him to a Health Care centre may only compound the problem, making it difficult for him to be transferred to another prison. It may well be perceived that the man has health problems which prevent him from leaving Health Care. If you really do have difficulties in providing for the man in the adult wing then my comment would be is there any possibility that he could be admitted to the Segregation Unit. The Seg has modern facilities which are well suited to the man's particular disabilities. Alternatively the man could be accommodated within the ground floor of B and C Wing which also has modern facilities. I will leave it for you to discuss the various options with the man himself.' The Deputy Governor confirmed to my investigator that during August 2002 he discussed the man's case with another senior officer who worked for him at that time in Norwich. Unfortunately, neither man could recall this specific case. The Deputy Governor confirmed that any concerns raised by the Medical Officer would have been case managed by the Operational Residential Management team in order to ensure the most appropriate location to meet the individual's needs, security and the prison's overall duty of care. The Deputy Governor explained that E wing (where the man spent the majority of his time, apart from when he was located in the healthcare centre) was at that time a small unit caring for approximately 40 vulnerable prisoners in single, double and dormitory style accommodation.

He said that all prisoners in that unit were thoroughly risk assessed prior to location and he confirmed that the ground floor accommodation, where the man was located, did accommodate people with disabilities.

46. On 14 August, the F2052SH was closed following a review undertaken by members of healthcare staff. On 16 August, the man was seen by the Governor, regarding his application of 7 August. By this time, it appears the man had been relocated to healthcare, was waiting for a new artificial limb to be fitted and still hoped to transfer to Littlehey.

47. On 17 September, the man returned from an eye clinic appointment. He was distressed as he had been told he might go blind. On 19 September, the man returned to the limb clinic.

48. On 30 September, there is a note in the man's medical record that he was back to his cheerful self and helping around the healthcare ward. On 10 October, he again attended an appointment at the limb clinic.

49. On 4 December, the medical record notes he was to be referred to the diabetic clinic in the first week of January 2003.

50. The man attended the limb clinic on 12 December. A letter from the consultant, dated 23 December, says that attempts to fit a prosthesis for him had been unsuccessful. He did not require further surgery but it was noted that he was to continue using his wheelchair. The man was low in mood on 24 December because of Christmas. He was reassured by a nurse. He was again noted to be low in mood on 29 December. On 30 December, it was reported in his medical record that he had improved and was more relaxed and more social.

51. The man was referred to the Diabetic clinic on 3 January 2003. He attended his first appointment there on 15 April.

52. On 7 January, the man attended the eye clinic and was said to be low in mood following his appointment. He was reassured by a member of healthcare staff (signature illegible). On 16 January, it was noted in his medical record that he had not been referred to the Physiotherapy Department, as the doctor wanted him to go to the Diabetic clinic first and to deal with his problems one at a time.

53. On 24 January, the man had a visit from his daughter which had a positive effect on his mood. On 7 February, there was an incident between the man and another prisoner. It is not clearly documented in the man's records what this was about, but it appears that he was threatened by the other prisoner. On 8 February, he was seen by a nurse in his cell as he was upset about the incident. He believed his food was being tampered with and refused to eat it. He was reassured by the nurse and landing staff that they would ensure that his food had not been tampered with. The man refused to identify who had threatened him.

54. On 9 February, the man said he had diarrhoea early in the morning. Initially, he refused to take his insulin and oral medication as he said he had been warned by another prisoner against eating, drinking or cleaning his cell. He believed his diarrhoea was caused by someone doctoring his food or drink. He was again seen by the nurse and the landing staff and told them that cleaners had been told to ignore him. Staff explained to him that none of that was true and that he must eat and take his medication, which he eventually did.

55. On 10 February, the man asked members of staff to read a letter from his wife as he believed that the letter had not been written by her but by a member of prison staff. An officer and Healthcare Officer read the letter and compared it with other letters. They considered the letters all had the same handwriting and style, and in their opinion were written by the same person.

56. On 24 February, the man attended another appointment at the eye clinic. The man was referred to the Physiotherapy Department on 4 March.

57. On 14 April, the man was told by a member of healthcare that he was to return to E wing when there was a place available. He was upset at going back to A1 or E wing, as he said he was abused there before, but he reluctantly accepted the move. He completed a formal complaint form as he had been unhappy with the previous accommodation on A Wing. He felt that the cell was too small, and said he had not been allowed to go on exercise and had spent three weeks inside his cell. He said that E Wing was not too bad in comparison and had more space and he could at least get some exercise in his wheelchair. He was seen by a Senior Officer who explained that he had to move on and return to E Wing, but the lift on E Wing was out of order. The man later told a member of healthcare that he had been trained to manage stairs so the physical aspects of A1/E wing should not be a problem. He started eating and taking his insulin again. The man attended a Physiotherapy appointment. This is not recorded on his movement history, but a letter dated 14 April confirms that he was seen at hospital.

58. On 15 April, the man attended a Diabetic clinic appointment and was referred to the ophthalmologist and podiatrist. The consultant's letter following the appointment noted that the man had perfect control of his diabetes. On 17 April, the man's sister-in-law died. He was seen by the chaplain and told that he would not be sent back to E Wing at that time.

59. On 22 April, the man telephoned his wife. It was noted that he seemed cheerful after the call. On 23 April, he was referred to see if the doctor would again drain his testicles of excess fluid as had been done in August 2002. On 8 May, the GP at Norwich, wrote a letter to the surgical outpatients department at the hospital about the possibility of a surgical procedure being undertaken after excess fluid had recurred following treatment in August 2002.

60. On 21 May, there is a note that the man was on 'medical hold'. He should not be transferred to another prison until he attended his appointment at surgical outpatients for treatment - unless his transfer was to HMP Wayland, a prison which specifically holds vulnerable prisoners. As the man's health deteriorated, he was placed on medical hold again. The prison has confirmed that OCA had no paperwork or plans to move him. He had by this time been located in the healthcare centre since August 2002.

61. On 22 May, there is an e-mail from a residential governor for A and E wings, to a member of staff who works in the administrative section within probation for the ultimate attention of another member of staff, a Probation Officer. The residential governor had received a letter from the man's solicitors saying he wanted to stay in the healthcare centre. The solicitors threatened Judicial Review if the man was moved from healthcare. There was also a telephone call from the man's son who was concerned about his father's welfare as he believed his father was going blind. The man's son seemed happier about the situation when the prison spoke to him. He asked if his father could phone his daughter and that message was relayed to his father. On 25 May, the Duty Governor spoke to the man about the reasons for transferring him to ordinary location and said he was still waiting for a place for him on E wing. The reasons for transferring the man to ordinary location are not documented.

62. On 27 May, the man attended an appointment at the eye clinic. On 30 May, he attended an outpatient's appointment for assessment of his right eye cataract. Surgery was scheduled for 17 November to remove the cataract.

63. According to his movement history, the man attended hospital appointments on 10 July and 16 July. It is not clear from his medical record what these appointments were for.

64. On 22 July, the man was spoken to on E wing by a member of healthcare staff. There were concerns that he appeared to be low in mood as his wheelchair could not go through the cell door, but he declined offers of help. He did not have any sweetener which he needed as a diabetic and his sink had not been mended. He said he generally felt uncared for and was finding the prison environment difficult to handle. He felt vulnerable in the wheelchair and was concerned for the safety of his medication. He also said he felt as if he was begging when he asked others to get hot water for him. A care-plan was drawn up for him. He was to be encouraged to talk to staff, regarding any practical day to day problems. Healthcare staff were to ensure that his insulin was given to him at the appropriate time in the morning and that the evening dose was correctly drawn up for him to administer. An appointment was made for him to see a doctor.

65. The man made a formal complaint, received by the complaints clerk on 22 July, about his location on E wing. He complained that the room where he was located was too small for him and his cellmate and that he could not get out through the door unless he got out of his wheelchair. He complained that he had to rely on other prisoners to set his insulin to the

correct measure and to collect his food for him. (My investigator has found no evidence of this.) The man said he felt he was better looked after and more mobile when he was located in healthcare.

66. On 4 August, the man was seen by a doctor on E wing as he collapsed twice and was anxious and agitated. He was admitted to healthcare for assessment of his diabetic and other medical needs, including possible depression. He was to be monitored and if stable would be able to return to normal location that night or whenever appropriate. It is not clear from the man's records when he returned to normal location. It is noted that he attended a urology appointment on 6 August.

67. According to his movement history, the man attended a hospital appointment on 20 August. It is not clear from his medical record what the appointment was for. On 26 August, he attended an eye clinic appointment. According to his movement history, he attended another hospital appointment on 4 September. Again, it is not clear from his medical record what the appointment was for.

68. On 19 September, the man attended healthcare for drainage of a hydrocele which was carried out on 2 October. On 13 October, he asked for a urology appointment scheduled for 17 October to be cancelled as he said he wanted to concentrate on his appeal. This was done.

69. On 28 October, the man attended a follow-up appointment at the Diabetic clinic. The consultant wrote to the prison and commented that his diabetes control was excellent. However, he raised concerns expressed by the man that nobody in the prison was monitoring his blood sugar which he could not do for himself as his eyesight was poor. The prison responded on 14 November, explaining that the man in fact had assistance from a nurse to take his insulin.

70. On 30 October, the man attended an appointment at the foot clinic. On 12 November, he attended the eye clinic for a cataract assessment before the cataract surgery scheduled for 17 November. On 17 November, he underwent a right cataract extraction. After the surgery, he attended review appointments at the eye clinic on 25 November and 12 December.

71. On 1 December, there is a note in the man's medical record that his medication had disappeared. Healthcare were able to get some of his medication but not his blood pressure tablets. He was given what medication was available and the pharmacy dispensed the rest on 2 December.

72. On 4 January 2004, the man submitted a formal complaint listing dates when he had not received his medication. The Deputy Healthcare Manager, replied to the complaint on 28 January, having spoken to the man about it on 27 January. He said, 'I met with you on the 27th to discuss your complaint. I agree that it was unacceptable that nobody came to see you on several occasions. You told me recently that you have had no problems

and are happy with the treatment you are getting. If there is a re-occurrence in that you are not seen again please will you ask one of the wing officers to contact me.'

73. On 5 January, it was noted that the man was stressed and worried about his forthcoming appeal. He attended an appointment at the foot clinic on 6 January. On 12 January, the prison received a request from the Criminal Appeal Office for a report on the man's medical condition. A report was forwarded as requested on 28 January. On 14 January, the man was referred to the genito-urinary clinic as the fluid in his testicle was getting worse.

74. On 2 February, there is a note in the man's medical records that he wrote a letter, which was subsequently intercepted, in which he said he had not eaten or taken his insulin for two days. After discussion between wing staff and healthcare staff, it was concluded that he was possibly trying for a move to healthcare and had in fact been seen taking his insulin that morning.

75. On 12 February, the man's appeal against conviction was dismissed and his application to appeal against sentence turned down. The man refused to take his medication.

76. On 14 February, an F2052SH was opened by an officer as the man said he was going to refuse to eat and take his insulin. After explanation of the consequences of that course of action, he was noted to have said he did not want to harm himself and just felt depressed because his appeal had been denied and felt that nobody was listening to him. The F2052SH was closed on 16 February following a review. The man was eating again and advised to seek legal advice about his appeal. He said he had no thoughts of self harm. The support plan was for the man to use the Listener scheme and staff support. On 24 February, he attended the foot clinic.

77. On 7 April, the man submitted an application for access to healthcare for a minor operation on his testicles. He also complained that his right arm was numb. On 14 April, the prison received a letter from the urology department asking whether the man still needed to be on their waiting list. On 16 April, a prison doctor replied to the urology department asking about the possibility of the man now having an operation to assist with his problem of fluid on the testicles (the original appointment on 17 October 2003 having been cancelled so that the man could concentrate on his appeal).

78. The man attended an appointment at the diabetic foot clinic on 23 April. On 5 May, the complaints clerk received a formal complaint from the man that he was no longer receiving items as part of his diabetic diet. He said he had not had milk, flora, sweetener, or jam for three weeks. The complaints clerk responded on 7 May that he would find out what had happened to these supplies.

79. On 6 May, the man was confirmed as being on the waiting list for a urology appointment. On 11 May, the man complained about continued pain in his testicles. The next day, he saw the doctor who drained the excess fluid. On 16 May, the man made an application for access to healthcare for trouble he was experiencing with his hands. He was referred to the doctor on 19 May. On 27 May, he complained of chest pains and shortness of breath. He was admitted to healthcare for observation and treatment for a chest infection. It was noted in his medical record that he wanted to go back to E wing. He therefore returned to E wing the same day.

80. On 15 June, the man attended the Diabetic clinic for an annual review of his condition. The consultant was concerned that he was not monitoring his blood sugar levels and had poor diabetic control. According to his movement history, the man attended a hospital appointment on 18 June. Again, it is not clear from his medical record what this appointment was for.

81. On 22 June, the man spoke to his grandchildren. This was in breach of Prison Service Order (PSO) 4000 as he was not allowed to contact any child under the age of 18 due to the nature of his offences. (His telephone calls were being monitored for that reason.)

82. On 24 June, the man submitted an application for access to healthcare due to anxiety attacks. There is no record that he actually saw a member of healthcare.

83. On 5 July, the man submitted a formal complaint. He alleged that he was being victimised (presumably by staff) because of his disability. The issue was discussed with him on 6 July by a Senior Officer (SO). The conclusion was that the man was feeling down when he wrote his complaint and no discrimination was found on the grounds of disability. The man decided he did not want to pursue the complaint. On 7 July, the man asked whether his grandchildren could be allowed to contact him. This was not allowed due to PSO 4000.

84. On 21 July, a re-categorisation board was held to consider the man. It was decided that he should remain a Category C prisoner. He was put on medical hold again. It is noted that he had a superficial cut to his left wrist. He was seen by a doctor and the wound was dressed.

85. The man attended an eye clinic appointment on 5 August. On 6 August, it is known that he attended the dermatology department in hospital. This is not recorded on his movement history.

86. According to his movement history, the man attended a hospital appointment on 14 September. It is not clear from his medical records what this appointment was for.

87. On 22 September, the man submitted an application for access to healthcare. He complained that his left leg was swollen and his finger joints were sore. He saw a doctor on 29 September. There was a plan to admit

him to healthcare for intensive blood sugar monitoring for a couple of days and then for him to attend the diabetic clinic. It was also planned to drain the fluid on his testicle while he was in healthcare.

88. On 7 October, the man was seen in healthcare complaining of a heavy cold. On 11 October, he was admitted to healthcare for blood sugar monitoring. A 'patient manual handling risk assessment' was completed concerning his use of a wheelchair. The conclusion was that the man was self-caring and independent by means of a wheelchair. No review date was set.

89. According to a letter from the consultant, the man was seen in the eye clinic on 12 October. This is not recorded on his movement history.

90. On 15 October, a doctor decided not to drain the excess fluid again in prison and wrote a letter to the urology department at the hospital to pursue an appointment for surgery. On 16 October, there is a note in the medical record to say that the man might return to E wing on 18 October and that he was in fact keen to return there.

91. On 20 October, the man returned to E wing. On 22 October, the man's solicitors wrote asking for a letter from healthcare outlining his healthcare issues and treatment received while in Norwich.

92. Norwich sent a medical report to the man's solicitors on 28 October. On 5 November, the man asked again for his testicle to be drained as he had requested a month previously. On 6 November, he made a formal application to access healthcare for a variety of problems, namely the problem with his testicle, phlegm on his chest and a swollen leg. He saw a doctor on 12 November. On 16 November, the man attended the diabetic outreach clinic.

93. On 24 November, the man was admitted to the hospital's urology department for the operation on his testicle. He had the operation on 25 November. He returned to Norwich on 26 November and was located on E wing. Late that day, he was taken to the treatment room as he was in severe pain following his operation, was having difficulty breathing, and appeared to be anxious. His wound was cleaned, he was reassured and his breathing soon returned to normal. On 27 November, he was again seen by a member of healthcare staff. He was still experiencing difficulties after his operation and the wound was still oozing. After discussion with the doctor, it was decided to admit him to healthcare for a full assessment of the wound. He was admitted on 27 November and located in H2-17, a dormitory for five patients. There is a note in the care plan record by a Healthcare Officer that the man attended an outpatient's appointment in the afternoon and appeared stable. There is no record of this on the man's movement history.

94. On 28 November, the man complained that he had not been sleeping well for weeks before his operation. He was quoted as telling a nurse, 'I don't know how I can cope. I feel as though my head is telling me one thing and

my body is saying something else.' The nurse felt the man was low in mood, and this was more serious than the trouble adjusting which might be expected after an operation. He was reluctant to be prescribed sleeping tablets but said he would welcome somebody to talk to. He was in discomfort following his operation and his stitches were checked by a Healthcare Officer. That evening, the man asked to speak to a nurse about increasing fluid around his back and a general feeling of sickness. He was seen by a nurse who found him to be of low mood and tearful. He was referred to see the doctor on 30 November. He actually saw the doctor on 29 November and was prescribed Co-codamol for the pain. The following day he was noted as being more settled and feeling much better. The Co-codamol was continued. However, his health deteriorated that evening.

EVENTS OF 30 NOVEMBER

95. On 30 November, at about 8.10pm, a Healthcare Officer was alerted by the other patients in H2-17 dormitory banging on the window that the man needed assistance. Before entering the ward, the healthcare officer called for help from a nurse. The Healthcare Officer then went into the ward and saw the man sitting in his wheelchair, his head thrown back and gasping for breath. The Healthcare Officer called out the man's name and tried to get a response by shaking his shoulder and patting the side of his face. The man then caught his breath and his head moved forward, and he appeared to be orientated for a moment and made eye contact. He then threw his head back again and began gasping for breath.

96. The nurse had joined the Healthcare Officer in the ward. The nurse then left and called for an ambulance. She went back into the ward and helped the Healthcare Officer to move the man from his wheelchair to the floor. They were then joined by a senior nurse. The nurse and the senior nurse checked for a pulse but there was nothing.

97. At 8.15pm, a senior officer responded to an urgent radio message for a Code 2 emergency in healthcare. He contacted the communications room to summon more assistance, informed the Deputy Governor, checked on the ambulance response, and cleared the other three prisoners from the ward along with two other prisoners who were within sight of the ward and relocated them to the education room. The nurse and Healthcare Officer commenced cardiopulmonary resuscitation (CPR) at about 8.15pm. The Healthcare Officer gave two rescue breaths and the nurse started chest compressions. The senior nurse took over mouth to mouth resuscitation from the Healthcare Officer with no apparent effect. The Healthcare Officer then went to fetch the defibrillator from the clinic room. He returned and placed the pulse/oxygen meter on the man's finger. He then took over the mouth to mouth resuscitation from the senior nurse who set up the defibrillator.

98. The nurse and Healthcare Officer continued with CPR while the defibrillator analysed the man's heart rhythm. The senior nurse shocked him twice but it had no effect. She continued to direct the nurse and Healthcare Officer with the CPR while she monitored the defibrillator. Paramedics arrived at approximately 8.25pm and took over CPR until approximately 8.45pm when collectively they decided to stop the resuscitation.

CLINICAL REVIEW

99. In accordance with procedures agreed with the NHS, the investigation team advised Norwich Primary Care Trust (PCT) of the man's death. The PCT then arranged to undertake a clinical review of the healthcare provided to the man while at Norwich. The review notes that the man had numerous physical ailments which appear, in the main, to have been managed effectively by a multi-disciplinary team of prison doctors and nurses - with appropriate specialist advice and help when required. The review concludes that the man's medical management was appropriate and all medical areas of care were considered and follow up interventions were arranged. The information from the man's GP indicates that his health was poor before he was located in prison. The man had not seen a diabetic specialist prior to his imprisonment and the review explains that, following reception to Norwich, the man's diabetes was better managed, as was his heart condition.

100. The clinical reviewer states, 'By tracking his progress through each speciality one can see evidence of stability and improvement in that area where it would reasonably have been expected to have taken place. Similarly, the incidents of anxiety appear to have subsided over time. Because of the chronic nature of the man's conditions it would be expected that there might be both regressive changes and intermittent fluctuations. At appropriate times he was located in healthcare. This might be seen as deteriorations in his health, but the long term picture appears to be one of effective clinical management. For these reasons I believe the man's health improved during his stay in HMP Norwich.'

101. The man had an operation on 25 November when fluid on his testicle was drained. He was discharged on 26 November. The clinical reviewer concludes that an early discharge from hospital would have been based on the clinical need as assessed by the hospital and not something which would have been decided by the prison.

102. The review notes that not all written medical submissions are legible - including notes in the man's Medical Record - and that his medication notes are incomplete.

103. In relation to the emergency on 30 November, the clinical reviewer concludes that appropriate action was taken by medical staff to try and help the man.

FAMILY CONCERNS

104. The family's concerns about the man's clinical care while in Norwich have already been addressed. As far as my investigator is aware, the man's family have now received all his personal possessions apart from the 2004 diary which the prison has been unable to find.

105. The man's family are concerned that they were not advised of his death until the next day. According to prison records, the man had nominated his daughter as his next of kin. There is no other address or contact number listed. At the time of the man's death, the local protocol for HMP Norwich was to inform the local police nearest to the next of kin to inform them of a death in custody. The man's daughter was therefore contacted by the police and advised of her father's death. This is no longer the case and the local protocol at Norwich is now for the prison to contact the next of kin in these circumstances. (As I note below, I strongly welcome this change.)

CONSIDERATION AND CONCLUSIONS

106. The man's health was clearly poor before he arrived at Norwich in April 2002. He required the use of a wheelchair, and had problems associated with diabetes, leading to significant visual difficulties, and a below the knee amputation. He also suffered with heart disease. While in prison, he was treated for swelling of his testicles.

107. This report has set out in some detail the medical treatment that the man received while he was in Norwich. Each of his physical disorders appears to have been effectively managed. His occasional low moods were identified, and in May and August 2002 and February 2004 concern was such that he was subject to suicide prevention procedures. There were occasional areas of difficulty in his medical care – for example, there is a record of an outpatient appointment being missed in July 2002, there was an incident of scalding that same month that does not appear to have been well handled, and in December 2003 there was a problem getting the man all his medication. But overall it would seem that he did receive appropriate medical treatment. This view is supported by the clinical review. The clinical reviewer states, 'Concerning his medical management it is my view that the man was appropriately treated. All medical areas of care were considered and follow up interventions arranged.'

108. The man complained that other prisoners assisted him to take his insulin. There is no documentary evidence that this was the case. On the contrary, the medical record shows that the man was assisted by nurses to administer his insulin.

109. Both my investigation and the clinical review have identified some problems with record keeping. Hospital appointments were not all documented on the man's movement history record. Not all written medical submissions are legible and the man's medication notes are incomplete.

Healthcare staff should be reminded of the need for clear, concise and contemporaneous record keeping in accordance with the NMC guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with standards for records and record keeping.

110. The man's complex physical health were such that caring for him in prison was challenging. He spent much of his time in healthcare. The man encountered significant problems on the main residential wings, mainly due to his inability to move around. It is apparent that he was much happier on E wing than on A wing as the cells are larger. However, there is no audit trail concerning any discussion which was had about transferring him to another prison, despite references to discussions between various staff members about this issue.

The Governor should remind all staff of the need to ensure that contemporaneous prisoner records are maintained and updated particularly to reflect decisions taken or considered and all prisoner movements.

111. The local police delivered the news of the man's death to his daughter according to the local protocol at the time. My strong preference is that, wherever possible, a senior manager from the prison where a prisoner has died should break the news to the family. Where this is not possible, consideration should be given to asking a senior manager from a prison in the nearby area to visit the family and break the news. The Prison Service's newly revised guidance Liaison with Bereaved Families Following a Death in Custody (Prison Service Order 2710) explores these issues. It recommends that the news is broken to a family as soon as possible after the death, face to face, by a dedicated Family Liaison Officer, along with the chaplain, Governor or most senior individual available. It is welcome that Norwich has a new local protocol reflecting these arrangements.

112. The man was clearly very ill prior to his location in Norwich. I note the views of the clinical reviewer that his health actually improved while there.

113. I consider that on 30 November 2004 all appropriate action was taken by medical staff to try and help the man.

RECOMMENDATIONS:

OPERATIONAL:

The Governor should remind all staff of the need to ensure that contemporaneous prisoner records are maintained and updated particularly to reflect decisions taken or considered and all prisoner movements.

HEALTHCARE:

Healthcare staff should be reminded of the need for clear, concise and contemporaneous record keeping in accordance with the National Medical Council guidelines for records and record keeping. A clinical audit system must be put in place to monitor compliance with standards for records and record keeping.

The Prison Service has accepted all the recommendations. There were no comments from the man's family.