

**Investigation into the circumstances surrounding  
the death of a prisoner  
at HMP Norwich, in December 2006**

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

**September 2007**

This is a sad case of an elderly person who spent the last three years of his life in prison when he could have been a free man.

The man who is the subject of this report, who was a prisoner at HMP Norwich, died at a local hospital in December 2006. The cause of death was recorded as aspirote pneumonia due to underlying cerebrovascular disease.

The man was born abroad, and apparently had a number of children in his country of origin. Sadly, none of his children have been traced. Nevertheless, I offer my sincere sympathy and condolences to all those touched by the man's death for their loss.

The investigation was carried out on my behalf by one of my colleagues. An independent review of the man's medical care in prison was carried out by the Norfolk Primary Care Trust. I am most grateful to the clinical reviewer for her assistance.

I would also like to thank the Governor and staff of Norwich for their full and ready co-operation during the course of the investigation.

The man in question was very ill. He was already in need of 24 hour nursing care when, in September 2003, he was recommended for release on life licence to hospital. However his hospital place collapsed, seemingly due to an argument over who was responsible for providing funding. No further hospital place was found for him and nobody pursued the matter with any energy or conviction

I make three recommendations and highlight two examples of good practice.

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

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**Prisons and Probation Ombudsman**

**September 2007**

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## SUMMARY

The man who is the subject of this report was born and raised abroad, emigrating to the UK in the 1950s when he was in his late 20s. He was sentenced to life imprisonment in 1968, with a tariff of 15 years. The man was released on life licence on two occasions in the 1980s, but returned to prison after a short while on each occasion. He transferred to HMP Norwich in April 2001 following a period of around three years in which his mental and physical health had begun to deteriorate. At the time, he already suffered from dementia and had a history of diabetes, high blood pressure and strokes.

By 2003, the man's mental and physical health had got much worse. He now required staff assistance to move even short distances and needed help with all of his personal care. However, he was still alert on occasions and able to make jokes with staff and fellow prisoners.

On 24 September 2003, the Secretary of State accepted a Parole Board recommendation for the man's release on life licence. A condition attached was that he reside at a hospital in the Midlands, at which he had been accepted earlier in the year. However, the place collapsed in October 2003 due to a disagreement over who was responsible for funding it.

No further place was found for the man, and he spent the last three years of his life in custody at HMP Norwich. Little progress was made in this time to resolve the issue. It was clear that the man needed to be housed in an environment with 24 hour nursing care, although the question of who was responsible for finding and funding such a place was never resolved. Indeed, no one appears to have taken responsibility for the man's future. The impression is that, other than occasional and largely ineffective communication between various agencies in the prison, probation and healthcare services, he was simply forgotten about. Sadly, due to his deteriorating condition, the man did not have the capacity to question why this was.

The man's physical and mental health continued to deteriorate over the years, particularly in 2005 when he became more lethargic and drowsy and less communicative. Nevertheless, the care that he received from healthcare staff at Norwich prison was comprehensive and appropriate. The man's condition stabilised in 2006 until, in late December, he was transferred to hospital when his breathing became very laboured. He did not regain consciousness and died two evenings later. The cause of death was recorded as aspirate pneumonia due to underlying cerebrovascular disease.

This report includes three recommendations and draws attention to two examples of good practice.

## **THE INVESTIGATION PROCESS**

The investigation was opened on 2 January 2007 when my investigator issued notices announcing the investigation to staff and prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners came forward as a result.

My investigator visited HMP Norwich on 26 March 2007. He toured Nelson unit, the specialist older prisoner unit on which the man lived, and met staff who knew and had cared for him. My investigator was given full access to the man's prison files, including his medical record.

An independent clinical review of the man's health needs whilst he was in custody was carried out by the Assistant Director of Quality and Nursing at the Norfolk Primary Care Trust.

One of my family liaison officers contacted a family friend of the man on 10 January 2007, whom the man had nominated as his next of kin. The man's friend did not raise any issues that he wished the investigation to address.

## **HMP NORWICH**

HMP Norwich is located within the city boundaries and holds convicted and remand prisoners, including adults and young offenders. It is designated as a local prison and serves the courts of East Anglia. The certified normal accommodation (the number of prisoners that can be held without overcrowding) is 591 and the prison has an operational capacity (maximum crowded capacity) of 823.

A car park and road divides the prison into two distinct sections. One section of the prison accommodates the young offenders and the healthcare centre. The latter also includes a specialist older prisoner unit (Nelson unit). The remainder of the population is accommodated in the main prison complex.

Nelson unit opened in 2004, and provides specialist nursing home style care for older and infirm prisoners. The unit has been specially designed and equipped to enable older and less able prisoners to live a relatively normal life within the confines of the custodial environment. It is managed by a dedicated team of healthcare workers with support from prison officers. A good approach to working in partnership has been developed between the prison and care providers in the community to ensure that the needs of older people in prison are being met.

Her Majesty's Chief Inspector of Prisons last reported on Norwich in November 2006. Her report found the standard of clinical care on Nelson unit to be good, but that there was little for prisoners there to do. Older prisoners were locked in their cells if there was no prison officer on the wing, a practice that the Chief Inspector felt was "disproportionate to the risk posed".

## KEY EVENTS

The man was convicted of a couple of minor offences in the mid-1960s, for which he was fined. On 30 December 1967, he was remanded to HMP Wandsworth following his arrest for murder. The man was convicted on 25 January 1968, and sentenced to life imprisonment on 12 March with a tariff of 15 years.

The man's first few years in prison were difficult, and he was involved in a number of incidents of violent behaviour. He subsequently seemed to settle into prison life, and was released on licence in May 1983. However, he was recalled to custody following an incident with his neighbour in March 1984, although he was later found not guilty of the charges against him. The man was released on licence for a second time in 1987, and placed in a Probation Hostel (now known as Approved Premises). However, he returned to prison shortly afterwards following a conviction for drink driving.

The man was held in a number of different establishments during his time in custody, mainly in the south and east of the country. He was transferred to an open prison in 1989, but returned to closed conditions after being found in possession of a knife.

The man transferred to Norwich from HMP Highpoint on 14 May 1999, as he was no longer coping well. He had become quite frail and had difficulty moving over long distances. He was also no longer able to care for himself, and had been diagnosed with hypertension (consistently high blood pressure) and diabetes for some time. It was thought that a move to Norwich, where he could be cared for in an inpatient facility, would be beneficial. On arrival at Norwich, it was noted that the man's short term memory was very poor and he was disoriented and unable to recall his age or date of birth. It was also noted that he had had a cerebrovascular accident (CVA, a stroke) that had left him weak on his left side.

On 20 August, the man transferred to HMP Littlehey, where he was admitted to the healthcare centre on arrival. He spent around three weeks on C wing in September, but was re-admitted to the healthcare centre as the wing staff said that they were "unable to cope with him". The man deteriorated physically at Littlehey. He began to experience regular incontinence and became less mobile. Mentally, however, he was quite alert and able to recollect events from his personal history as well as major political events. But as dementia set in, his memory began to decline.

On 3 April 2001, the man returned to Norwich and resided in the healthcare centre. This was as a result of the closure of the inpatient facility at Littlehey and the termination of 24 hour nursing cover at that prison. On 20 June, he was observed to have had a transient ischaemic attack (TIA, an episode similar to a stroke in which the symptoms resolve in the short term, usually within a few hours) and on 28 July it was noted that he had a left-sided droop to his mouth on rising in the morning. On 12 October, he was admitted to a local hospital following another suspected stroke, returning to prison on the same evening.

The man's physical and mental health continued to deteriorate, although he was still noted to be very alert on some occasions. He was sociable with other prisoners at times, and was able to make jokes with staff. His mobility declined, however, and he

now needed staff assistance to move over even the shortest of distances. On 14 August 2002, he was assessed by a Consultant specialising in medicine for the elderly at the local hospital. The Consultant noted that the man now needed three nursing staff to transfer him from his bed to a chair or the toilet. She also noted that he was incontinent and needed help with all personal care, except for brushing his teeth. The man was able to walk occasionally with the help of two male nurses. His diabetes and hypertension were assessed as being well controlled.

Following this assessment an application for compassionate release on medical grounds was made, supported by the Consultant. However, the application was rejected on 6 September as the man did not meet the criteria set out in the Lifer Casework Manual. Specifically, he was not suffering from a terminal illness and his death was not likely to occur imminently.

The man remained settled for the rest of the year. He was often very talkative and interacted well with staff and fellow prisoners. He was able to recall his family and friends in the UK and abroad, although specific dates and places were often beyond his capability. But on 2 January 2003, the man had a suspected TIA. This resulted in left-sided weakness over the next few weeks, and affected his co-ordination considerably. He remained settled for the remainder of the year and, as during the previous autumn, was often noted to be very alert and talkative. However, he would also go through spells in which he would be lethargic and unresponsive to staff.

On 16 June 2003, the man was assessed by a Consultant Psychiatrist at a hospital in the Midlands. The man had been drawn to the attention of a colleague of the Consultant Psychiatrist during a previous visit to assess another prisoner at Norwich. On 18 June, the Operational Manager at the Midlands hospital wrote to the Medical Officer at Norwich to say that the man had been considered suitable for admission to the hospital. This was subject to agreement over funding.

The Consultant Psychiatrist wrote in detail to the Medical Officer on 15 July. His main diagnosis was advanced dementia syndrome. The Consultant Psychiatrist felt that the man would be more appropriately looked after in a hospital environment in order to maintain his mental and physical functions at the highest possible level for the longest possible time. He reiterated that the Midlands hospital was a suitable environment for such care.

On 11 August, the Operational Manager at the Midlands hospital contacted the prison to inform them that she had approached the Middlesex Health Authority to fund the man's placement (as his offence had been committed in their area). She confirmed that a bed was available for the man once his release plan and funding was in place. The Operational Manager telephoned the prison again on 21 August to say that funding was now to be provided by the Norwich Primary Care Trust (PCT). However, ten days later (1 September 2003), a representative of the Norwich PCT contacted the prison to say that they were not responsible for funding. On 3 September, the Operational Manager telephoned again to say that they were now trying to get a London PCT to fund the place (the man was believed to have been living in this borough at the time of his imprisonment in 1967).

On 24 September, the Secretary of State accepted a Parole Board recommendation for the man's release on life licence. An extra condition was added to the terms of the licence that he reside at the Midlands hospital, and must not live elsewhere without obtaining the prior approval of his probation officer. Nevertheless, at this stage the issue of funding had still not been resolved.

On 2 October, the Business Manager at a London NHS Trust, contacted the Midlands hospital. She said that the Trust and the London PCT had taken the view that the man needed general health care rather than forensic services (healthcare services in a secure environment), which would therefore be the responsibility of Norwich PCT.

This email was forwarded to the Norfolk NHS Trust. They responded the following day that the Consultant Psychiatrist had deemed that the man needed more than general healthcare, hence the referral to the Midlands hospital. She went on to say that the London NHS Trust and the London PCT should take it up with the prison if they wished to challenge this. As a result of this disagreement, it was subsequently confirmed in an email from the Operational Manager of the Midlands hospital to the Lifer Unit of the Home Office that the man's placement had collapsed.

Little progress appears to have been made in resolving this issue for the next six months. On 15 March 2004, a Lead Clinician for the London NHS Trust, wrote to the Senior Medical Officer at Norwich. He said that he did not propose to "agree to a funded placement at the Midlands hospital for continuing medical care in a secure environment for a man who has no security care needs". He suggested that the prison request an assessment from their catchment area's old age services, and that funding should be supplied by the local PCT.

In August 2004, the man moved to Nelson unit, the specialist older prisoner unit, when it opened. He appeared to settle in quickly, and remarked that he liked his new cell as it was quieter than his previous location. The man experienced a further TIA in September, following which he experienced occasional difficulty in swallowing.

On 3 February 2005, a case conference was held between a nurse, the Lifer Manager at Norwich, and a probation officer at the prison. It was agreed that the probation officer would contact a lifer probation officer at the town in which the Midlands hospital was located as the starting point for putting together a new release plan.

A probation officer from the area responsible for the Midlands town subsequently contacted the prison probation officer on 14 April, shortly after taking on the case. She argued that it was the role of probation officers at Norwich to arrange accommodation and funding, quoting section 13.18 of the Lifer Manual:

"... if the prison has no immediate resettlement plan, the seconded probation officer will ensure that appropriate arrangements are made, in conjunction with the lifer liaison officer in making these arrangements."

In June 2005, however, the senior probation officer at Norwich contacted the Lifer Unit in the Home Office with regard to this issue. They replied that it was the

responsibility of the home probation area to find a suitable release address for a life sentenced prisoner.

The man's health continued to deteriorate in 2005. He became more lethargic and drowsy, and now spent more and more time in bed. He continued to have difficulty swallowing, and a decision was therefore taken to give him food in a syrupy form. Despite this, his appetite continued to be healthy, although in August he took Ensure, a nutritional supplement drink, for a period of around three weeks.

There was little change to the man's condition through most of 2006. By now his responses to staff were limited to the occasional one word answer or movement of his hand, and he needed complete care in all day to day activities. Despite this, his appetite remained healthy and there were no medical incidents of any significance.

On 4 November 2006, a manager in the Lifer Review and Recall Section of the Home Office, wrote to the Lifer Manager at Norwich. He expressed concern at the amount of time that had passed since the man was accepted for release on life licence. He suggested that the seconded probation officer at Norwich contact his counterpart in the community and try to set up a release plan.

At lunchtime on 25 December 2006, a nurse examined the man after a solid lump was discovered above his groin area. The nurse recorded that his bladder felt as though it was full, although he had been passing urine. She advised staff to monitor the man through the day.

At around 10.15pm, a night nurse attended the man for a routine check. She found that he had vomited, which appeared to be projectile in nature. The man's breathing was very laboured and he was completely unresponsive when spoken to. The night nurse took observations and found that the man's pulse was rapid, although his blood pressure and temperature were within normal limits. She contacted the on call GP who advised that the man should be transferred to hospital by ambulance as soon as possible.

The man arrived at a local hospital at around 12.15am on 26 December. He was escorted by two officers, with no restraints used. At 8.45am, following a review, the escort was reduced to one officer. The man was diagnosed with having had a stroke, having a collapsed lung, and having contracted pneumonia. He did not regain consciousness following his admission to hospital, and died at around 6.45pm on 27 December. The cause of death was recorded as aspirate pneumonia due to underlying cerebrovascular disease.

The man's next of kin was recorded as being one of his friends. As his friend lives in north London, HMP Wormwood Scrubs was contacted and asked to break the news of the man's death. The duty Governor at Wormwood Scrubs subsequently visited the man's friend on the evening of 27 December.

The man was believed to have 15 children, either in his home country or the United Kingdom. The Head of Safer Custody at Norwich spoke to various persons in his home country, but they were unable to trace any of his relatives. It has also been impossible to trace any relatives in the UK. The man's funeral was arranged and

paid for by the prison, and he was buried in a plot of land in a Norwich cemetery that had been purchased by the Governor.

## ISSUES

### ***Quality of care provided at Norwich***

The clinical review, conducted by the Norfolk Primary Care Trust, concludes that the man's "treatment and continuing care needs were met at all stages by the healthcare teams at Norwich". The clinical reviewer goes on to say that the risk assessments and care plans in place were "comprehensive and appropriate" and were regularly reassessed and amended accordingly. She considers that a multi-professional approach was taken to deliver the man's care, including referral to appropriate community based carers. The clinical reviewer concludes that the level of nursing care that the man received was high, and puts this down as an example of good practice.

**The man's medical conditions and dementia meant he had become totally dependent. Whilst at Norwich he received high levels of nursing care in order to meet his needs and die with dignity.**

### ***Release on life licence***

The man's release on life licence was accepted by the Secretary of State on 24 September 2003. At the time, he was expected to take a place at a Midlands hospital. However, the placement collapsed in early October, seemingly as a result of disagreements between healthcare providers over the level of care that the man needed and whose responsibility it was to fund such care.

No further placement was found for the man, and he spent the remainder of his life in prison. This is both sad and disturbing. There are two main issues that need to be addressed: whose responsibility it was to find suitable accommodation once the hospital place collapsed, and which organisation would be responsible for funding such a place.

Until 7 October 2003, the man's home probation area was deemed to be Middlesex. This would appear to be because, despite living in a south London borough prior to his imprisonment, he lived with friends in north London when released on parole in the 1980s. On 7 October 2003, his case was transferred to a Midlands probation area on account of the hospital placement that was found for the man in that region. When this place collapsed, the case should theoretically have been transferred back to Middlesex. This did not happen, although for reasons that are not clear.

In correspondence with Norwich in April 2005, the Midlands probation officer to whom the case was assigned, argued that it was the responsibility of the seconded probation officer at Norwich to find suitable accommodation for the man. However, the section of the Lifer Manual that she quoted in support of this (see page 9 for details) was removed when the relevant chapter was updated in March 2001.

The senior probation officer at Norwich, contacted the Lifer Unit of the Home Office in June 2005. He was told that it was the responsibility of the home probation area to find a suitable release address for a life sentenced prisoner.

In the man's case, it is not clear which area should be taken to be his home area. He was believed to be living in a south London borough prior to his imprisonment in the 1960s. However, an entry in his medical record on 30 September 2003 says that the prison has been informed that the address given in this borough does not exist. When the man was released on parole in the 1980s, he was under the supervision of the then Middlesex Probation Service. However, his only connection to this area appears to be that he lived there with friends for around two months during this period on parole. His case was transferred to a Midlands town in October 2003, although he had no connection whatsoever to this area other than the failed hospital placement.

On top of the difficulty in identifying the man's home probation area, there is the question of the level of expectation placed on the home probation officer to find hospital accommodation. There is no statutory responsibility for the home probation area to find release accommodation. If there was a public protection issue then the home probation area would be expected to find a place in an Approved Premises. However, there were no such issues in this case and such accommodation was clearly not suitable for the man's needs.

My investigator contacted the Assistant Chief Officer at the London Probation Area with responsibility for prisons and resettlement. She said that responsibility depends on where the community connection is. Given the paucity of the man's connection to each area mentioned, it is unlikely that these areas would be willing to take the case forward.

Even if a suitable place were found, it is difficult to imagine that agreement would have been reached with regard to funding. Several bodies were approached with a view to funding the man's place at the Midlands hospital. These included the Middlesex Health Authority, Norwich PCT (now part of Norfolk PCT), a London NHS Trust and a London PCT. None of these organisations agreed to fund the place, for varying reasons.

Over the course of the three years from the placement at the Midlands hospital collapsing until the man's death, very little action appears to have been taken to resolve his situation. There would occasionally be communication between various parties although little, if anything, came from this. The man himself sadly did not have the mental capacity to question why he was still in prison and why nothing was seemingly being done about it. Nor did he have any family or regular visitors to advocate on his behalf.

This case is both complicated and unusual. There do not appear to be any guidelines in place to determine who should take overall responsibility for finding accommodation and funding in a suitable environment for such a prisoner. As such, the impression is that he was forgotten about and allowed to drift through his remaining years as a prisoner rather than as a free man.

**In light of this report, the Department of Health and NOMS should issue clear guidance on where responsibility lies for finding and funding accommodation for prisoners who are accepted for release on licence and are in need of continuing 24 hour nursing care.**

During the course of this investigation, my investigator spoke to the Midlands probation officer to whom the case was assigned. She said that she contacted Norwich on several occasions to request various reports concerning the man, but never received any of them. My investigator interviewed the senior probation officer at Norwich and a probation officer at the prison. Both accepted that the man's case was put on the 'back burner' at the prison and not given the attention that it should have received. They felt that there were several reasons for this:

- the role of Lifer Governor was one that was balanced with other roles and responsibilities
- there was no full time lifer clerk
- Lifer Boards were not held.

In early 2007, a dedicated lifer clerk was appointed at Norwich. Prior to this, the post had been in existence for around one year but was held part time and as an addition to the clerk's other post. Both probation officers that my investigator interviewed at Norwich felt that the introduction of a full-time lifer clerk, with responsibility for arranging Lifer Boards and chasing reports, had made a big difference.

The absence of Lifer Boards (which review each lifer and see how they are progressing) and a lifer clerk meant that there was no system in place at Norwich to drive the man's case forward. Lifer Boards are now held at Norwich.

**The Lifer Manager should ensure that Lifer Boards continue to be held on a regular basis, and that appropriate action is taken to progress each case.**

As a result of his deteriorating condition, the man did not have the capacity to draw attention to his case. The clinical reviewer suggests that the use of an independent advocacy service is explored where a prisoner is unable to or has difficulty in communicating. I endorse this proposal.

**The Governor of HMP Norwich should explore the use and benefits of an advocacy service for older prisoners who require 24 hour nursing care and/or have difficulties in communicating.**

## **RECOMMENDATIONS AND GOOD PRACTICE**

**In light of this report, the Department of Health and NOMS should issue clear guidance on where responsibility lies for finding and funding accommodation for prisoners who are accepted for release on licence and are in need of continuing 24 hour nursing care.**

Partially accepted – There is already published guidance which covers these issues. In summary, where a probation area is responsible for managing an offender it is that area's responsibility to prepare a release plan which would include any referral for an assessment for funding under the care programme approach and/or referral to accommodation agencies. However, it is not the responsibility of the probation area to provide accommodation, merely to facilitate access to providers.

Where there is no home area (ie the offender in NFA) then the offender management responsibility reverts to the area covering the court in which the offender was originally sentenced. Probation Circular 60/2002 makes reference to how responsibility for the preparation of a pre-sentence report for an offender who is NFA is determined. It is in the process of being updated. We will consider whether this update should include any further guidance on where responsibility lies for the management of offenders who are NFA upon sentence.

**The Lifer Manager should ensure that Lifer Boards continue to be held on a regular basis, and that appropriate action is taken to progress each case.**

Accepted – Lifer Sentence Planning Boards are now established and those outstanding will have been completed by end October 2007. Thereafter Boards will continue to take place as a matter of routine. The monthly Lifer Team Meeting will satisfy itself that the Boards and case management remain timely and appropriately progressed, taking forward any remedial managerial action on a monthly basis.

Phase III of Offender Management implementation is expected to include Indeterminate Sentenced Prisoners, and to consolidate case management and boarding arrangements.

**The Governor of HMP Norwich should explore the use and benefits of an advocacy service for older prisoners who require 24 hour nursing care and/or have difficulties in communicating.**

Accepted – In line with the introduction of the Mental Capacity Act, HMP Norwich will be introducing IMCAs (Independent Mental Capacity Advocates) for those who require it.

### ***Good Practice***

**The man's medical conditions and dementia meant he had become totally dependent. Whilst at Norwich he received high levels of nursing care in order to meet his needs and die with dignity.**

Accepted – In recognition of the high level of nursing care given to the man, staff on Nelson Unit at HMP Norwich will be given a commendation by the Governor.

**The Duty Governor of HMP Wormwood Scrubs was asked to break the news to the man's next of kin in person, as they lived near to the prison.**

Accepted – The Governor of Norwich will personally write to the Duty Governor of Wormwood Scrubs thanking him for the professionalism shown.