Circumstances surrounding the death of a man on 27 February 2009, at HMP Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

June 2010

This is the report of an investigation into the death of a man, who was a prisoner at HMP Norwich. The man died from natural causes on 27 February 2009, in the Nelson Unit of the prison. He had been at the prison for seven months.

I would like to add my personal condolences to those already expressed to the man's family by the Family Liaison Officer, on behalf of this office. I apologise for the delay producing my report and for any additional distress this may have caused.

The investigation was undertaken by one of the Ombudsman's senior investigators. The report has been written subsequently by a fellow Investigator from my office. My colleagues and I would like to thank the Governor of HMP Norwich and his staff for their assistance. The man served most of his sentence at HMP Manchester and I am also indebted to staff in the healthcare centre for their assistance.

A Clinical Quality and Patient Safety Manager, from NHS Norfolk undertook a review of the man's clinical care and we appreciate all her help. I endorse the recommendations to HMP Norwich and NHS Norfolk which the Clinical Reviewer made in her clinical review. I am pleased to say that NOMS has confirmed that my recommendations to HMP Norwich have been accepted and implemented. Although I make no recommendations to North Manchester PCT, I will share my report with them.

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.

Jane Webb
Acting Prisons and Probation Ombudsman **June 2010**

CONTENTS

SUMMARY

The man was born in 1920. He died on 27 February 2009 in the Nelson Unit at HMP Norwich. (The unit provides specialist healthcare for older prisoners and is the only such resource in the Prison Service.) He died from the effects of prostate cancer that was already at an advanced stage when it was diagnosed in December 2008.

The man was remanded into custody on 4 June 2005. He was sentenced at Manchester Crown Court on 20 October and returned to HMP Manchester. Prior to sentence, the man underwent a full medical assessment. Although he had suffered a mild heart attack some two years previously, he was said to be reasonably physically and mentally alert for a man of his age.

In February 2007, the man's case was referred to the Parole Board for consideration. Progress reports noted that he had a major problem with his hearing, and given his age and medical problems, it was unlikely that he could make any progress towards meeting his sentence planning targets. As no release plan had been prepared, the Parole Board adjourned the hearing.

The man's mental and physical health deteriorated until, in January 2008, he was said to be confused and unable to care for himself. By March, he was identified as having complex medical needs and a full psycho-geriatric assessment was requested. At the deferred parole hearing on 4 April, it was noted that the Probation Service had been unable to identify any accommodation that could provide both adequate nursing care and the level of security necessary to manage risk. Consequently, parole was refused.

Later in April the man was diagnosed as suffering from vascular dementia and was referred to the Nelson Unit where he transferred in July. The man continued to be unwell. By October he was complaining of abdominal and back pain. It was also noted that he had lost weight, and he was referred to an outside hospital consultant. In December, he was diagnosed as suffering with cancer of the prostate that was at an advanced stage. He was to be given palliative treatment, delivered according to a recognised clinical pathway, to relieve his pain and make him comfortable.

The man returned to the Nelson Unit where it was quickly noted that his condition was deteriorating. His palliative care was regularly reviewed and, on 26 January 2009, it was noted that he was comfortable although reaching the end of his life. On the morning of 27 February, one of the health care assistants responsible for the man's care noted that he was breathing peacefully and not in pain. Later that evening, the same member of staff saw that the man's breathing had become shallow. She decided to sit with him and remained with him until 6.30pm that evening when the man passed away peacefully.

The clinical review concludes that the care the man received was equitable to that which he would have received in the community, and that he was nursed appropriately.

THE INVESTIGATION PROCESS

1. The investigation was opened on 2 March 2009 when the Investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to anyone who wished to submit information relating to the man's death to make himself known to the investigator. No one came forward as a result.

2. The Investigator also obtained all the relevant prison documents about the man. They included his main prison record, medical records and statements made by staff shortly after the man's death. The documents were studied by the fellow Investigator, who also liaised with HMP Norwich and wrote this report.

3. The Norfolk Primary Care Trust identified a Clinical Quality and Patient Safety Manager, to conduct a review of the man's clinical care. I am grateful to her for her prompt attention.

4. The Investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

5. One of the Ombudsman's Family Liaison Officers, contacted the man's family to offer the opportunity to discuss the purpose of the investigation. They were able to raise any concerns or questions that they would like addressed. The family spoke positively about the care and attention they had received from HMP Norwich, both before and after the man's death. The family particularly wished to thank the Healthcare Assistant for sitting with the man at the end of his life. Although the family had no concerns about the care he received at Norwich they question why the man was transferred from Manchester to a prison so far away from them and why they were not informed in advance of the transfer. The family also wished to know why the man was not released on compassionate grounds. My report explores these questions and I trust it will provide explanations for the man's family.

HMP NORWICH

6. The building of HMP Norwich was completed in 1887. Today it is a multi functional prison serving courts in Suffolk and Norfolk, taking male prisoners both convicted and on remand. Mostly it is a category B prison holding adult men but it also has a category C training wing for longer sentenced men, and a separate unit for young offenders from 18 to 21 years.

7. Nelson Unit is a specialist unit on the ground floor of the healthcare centre which was established in March 2004 to accommodate elderly life sentenced prisoners facing lengthy periods in custody. The unit's aim was to provide care programmes to maximise each individual's potential quality of life. Although the prisoners do not necessarily require acute hospital or nursing services, the unit was designed and equipped to enable those with high maintenance health needs to be suitably supported and cared for within the prison environment. The unit now also accepts prisoners who need palliative care. There are no other similar facilities in prisons in the North West.

8. The specialist nature of the Nelson Unit means that a number of prisoners have died there, all of which have been investigated by the Prisons and Probation Ombudsman.

9. The prison was inspected by Her Majesty's Chief Inspector of Prisons, shortly after the unit opened in 2005 and she conducted a follow-up inspection in November 2006. She reported that facilities on Nelson Unit were very good with spacious well equipped rooms. Prisoners were reported as speaking very highly of staff and the level of care they received.

10. Her Majesty's Chief Inspector of Prisons also acknowledged the existence of good links with palliative care teams and good use of the Liverpool Care Pathway (LCP). The LCP is a key recommendation in the National Institute for Health and Clinical Excellence (NICE) guidelines for supportive and palliative care. It is a continuous quality improvement programme of care for a dying patient that was developed to enable the hospice model of care to be used in other settings.

11. LCP uses a multi-disciplinary document to provide an evidence-based framework for end-of-life care. The LCP provides guidance on the different aspects of care required, including measures to ensure the patient's comfort, medicines to be prescribed and identification of interventions that may no longer be appropriate.

KEY EVENTS

12. When he was sentenced on 20 October 2005, the man returned to HMP Manchester where he had been held on remand since early June. He was said to be suffering with arthritis but was otherwise generally well for a man of his age. By December of the same year staff noted that he had a lot of difficulty understanding some things and was 'too old' to make use of work or education facilities. He was said to spend a lot of time in his cell, watching television or dozing, although from time to time he 'pottered about' on the wing. On occasions staff reminded him about the need to maintain his personal hygiene but otherwise he presented no problems.

13. By the beginning of the following year, staff noted that the man's personal hygiene had deteriorated further and he sometimes needed encouragement to keep himself and his cell clean. In August he was diagnosed as suffering with hypothyroidism – an under active thyroid gland - and thyroxone was prescribed.

14. In January 2007, the man developed a minor fibroma – a small benign fibroid type growth - in his right eye and was referred for surgery. His hearing was deteriorating and he was provided with a new hearing aid. The man also complained of difficulty passing urine and was referred to the Department of Urology at the Pennine Acute Hospital.

15. The man was fitted with a catheter and a rectal examination showed an enlarged but 'benign feeling' prostate. He was prescribed Tamsulosin, a drug used to treat men who have difficulty urinating due to enlargement of the prostate. He returned to the healthcare unit in Manchester where he remained for four days before being transferred back to the wing. On 30 January, he returned to the hospital for a trial without the catheter but this failed and he was re-catheterised. He went back to the healthcare unit.

16. Entries in the man's record indicated he was managing his catheter reasonably well and exhibiting no further problems. In May he was given a course of antibiotics for a mild chest infection, following which he was said to be well although a little unsteady on his feet.

17. The man was informed in June that the Parole Board had adjourned the hearing into his application for early release on parole as a release plan had not been put in place. The Board noted that the man's age, disabilities and rigid thinking patterns prevented him from undertaking any offence focussed work to reduce his risk. They considered that there was no realistic prospect of him being able to do so. The Board

was also informed that, in the community, the man would need some form of supervised elderly persons' provision.

18. Over the following months entries in the man's medical record indicated that he managed his catheter bag with varying degrees of efficiency and stayed reasonably well for his age. He could collect his meals and bathe himself although he needed assistance to get out of the bath. Nevertheless, he was found to be confused at times and needed constant prompting to maintain personal hygiene.

19. Records indicated that by December, the man's health was deteriorating. He was becoming more confused and unsteady on his feet and he had two falls. At the end of the month he had a mini-mental state examination and scored poorly. When the test was repeated in February 2008, his score had not changed. A medical report prepared for the Parole Board identified the man as having complex medical needs and said that intensive nursing care would be required in the community.

20. In April, the man was assessed by a Doctor who is a specialist in old age psychiatry from Manchester Mental Health and Social Care Trust. The Doctor found him to be suffering from a 'mild mixed or vascular dementia'. The psychiatrist also said that staff had described a gradual deterioration that could indicate the possibility of Alzheimer's disease. It was thought that the man could benefit from an environment that was less restrictive than Manchester. (HMP Manchester is part of the Prison Service's high security estate.) The Parole Board again found that the man was unable to address his offending behaviour due to his poor mental state and his application for parole was refused. On 13 May, the Court of Appeal granted the man's application for an appeal against his sentence of imprisonment for public protection.

21. By June the man was said to be increasingly confused. He was also unsteady on his feet and suffering intermittent bouts of constipation. On 11 June, he was referred to North Manchester General Hospital where he was diagnosed with a urinary tract infection, mild dehydration and constipation. He was discharged back to the prison the same day. After he was found on the floor in his room, an open door policy was implemented to enable constant monitoring at night.

22. On 1 July, the man's appeal was dismissed and the Appeal Court judges recommended that he should be transferred to a prison with 'a specialist elderly persons' unit. At that time Manchester had recently received a memorandum from Norwich confirming that Nelson Unit was a dedicated medical facility for prisoners with chronic medical conditions who needed 24 hour care. The memorandum stated that, although the unit was set up for elderly male lifer prisoners, the current level of vacancies meant they would consider any male prisoner requiring the medical care facilities that the unit provided. Staff at

Manchester assessed the man as meeting the required criteria and Norwich agreed to accept him. Due to the nature and frequency of transfers throughout the prison estate, it is impractical to inform prisoners' families of impending moves and there is no requirement for prisons to do so. It is usually left to prisoners themselves to ensure that their families know where they are. The man's contact with his family had been infrequent and they were not informed in advance of his move or the reasons behind it. Although I do not criticise Manchester for the omission, given the man's ill health and confusion, I consider that a more pro active approach could have been considered.

23. The man's file noted that on 17 July, he was 'discharged to specialist elderly care unit in Norwich'. His medical records indicated he had a 'long term in dwelling catheter' and he was prescribed Trimethoprim for the recurring urinary tract infections which were thought to contribute to his confusion. Within a month staff noted that the man had poor motivation, did not sleep well and was incontinent of faeces. During August and September, it was noted that he was losing weight and by mid-September he was said to have been vomiting and feeling unwell.

24. In October, the man was referred to the Urology department at Norfolk and Norwich University Hospital as he had not been seen by an urologist for some months. The referral letter described him as having a history of 'benign prostate hypertrophy and a long term catheter in situ'. The man was seen by a Consultant Urological Surgeon, on 17 December. The Surgeon found that the man had a swelling in his right groin consistent with enlarged lymph nodes. A rectal examination found 'hard prostate in keeping with malignancy'. The surgeon commented that he had explained to the man he had prostate cancer and it was not necessary to carry out a biopsy to confirm the diagnosis. He suggested that the man should start to have 'androgen deprivation according to the pro-forma' and did not recommend further assessment. (Androgens are produced mainly in the testicles and can stimulate the growth of prostate cancer cells. Lowering androgen levels can help eliminate cancer cells and this is the recommended treatment in widespread use.)

25. During the next week, the man complained that the pain in his groin was increasing and paracetamol was providing only limited relief. He was not sleeping well and had little appetite. Consequently, on 24 December, he was referred to NHS Norfolk's specialist palliative care service for review. He was seen on 6 January 2009 when co-codamol was prescribed as an alternative pain relief. He was also prescribed medication to relieve constipation, and it was noted it could be some months before the androgen deprivation medication had any effect.

26. By 10 January, there had been a general deterioration in the man condition. His wife, was frail with health problems. She had indicated to the prison that she did not wish to be contacted directly if her husband's condition deteriorated. As hers was the only direct point of

contact known to the prison, the police were asked to trace other members of the man's family.

27. The man was unsteady on his feet and the doctor diagnosed another urinary tract infection. However, during the afternoon he vomited, and the Head of Healthcare referred him to Norfolk and Norwich University Hospital. He returned to Nelson Unit the following day. On 17 January, the man fell in a corridor and fell again in his cell the following day. Although there were no obvious injuries from either fall, they were evidence of his increasing frailty and staff expressed concern about the risk of further falls.

28. The palliative care nurse again reviewed the man on 23 January and prescribed stronger pain relief. She requested a pressure mattress with a sensor pad to make him more comfortable. By this time the police had contacted the man's family. It was clear that his condition was deteriorating and, after consultation with the family, it was agreed that if the need arose, he should not be resuscitated. Unfortunately, despite the nature of his condition, the seriousness of the man's offences that resulted in an indeterminate sentence for public protection combined with the conditions specified by the Parole Board precluded him from being considered for early release on compassionate grounds. Three days later staff reported that the man was difficult to rouse and said he was 'at the end stage of his life'. In order to nurse him properly, an open door policy was again implemented and his cell door was to remain unlocked at all times.

29. By early February the man was too unwell to take medication through his mouth and so it was decided to that pain relief would be administered through a syringe driver. The palliative care nurse also prescribed Fentanyl pain relief patches. A new bed with the necessary mattress and sensor pad was provided on 3 February and this appeared to make him more comfortable. On 6 February, the man's condition was described as deteriorating and communication was difficult as he could only mumble. However, he had a Fentanyl patch and was said to be in no pain.

30. The palliative care team noted on 11 February that the man should perhaps have had more medication but this was difficult 'given staff resources and the man being muddled making pain assessment problematic'. On 15 February the open door policy was reaffirmed and the Liverpool Care Pathway (LCP) palliative care was put in place. The LCP record indicated that the man had become less responsive over the past 12 hours. He was unable to take solid food and struggled to swallow. A number of entries over the following days indicated that he was comfortable, pain free and turned often to avoid pressure sores. The man was able to acknowledge staff and communicate at a basic level until 20 February. Thereafter a number of entries indicate that he was asleep most of the time and did not respond to the staff.

31. Pain medication had continued to be taken orally but, on 24 February, staff noted that the man was unable to swallow even small amounts without struggling and the syringe driver was put in place. The clinical reviewer noted a problem with the driver on 25 February when the man did not receive the correct dosage of pain medication although this did not appear to have any adverse effect upon his condition.

32. On the morning of 27 February, a health care assistant with five years experience who had helped to nurse the man for several weeks, noted that he was very peaceful. He did not seem to be in any pain. Around 6.00pm the Healthcare Assistant, noticed that the man's breathing was becoming shallow. She had an instinct that the man was reaching the end of his life and sat with him as she did not want him to be alone when he died. The man passed away peacefully at 6.30pm. The Healthcare Assistant immediately notified the health care manager who certified his death at 6.45pm.

ISSUES CONSIDERED

Clinical care

33. A Clinical Quality and Patient Safety Manager, undertook a review of the man's medical and palliative care on behalf of the Norfolk Primary Care Trust. The clinical reviewer found that the man received 'equitable care to someone who isn't within the secure environment'. Nevertheless, she found some minor failings and made suggestions for improvements to clinical practice.

HMP Manchester

34. It was clear from the man's medical records that his frailty was identified when he arrived at HMP Manchester and was suitably monitored. Although he experienced difficulty managing his catheter and maintaining his personal hygiene, there was evidence that staff were patient and helpful to him. The man was seen regularly by healthcare staff and referred to services outside the prison when appropriate.

35. The reviewer said that some of the letters and results arising from HMP Manchester's referrals to the District General Hospital were not in the prison medical notes. In particular, the man attended the out patients department after the local District General Hospital had diagnosed an enlarged prostate gland and started him on a drug regime. There was no copy of the hospital letter in the medical record.
The reviewer commented that documentation should be sent to the receiving health care provider to maintain effective and safe clinical care. The results and recommendations arising from referrals to healthcare providers outside the prison should be clearly recorded in a prisoner's medical records.

36. The Clinical Reviewer also commented that the handwritten medical notes were sometimes difficult to follow. She said that some entries were difficult to decipher and signatures were not underwritten with names, making it difficult to identify the authors. All the signatures in a prisoner's medical notes should have the author's names printed underneath the signature.

37. In view of the time which has elapsed since the man's death, and that it did not actually occur in Manchester, I make no recommendations on any of these matters. However I will send a copy of my report to the Governor and healthcare manager and encourage them to consider my comments.

HMP Norwich

38. In respect of the healthcare delivered at HMP Norwich, where the man spent the last seven months of his life, the clinical reviewer comments that his records note weight loss in August, September October and November 2008. However there is no evidence that it was either investigated or monitored. Unexplained weight loss should be followed up by healthcare staff.

Ongoing unexplained weight loss over a significant period of time should be monitored and investigated.

39. The Clinical Reviewer also comments on the delay of two months between the referral for an urgent urology appointment and the date of that appointment. The reviewer questions whether the referral should have been made within the 'Two Week Wait Pathway' for suspected cancer.

The healthcare manager should review the processes for referring patients to outside hospitals and consider if they should be amended.

40. On 23 January 2009, a palliative care nurse requested a bed with a pressure mattress and a sensor pad for the man who had fallen more than once. Six days later, on 29 January, it was noted that the bed had not yet arrived and the man had fallen again. The bed was provided on 4 February. The reviewer commented that a delay of ten days between the request and the provision of the bed was too long.

The Primary Care Trust should review the procedures for request and provision of vital equipment.

41. An entry in the medical notes on 11 February 2009, recorded 'Would likely have more frequent Oromorph, but difficult given staffing resources and the man being muddled making pain assessment problematic'. The entry in the medical notes indicates the possibility that he should have received more pain medication 'but given staffing resources and the man being muddled making pain assessment problematic'. It appears that a member of staff was sufficiently concerned to mention the possibility of staff shortages.

42. Despite the implications of this statement, I have found no evidence to indicate that the unit experienced ongoing staffing problems and it does not appear that the man suffered unnecessary discomfort. There were many examples of thoughtful and compassionate treatment. On 15 February, staff were authorised to leave the man's cell door unlocked as he needed constant care. This compassionate action allowed nursing staff quick, easy and regular access to deal with the man's needs. As well, the Healthcare Assistant, remained with the man at the

end of his life ensuring he was not alone and enabling him to die with dignity.

43. Nevertheless, ongoing staff shortages could have a considerable impact on the smooth running of the unit and the comfort of seriously ill prisoners. The reviewer queried the implications of this entry and questioned if the man received adequate pain relief and I endorse her recommendation.

The Primary Care Trust should review staffing levels in the palliative care team and consider if they are adequate.

Transfer to HMP Norwich

44. In July 2008, when the man had been refused early release on parole and his appeal was dismissed, Appeal Court judges recommended he be transferred to a specialist unit for elderly prisoners but there are no such specialist units within the prison estate.

45. Prison Service statistics indicate that like the man, about 50 per cent of prisoners in their sixties and 70 per cent of those in their seventies have committed offences of a sexual nature. Consequently several prisons accommodate large numbers of older prisoners in their sex offender units and have developed facilities to manage them. Once a prison has established the necessary facilities, there is a tendency to refer more elderly prisoners there.

46. The man's family were concerned to know why he had been transferred to Norwich rather than to a prison closer to home. Nelson Unit in HMP Norwich was developed as a 'needs-based inpatient health care facility' for elderly life sentenced prisoners for whom early release to the community is not an option. It has since developed to provide palliative care for prisoners of all ages.

47. Although at the time of his transfer, the man's terminal illness had not been diagnosed, he was assessed as having multiple needs requiring a high level of healthcare supervision equitable to that which would be provided in a nursing home. In those circumstances, prison staff decided that the need to ensure the man's comfort and well-being outweighed other considerations such as ease of family visits, and he was referred to Norwich as the most appropriate establishment. It is unfortunate that there were no similar facilities nearer to his family home.

48. The prison population is ageing and the numbers of prisoners who die due to natural causes is rising. The Ombudsman has drawn the implications to the attention of the National Offender Management Service and the Director of Offender Health, and will continue to monitor the position. I hope this clarifies the issue for the family. I am satisfied from the records and the clinical review that the man's needs

were promptly assessed and addressed in the Nelson Unit where he received sympathetic nursing care.

49. In the light of this investigation and the findings of the clinical reviewer, I conclude that the mans' care was almost entirely satisfactory and equivalent to that which he would have received in the community. He had multiple health needs which I believe were met throughout his stay at Norwich.

RECOMMENDATIONS

HMP Norwich and NHS Norfolk

1. Ongoing unexplained weight loss over a significant period of time should be monitored and investigated.

   The new Head of Healthcare at HMP Norwich put monitoring systems in place from October 2009. Staff are required to complete an electronic form with body mass index measurements and provide regular updates. Nutritional assessment is now undertaken on reception for all prisoners.

2. The healthcare manager should review the processes for referring patients to outside hospitals and consider if they should be amended.

   A new process has been put in place to monitor all referrals to acute services to ensure they meet the referral standards. There is a tendering process in place to provide consistent medical care from GP's. The target date for completion is July 2010.

3. The Primary Care Trust should review the procedures for request and provision of vital equipment.

4. The Primary Care Trust should review staffing levels in the palliative care team and consider if they are adequate.