



**Investigation into the circumstances surrounding the  
death of a man in December 2011 at hospital while in  
the custody of HMP and YOI Norwich**

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

**June 2012**

This is the report of an investigation into the death of a man who died at hospital in December 2011, while in the custody of HMP and YOI Norwich. He had been admitted in the early hours of 17 December, suffering from breathing difficulties. He was 75 years of age at the time of his death.

I extend my condolences to the man's family. I hope that my report goes some way to answering any questions they might have.

The investigation into the man's death was undertaken by an investigator. In addition, a clinical review was conducted by a clinical reviewer on behalf of the local PCT.

The man arrived at HMP and YOI Norwich in April 2009, having been diagnosed with motor neurone disease a year earlier. In the last years of his life he became totally dependent on others for his care, welfare and personal needs, including personal hygiene, eating and drinking.

Throughout his illness the man was kept fully informed of his condition. He was reviewed regularly and care plans were formulated. Other healthcare services including psychotherapists, dieticians and occupational therapists were involved in his care, along with specialist motor neurone disease and palliative care nurses.

There is no evidence that the man's imprisonment at HMP and YOI Norwich significantly compromised the standard of medical care he received. Indeed, the clinical reviewer concludes that his care was equivalent to that which he might have expected in the community. Nevertheless, five recommendations are made for improvement regarding certain minor omissions in his healthcare which the report has identified.

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

## **CONTENTS**

Summary

The Investigation Process

HMP and YOI Norwich

Issues

Conclusion

Recommendations

## **SUMMARY**

1. On 21 July 1976, the man was convicted and given a life sentence for the murder of a young woman whom he had kidnapped earlier that year. Having served the first part of his sentence at various high security prisons, he was transferred to HMP Full Sutton in March 1991.
2. The man was a regular, but not frequent user of healthcare while in prison. Following a number of medical examinations he was diagnosed with probable motor neurone disease (MND) in February 2008. Due to the difficulty in diagnosing the disease, a definitive diagnosis was not made until a year later, in January 2009.
3. During his time at Full Sutton, the man's health deteriorated significantly and over time he became more reliant on both prison and healthcare staff to meet his needs, including those of personal hygiene, eating and drinking. In consultation, and with the agreement of the Governor of HMP and YOI Norwich, he was transferred to the healthcare unit at Norwich, where 24-hour medical care was available.
4. Throughout his illness, the man was fully informed about his condition and treatments. Regular case reviews were completed and care plans formulated. He received input from a diverse range of healthcare services including occupational therapy, dieticians and physiotherapy. He received additional care from specialist MND and palliative care nurses while at the prison.
5. In August 2011, the man was treated successfully for pneumonia. However, in late November to early December, he was recorded as suffering from a chest infection. In the early hours of 17 December, he was admitted to hospital. His health deteriorated significantly and he subsequently died.
6. This report into the man's death concludes that his care was equivalent to that he would have received in the community and that being in prison did not compromise his care. However, the clinical reviewer makes a number of recommendations which we endorse.

## THE INVESTIGATION PROCESS

7. An investigator was appointed to conduct the investigation into the circumstances surrounding the man's death. He opened the investigation on 19 December 2011, when he visited HMP and YOI Norwich. He met the Governor of Norwich, Safer Custody Manager and the Head of Healthcare.
8. The investigator also asked to speak with a member of the Independent Monitoring Board (IMB), but no one was available. IMB members are independent and unpaid. They monitor day to day life in the prison to ensure that proper standards of care and decency are maintained. No members of the Prison Officers' Association (POA, the trade union for prison officers) asked to see the investigator.
9. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Norwich. The notices were displayed around the prison and invited staff and prisoners to contact the investigator with any information they felt might be relevant to the investigation. No prisoners or staff came forward to speak with the investigator as a result of these notices.
10. The investigator reviewed the man's prison and medical records and arranged for copies of documents relevant to this investigation to be sent to him. He was shown the cell and wing where the man spent the last months of his life.
11. The clinical reviewer, on behalf of the local PCT, conducted an independent clinical review of the medical care given to the man while in custody at Norwich.
12. The investigator has also been in contact with the Coroner's Office and a copy of this report will be sent to the Coroner to assist him with his enquiries.
13. One of the Ombudsman's family liaison officers wrote to a member of the man's family informing them of the Ombudsman's role and investigation and offering them the chance to meet with him and the investigator. To date, the family have not made contact with this office, but they will be offered the opportunity to receive a copy of the investigation report.
14. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, location and security arrangements, palliative care and provision of specialist equipment were provided and considered satisfactorily.

## **HMP AND YOI NORWICH**

15. HMP and YOI Norwich is a local prison which serves courts in Norfolk and Suffolk and holds a maximum of 767 male prisoners. The site is split into two locations, the main prison and a dedicated healthcare centre treating, amongst others, elderly prisoners and those suffering from chronic or terminal illnesses.

### **“L” Healthcare Unit - older prisoners’ unit**

16. L wing caters for 15 patients, many of whom are over 65 years old. During the day, a registered nurse is always on duty, while nights are staffed by a registered nurse from the healthcare centre. There is also a healthcare assistant on duty and a prison officer trained in healthcare duties. All the cells in the unit are adapted for wheelchairs and have en-suite facilities. Patients, such as the man are provided with special hospital beds if required.
17. In correspondence with this office, the Governor has made it clear that this unit, “... is not commissioned, resourced or equipped to provide palliative care”. The Governor has confirmed this position with the healthcare commissioners at NHS Norfolk and Waveney and the Department of Health.

### **Motor Neurone Disease**

18. Motor neurone disease (MND) is a progressive neurodegenerative disease that attacks the upper and lower motor neurones. Degeneration of the motor neurones leads to weakness and wasting of muscles, causing increasing loss of mobility in the limbs, and difficulties with speech, swallowing and breathing.

### **Previous self inflicted deaths at HMP and YOI Norwich**

19. In recent years Norwich has specialised in caring for older prisoners, many who have been located on L wing and as a consequence the prison has experienced a high level of deaths. In the twelve months prior to the man’s death, there were three natural cause deaths at the prison. There are no similarities with regard to the recommendations made in those reports and those made as a result of this investigation.

## **ISSUES**

### **Background**

20. The man was born in 1936, in Bradford West Yorkshire. As a young man he served in the British Army. On leaving the army he carried out a number of armed robberies, three of which resulted in the death of post office workers. On 19 December 1975, he was arrested and later charged with the death of a young woman, who he had kidnapped in January of that year.
21. On 21 July 1976, the man was convicted of murder and given a life sentence. He spent the early years of his sentence at HMP Birmingham and HMP Parkhurst, before being transferred to HMP Full Sutton in March 1991.
22. While at Full Sutton the man was a regular but not frequent user of healthcare, including dentistry and optician services. He also suffered from a number of medical complaints, unrelated to and before his diagnosis of MND. The clinical reviewer raises no concerns with regard to the treatment he received for these conditions.

### **The diagnosis of the man's terminal illness**

23. On 6 November 2007, the man reported a weakness in his arms to healthcare staff at Full Sutton, which he described as getting worse over the preceding months. He was assessed by a prison doctor the following day, who noted muscle wastage and made a referral for a second opinion.
24. The man was seen by a visiting consultant on 12 December, who suspected that he was suffering from MND. Over the next few weeks further tests were undertaken and, on 27 February 2008, a consultant neurologist suggested a probable diagnosis of MND. However, it was noted that further tests would be required before the diagnosis could be confirmed. Following these further tests an un-confirmed diagnosis of aggressive MND was made by consultants on 13 May. It was not until the 16 January 2009 that it was confirmed he had MND.
25. As soon as the man reported an ongoing problem with his arm, his condition was treated seriously and appropriate referrals made. Despite the protracted diagnosis, there was evidence that prison healthcare staff were proactive in confirming what was wrong with him. Given the difficulty in diagnosing MND, the clinical reviewer and this office is satisfied with the timely and appropriate diagnosis of his condition.

### **Informing the man about his condition and treatment**

26. Although it was suspected that the man was suffering from MND on 12 December 2007, he was not told about the possibility at the time. However, five days later another of the prison doctors discussed with him

other possible diagnoses, including that he could have been suffering from some form of severe muscle wasting disease. MND was not specifically mentioned during this discussion.

27. Over the following weeks, the man's condition continued to deteriorate. Having undergone a number of tests, he was informed on 17 March 2008, that the most probable diagnosis for his condition was MND. He was advised that further tests would be needed before the diagnosis could be confirmed. He was told of his indeterminate diagnosis on 13 May. As soon as the definitive diagnosis was made on 16 January 2009, he was told that he had MND.
28. Throughout his illness the man was fully informed about his condition and his ongoing prognosis. He was provided with information about the treatments he was receiving. He was also provided with specialist equipment, including an electric wheelchair, a voice activated computer and other aids, such as a page turning device.
29. Communication with the man was effective and well documented in his prison medical record. Healthcare staff continued to provide him with information regarding his condition, throughout his illness, and his prognosis in the hours before his death. We are satisfied that this was carried out appropriately.

### **The man's medical appointments and treatment**

30. By January 2008, the man's ability to write and carry out other day to day tasks, such as eating and dressing had deteriorated. Support was provided to assist with day to day tasks, some of which he declined to utilise. During this time a request for a specialist hospital bed, to assist with his care and comfort, was also made and approved. In order that he might retain as much independence as possible, an electric wheelchair and other aids to assist with his mobility were also provided.
31. Throughout his illness, the man continued to be assessed and attended numerous medical appointments with consultant neurologists, as well as receiving monthly physiotherapy. In addition, he was regularly reviewed by prison doctors and monitored by nursing staff. Case reviews were completed monthly, regarding his healthcare requirements, which were noted in his medical record. In her clinical review the reviewer reports that other appropriate external services, such as occupational therapists, dieticians, an MND nurse and a palliative care nurse provided input into his care plans and that these were appropriate.
32. Nursing staff and prison officers continued to provide assistance to the man with regard to his everyday hygiene needs, assistance with going to the toilet and with eating and drinking. His needs were reviewed regularly by the prison doctor and the other health professionals involved in his care throughout his time in prison.

33. The clinical reviewer reports that:

“For all of his time in HMP Norwich he required a high level of care to meet his needs; he appears to have received good nursing care; his Waterlow score (for pressure areas/bedsores) was regularly reviewed, along with his care plan and he therefore only incurred minor pressure area problems all of which he recovered from and some of which might have been avoided if he had been more cooperative.”

34. In her clinical review, the reviewer reports that the man had his first significant chest infection in August 2011, which she noted he was treated appropriately with antibiotics and fully recovered. However, she reports that on 24 August, he had an oxygen saturation reading, measuring the quantity of oxygen in his blood, and it was below the expected level. The clinical reviewer notes that there was no action recorded as a consequence of that low reading and therefore makes the following recommendation:

**The Head of Healthcare should ensure that staff record appropriate actions taken when recording abnormal oxygen saturation levels.**

35. On 6 November, the man was reported to be making “gurgling sounds” after eating. On 9 November, he was seen by one of the prison doctors who noted that he had a “bubbly” chest and was diagnosed with a chest infection. He was prescribed antibiotics, but he declined to take the medication saying that he did not believe that he had an infection.
36. In a medical entry on 29 November, it was noted that the man’s chest infection seemed to be continuing “on and off” and he might be aspirating small amounts of fluid. Nursing staff recorded that there was a small to moderate risk of an ongoing chest infection. On 13 December, a further note was made by healthcare staff that he was “chesty and coughing”.
37. On 16 December, staff noted that the man had been “chesty” all week and that it was suspected he had another chest infection. He deteriorated significantly over the following 24 hours and the decision was taken for him to be transferred to hospital. Despite further medical interventions by hospital staff he died from pneumonia.
38. The investigator asked the clinical reviewer to comment on the appropriateness of the man’s treatment from 6 November when it was first reported that he appeared to be suffering from a chest infection. In her response, the clinical reviewer raised no concerns.
39. However, in her clinical review, she notes that on two occasions, 27 August and 15 December, no entries were made in the man’s medical record. Although she concludes that entries should have been made daily, she reports that the deficiency would have had no impact upon his care. Nevertheless, she makes the following recommendations.

**The Head of Healthcare should ensure that all staff record all significant contact in the patient's clinical record.**

**The man's pain relief and medication**

40. During his time in prison the man was in receipt of 26 different medications. In December 2008, his consultant neurologist suggested that he commence medications with regard to his diagnosis of MND. The investigator asked the clinical reviewer to consider whether this medication, his pain relief and other medications were appropriate. She responded by confirming that his pain relief was appropriate.

**The man's location**

41. On several occasions at Full Sutton, the man declined to be relocated in the prison's healthcare unit despite his deterioration. He wanted to remain as independent as possible for as long he could on a residential wing. However, despite the efforts of nursing and other prison staff, it became increasingly difficult to meet his needs, including those of personal hygiene, eating and drinking. On 28 May 2008, with his agreement, he was moved to the prison's healthcare unit where he was able to receive closer monitoring and assistance.
42. Towards the end of 2008, and into the early months of 2009, the man's medical needs became more complex. He suffered increasingly from incontinence, general weakness and other mobility issues. In December 2008, his welfare and healthcare needs were discussed during one of the regular care planning meetings. It was concluded that staff at Full Sutton could no longer meet his increasing care needs.
43. In consultation with the Governor of Norwich prison, arrangements were made for the man to be transferred to Norwich. It was intended that the prisons' Heads of Healthcare liaise to co-ordinate the move, although this investigation could find no evidence to suggest that this was the case.
44. On 19 April 2009, the man was transferred to Norwich prison. There is no note in his medical record that healthcare staff made contact with, or discussed his transfer with healthcare staff at Norwich in advance of the transfer, or subsequently. On his arrival at Norwich, he was located on L wing, the prison's older prisoners' unit, where he was able to receive 24 hour medical care.
45. On 21 May 2009, a month after his transfer, staff at Norwich were still trying to obtain equipment that the man had at Full Sutton but which had not transferred with him to Norwich. In particular, the Motor Neurone Association had advised he be given a specialist chair which should have transferred with him to Norwich. Eventually Norwich made applications for and obtained the necessary equipment to assist in his needs of their own accord. The investigation could find no recorded evidence to suggest that there was any detailed liaison between the healthcare units of each

establishment.

46. In her clinical review the reviewer reports that:

“When the man was transferred from HMP Full Sutton to HMP Norwich it was without his disability aids (for example chair and page turning device) and it took a considerable time for the staff to replace them during which time they managed him as best they could...”

She concludes that he did not appear to have suffered any ill consequence. However, she makes the following recommendation for staff at Full Sutton which we endorse:

**The Governor and Healthcare Manager at Full Sutton should ensure that all disability aids accompany prisoners on transfer to other prisons.**

47. On 14 August 2009, the Governor of Norwich authorised an open door policy for the man’s cell. This allowed healthcare and other staff unrestricted access in order to meet his needs and provide 24 hour medical care, without the necessity of requesting an officer to unlock his cell, in particular during the night.
48. We are satisfied that the transfer was appropriate and that the man’s needs were met at the prison, where he had told staff he wanted to remain for as long as possible. As soon as his condition became urgent, in the early hours of the 17 December, on his deterioration in health, he was appropriately transferred to hospital by emergency ambulance.

### **Palliative Care**

49. Palliative care attempts to improve the quality of life of patients and their families who are facing life-threatening illness through the prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems. No formal palliative care plans were in place for the man because his death was not expected. However, given his continued deterioration and the critical state of his health, staff used palliative care principles to manage his care.
50. On 20 April 2009, referrals were made for the man to have an air mattress and pressure relieving cushions to assist in the relief and prevention of pressure ulcers and for specialised lifting equipment. Additionally applications were made, and a number of items were subsequently received, such as, an electric wheelchair, a voice activated personal computer and a book page turning device.
51. The man was also referred to other services to assist with his care including regular psychotherapy, review by dieticians and input from speech and language and MND occupational therapists. Staff at both Full Sutton and Norwich contacted the Motor Neurone Association for advice

and assistance as was required.

52. Norwich prison works closely with Priscilla Bacon Lodge, a local hospice, to manage elderly prisoners. The hospice confirmed that they had a consultant who would be able to provide staff with advice and support in dealing with patients with MND.
53. On 1 June 2009, the man told the prison doctor and nurses he did not wish to be resuscitated in the event of a heart attack. The relevant do not resuscitate (DNR) forms were completed and signed by him. His request not to be resuscitated was regularly reviewed throughout the remainder of his illness and was reviewed for the last time on 9 November 2011.
54. In her clinical review, the reviewer comments that the DNR paperwork did not accompany the man on his emergency transfer to hospital as it should have, but was faxed through some hours later. As a consequence, paramedics and nursing staff receiving him on the evening of his admission would not have known of his wishes until several hours after his arrival at the hospital. She made the following recommendation, which we endorse:

**The Head of Healthcare should ensure that DNR orders are effectively communicated to the ambulance service in the event of an emergency.**

#### **Access to equipment**

55. 23 October 2011, staff attempted to flush the man's catheter but could do so as the correct type of syringe to carry out the procedure could not be found. (A catheter is a tube inserted into the penis to drain urine from the bladder. On occasions catheters require cleaning which is done by the injection of a saline solution through the use of a syringe.)
56. On 16 December 2011, the day before his admission to hospital with pneumonia, nursing staff were unable to take the man's temperature due to their being "unable to find a reliable thermometer". As a consequence, the nurse simply recorded in his medical record that he looked flushed and felt hot.

When asked to comment on the unavailability of the above equipment the clinical reviewer said:

"The clinical record show that on two occasions the appropriate clinical equipment (thermometers and syringes) were not available but he [the man] does not appear to have suffered any significant consequences."

57. It was the clinical reviewer's opinion that these were isolated incidents and that there were no serious consequences for the man's care. However, she makes the following recommendation which we endorse:

**The Head of Healthcare should conduct regular audits of clinical equipment to ensure it is available at all times.**

**Liaison with the man's family**

58. On his admission to hospital, the man was told about the seriousness of his condition. He instructed prison staff to only contact his next of kin upon his death, as he was concerned about the intrusion of media attention upon them.
59. Nevertheless, Prison Rule 22 state that a prisoner's family should be notified if they become seriously ill. Given his prognosis prison staff, with the assistance of police, attempted to make contact with his next of kin in the hours after his admittance to hospital on 17 December. However, this proved difficult as he only method of communicating with his family was through a PO Box number. There was no listed telephone contact in his record.
60. Unfortunately, the man's next of kin learnt of his death through the media. Norwich wrote to the family though the PO Box number officially informing them of his death. On receipt of the letter, the family contacted the prison. As per his instructions, Norwich made arrangements for his funeral at which the prison's chaplain officiated.
61. Given the circumstances and the man's own wishes we believe that the prison acted appropriately in the matters of family liaison.

**Compassionate release**

62. Prisoners who are suffering from a terminal illness and for whom death is thought likely to occur soon can be released from prison by early release on compassionate grounds. The prison made no application for the man's early release on compassionate grounds. In the circumstances it would have been difficult for the tests in Prison Service Instruction (PSI) 29/2010, which sets out the criteria for compassionate release for indeterminate sentenced prisoners to have been met. These include that there should be adequate arrangements for the prisoner's care and treatment outside prison and that early release would bring significant benefit to the prisoner and or his family.

**Restraints, security and bed watch**

63. During his time in prison, the man attended hospital on numerous occasions while in prison. Assessments were carried out on each occasion and medical advice was sought when assessing the types of restraint to be used during the transfers. Given his condition, restraints were not used, but he was accompanied by prison officers. We consider this to be appropriate.

64. Documents relating to his transfers to hospital and bed watch entries were made to a good standard and it was apparent that escort staff were dignified in their dealings with the man while in hospital and during the period leading to his death. This included a member of the chaplaincy being present at this time.
65. However, on 29 October, having returned from hospital for surgery for the insertion of a feeding tube into his bowel, the man woke in the night complaining of severe abdominal pain. Healthcare staff phoned the hospital to seek advice but, this could not be provided without an examination of him. Staff then called the out of hours doctor who advised admission to A & E for assessment within the hour. Staff called for a non urgent ambulance to attend within the hour.
66. However, on arrival of the ambulance the man refused to be transferred, as the decision was taken that the use of restraints would be required during his transfer to hospital. Although risk assessment paperwork exists with regard to his previous and subsequent transfer to hospital, which concludes that restraints are not necessary, the documentation does not record why the decision to use restraints on 29 October, was made.
67. However, we are satisfied that, although unfortunate, this was an isolated incident and that on previous occasions during transfers to hospital restraints were, appropriately, not used. Although the man did not attend hospital he was seen by the prison doctor the following day and, having been given pain killers during the night, his pain subsided. The doctor made the decision that a transfer to hospital was unnecessary.
68. The investigator asked the clinical reviewer to comment on whether the man's non attendance at hospital had any impact upon his health and care. She made no further comment.
69. We consider that appropriate arrangements were made for the man when he was transferred to hospital on 17 December, and during previous transfers to attend appointments since the diagnosis of his illness. Because of his inability to move unaided, age and circumstances of his admittance, he was not handcuffed during his transfer to hospital by ambulance.

### **Post Mortem and Toxicology**

70. No post mortem examination or toxicology tests were undertaken upon the death of the man. However, hospital doctors confirmed his death as being from pneumonia and MND.

## **CONCLUSION**

71. The man was diagnosed with MND in 2008, and died three years later from pneumonia. In the intervening years his health deteriorated significantly and in the final years of his life he was totally reliant on the support and care of others, in particular from nursing staff at HMP Norwich where he spent his last years.

72. In her clinical review the reviewer draws the following conclusion:

“There is no evidence that the fact that the man was in prison in any way compromised the standard of care he received: he accessed secondary care, and community services in a timely and appropriate way. Nursing care was given as best it could be within the constraints of an at times, uncooperative and challenging patient. There was no evidence of any long term deficiencies as a result of these omissions of nursing care.”

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that staff record appropriate actions taken when recording abnormal oxygen saturation levels.

**Accepted** – A new clinical lead for Healthcare is now in post and is working to ensure that the two levels of Healthcare operate at the required clinical standards.

2. The Head of Healthcare should ensure that all staff record all significant contact in the patient's clinical record.

**Accepted** – Reviews of medical records and care plans are now an ongoing remit of the clinical lead and her team.

3. The Governor and Healthcare Manager at Full Sutton should ensure that all disability aids accompany prisoners on transfer to other prisons.

**Partially Accepted** – The specialist chair was only on loan from the local MND society and it was not ours to transfer out of areas. The computer and voice activator was loaned from the disability team who have a limited supply of equipment for all prisoners housed at HMPFS.

4. The Head of Healthcare should ensure that DNR orders are effectively communicated to the ambulance service in the event of an emergency.

**Accepted** – The clinical lead will ensure this happens and information from the Liverpool Care Pathway will reinforce this measure. Staff have since received training and mentorship on this department and are now expected to act and communicate information in areas such as this.

5. The Head of Healthcare should conduct regular audits of clinical equipment to ensure it is available at all times.

**Accepted** – All clinical equipment in respective area has been checked and either disposed of or replaced as new.