Investigation into the death of a man at HMP&YOI Norwich on 19 January 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

Final Report:

This is the report of an investigation into the circumstances surrounding the death of a man who died on 19 January 2007 in Nelson Unit (the older prisoners unit) at HMP & YOI Norwich. He had been diagnosed with terminal cancer in May 2006 while at HMP Wayland, and transferred to Norwich on 2 June 2006 so that he could receive 24 hour nursing care. He was aged 70.

I would like to offer my condolences to his wife. Although he had been in poor health for some years and his death was expected, it is nevertheless especially difficult to lose someone when they are in custody. I am pleased that his wife was given the opportunity to be with her husband during his last hours.

The investigation was led by one of my investigators and one of my family liaison officers spoke by telephone with the man's wife.

An independent review into the man's medical care was undertaken by Norfolk Primary Care Trust. I am most grateful to the PCT for their assistance. I am also grateful to the liaison officer, the Head of Healthcare and the staff on Nelson Unit for their co-operation with this investigation. The clinical review makes two recommendations and highlights one area of good practice.

The nature of the population on Nelson Unit means that I investigate a number of deaths from natural causes at HMP Norwich. In common with previous reports, I have been pleased to commend again the high standard of collaborative work which allows prisoners there to die with dignity. I add to the clinical review a further example of good practice of my own.

This version of the report has been anonymised following the inquest into the man's death and will be published on my website.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2007**

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Documents considered but not annexed

Death in custody incident logs completed on 19 January
The man's F2050 core prison record
Custodial documents file
OASys file
Parole Dossier completed May 2006
Parole Dossier started November 2006
MAPPP folder
HMP&YOI Norwich healthcare resuscitation policy
HMP&YOI Norwich healthcare protocol for palliative care
HMP&YOI Norwich healthcare protocol for facilitation of visits to terminally ill prisoners within the elderly prisoners unit
HMP&YOI Norwich healthcare protocol for confirmation of expected death
The Ombudsman's reports into four previous deaths at Norwich
'No problems – old and quiet' a thematic review of older prisoners by HM Chief Inspector of Prisons
PSO 6000 chapter 12: Early release on compassionate grounds

SUMMARY

The man was sentenced to eight years in prison in July 2002. It was his first prison sentence and he was already 65 years old and in poor health. He spent the majority of his sentence in HMP Wayland.

In January 2006, he was diagnosed with cancer of the colon. The next month, he underwent a major operation.

In April 2006, an abdominal scan revealed the cancer had spread to his liver and he was given only months to live. He decided against chemotherapy and was transferred to HMP Norwich on 2 June so that he could receive 24 hour nursing care and specialist palliative care.

His condition deteriorated. He died on 19 January 2007 aged 70 in the elderly prisoners unit (Nelson Unit) in Norwich's healthcare centre. His wife and a close family friend were with him. Although his death was expected, his condition had worsened very rapidly in the 48 hours before he died and it was not considered appropriate to apply for his release on temporary licence (ROTL).

His wife told my family liaison officer that she was very grateful for the help and information she received from staff at Norwich. She thought the staff had been very good to her husband in his last months.

The clinical review found that the man received appropriate care during his time in Norwich. The review makes two recommendations about the application of the Liverpool Care Pathway and the risk assessment of falls. It also highlights good practice in collaborative working between healthcare staff and the specialist palliative care team. I endorse both recommendations and make a further observation about good practice in communicating a decision not to resuscitate the man.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 22 January 2007. Notices were issued to staff and prisoners at Norwich telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The Coroner was contacted and he wrote to my investigator to confirm that no post mortem had been performed. He was satisfied that the man had died from natural causes. The Coroner also sent copies of police statements and a report from a palliative care specialist at Priscilla Bacon Lodge (a centre specialising in palliative care).

2. My investigator visited Norwich on 14 February 2007. She met the Safer Custody Manager and the Head of Healthcare. She was provided with the man's prison record, and copies of the notices, reports and other records associated with his death. She visited Nelson Unit and spoke informally to staff.

3. A clinical review of the man's medical care was commissioned from Norfolk Primary Care Trust (PCT). It was agreed that the review would focus on The man's treatment following his diagnosis with terminal cancer. The clinical review appears as an annex to this report.

4. One of my family liaison officers, contacted the man's wife by telephone. She asked to be informed of the progress of the investigation.

5. The man's wife said she had been allowed to be with her husband when he attended hospital appointments from Wayland and had appreciated this. She also spoke very highly of the staff at Norwich, and said she could not stress enough how good they had been to her and the friend who came to the prison with her. She said that the prison had helped her with a claim for petrol costs, and that she had spoken to the Clinical Manager several times and to a doctor from the palliative care team. The man's wife was grateful to the Head of Healthcare for explaining the visiting order process and helping her to fill one out. She said that the prison had offered to pay the funeral expenses and had arranged for the man's property to be sent by courier to her home. The prison's family liaison officer, had been very helpful and had attended her husband's funeral.

6. The man's wife raised one issue of concern – that her husband had been cold on the occasions he had transferred between the two sites at Norwich. The problem had been resolved when he had borrowed a fleece from another prisoner. My investigator was unable to find a member of staff who remembered the man complaining of being cold. However, she was told that, had the man complained, staff would have made efforts to provide him with suitable clothing.

THE MAN

7. This section has been removed from the anonymised version of the report.

HMP&YOI NORWICH

8. HMP&YOI Norwich is a multi-functional adult prison and young offender institution on two separate but adjacent sites. It is a local prison serving the courts of East Anglia and accepts male prisoners whether convicted or on remand. In total, the prison can accommodate 823 prisoners.

9. The prison's healthcare unit covers two floors. It provides accommodation for 28 prisoners on the upper floor while the lower floor is given over to Nelson Unit, a dedicated unit for older prisoners which opened in 2004. Nelson Unit provides specialist nursing home style care, and has been specially designed and equipped to enable older and less able prisoners to live a relatively normal life within the custodial environment. It is managed by a dedicated team of healthcare workers with support from prison officers. A positive partnership approach has been adopted, enabling local specialist secondary care providers to come into the prison and support the full time staff. As part of this approach, the prison works closely with the palliative care team from Norfolk PCT and staff at Priscilla Bacon Lodge.

10. I have investigated six other deaths from natural causes in Norwich. In each case, I have commended the care offered by the prison's healthcare department and highlighted it as a model of good practice to the rest of the Prison Service.

THE EVENTS LEADING UP TO THE MAN'S DEATH

11. The man did not enjoy good health. He was a non-insulin dependent diabetic and this condition had led him to develop peripheral neuropathy (damage to the peripheral nervous system which causes mobility problems) and cataracts. In addition, he suffered from ulcerative colitis (an inflammation of the lower bowel), anaemia, deep vein thrombosis, pulmonary embolism, asthma, osteoporosis and arthritis. On 29 September 2005, while in Wayland prison, the man was referred to the consultant gastroenterologist at Queen Elizabeth Hospital due to a worsening of his anaemia. He had a colonoscopy on 12 January 2006 which revealed he had cancer of the colon.

12. The man underwent surgery to remove a considerable part of his bowel on 23 February 2006 and returned to Wayland. In April, he returned to the Queen Elizabeth Hospital for an abdominal scan. This revealed multiple secondary tumours in his liver and spleen. His wife was with him at this time and the man was told he had only months to live

13. An application for early release on compassionate grounds appears to have been started at Wayland. The application did not progress because the man had his first Parole Board hearing on 31 May. The Board was aware that he was terminally ill, but the man's release plan was not supported by his supervising probation officer or by the prison probation officer, and the man had not undertaken necessary offence related work. The Board considered that the man had not reduced his risk to others sufficiently and parole was refused.

14. On 2 June, the man attended an out-patient appointment at Queen Elizabeth Hospital. After discussion with the consultant oncologist, the man decided not to go ahead with chemotherapy as he was very frail. He was transferred to Norwich prison immediately after this appointment. The man was first located on the upper floor of the healthcare centre, but moved to the elderly prisoners unit (Nelson Unit) on the lower floor on 19 June. (Nelson Unit is primarily for life sentence prisoners but staff decided, in the light of the man's symptoms, that he should be afforded more privacy. The man was also troubled by prisoners on the upper floor who were smoking which made his nausea worse.)

15. On 15 August, the man was referred to the specialist palliative care team from Norfolk PCT. He was seen the same day by a Macmillan nurse who carried out an initial review and arranged to see him monthly.

16. On 31 August, the man's solicitors wrote to the Governor of Norwich seeking to appeal against the refusal of parole. On 6 September, the parole clerk from the prison replied that there was no appeal against parole decisions but, given that the man's life expectancy was so short, she had forwarded their letter to the Parole Board to ask if his next review (due in July 2007) could be brought forward. A second application to the Parole Board was in the process of being made when the man died. There is no correspondence on the prison file from the Parole Board in response to the solicitor's letter.

17. At his second palliative care review on 11 September, the man raised the issue of where he wanted to die. He said that he would like to die "in a hospice and be free". At this point, his symptoms were not sufficiently severe to warrant transfer to a hospice. He was told that, for the immediate future, he would continue to be cared for on Nelson Unit.

18. The man continued to have monthly palliative care reviews. In December, an extra review was necessitated as the man was suffering from increased nausea and pain. Several changes were made to his medication and he is recorded as being more comfortable and pain free by 31 December. On 5 January 2007, the man fell in his cell and staff were advised to observe him frequently. On 8 January, he had another palliative care review and reported feeling increasingly tired and nauseous. On 10 January, a blood test revealed abnormalities and he was placed on hourly observations during the night. The next day, he was diagnosed with kidney failure.

19. On 12 January, the Head of Healthcare, the Clinical Manager and a locum GP told the man that his prognosis was now very poor. They asked the man whether he wanted to be resuscitated in the event of cardiac or respiratory arrest and he said he would like to be. The man accepted the offer of a blood transfusion and arrangements were made with the palliative care team. The man continued to be observed hourly throughout the night.

20. The man was found lying on the floor of his cell in the early morning of 17 January. His condition had deteriorated further overnight, and an application was made for open door access to his cell so that he could have one to one nursing care. He was checked every 30 minutes and visited by the chaplain. Later the same day, he was seen by a specialist registrar in palliative care. In her letter to the Coroner of 31 January 2007, she said she discussed the options with the man and with healthcare staff. She also spoke to his wife on the telephone. The doctor decided that the man was too ill to be transferred to hospital to undergo tests and treatment for his kidney failure. She decided not to bring up the subject of resuscitation with him because he appeared frightened and overwhelmed and she did not wish to add to his anxiety. She completed a 'Not for Resuscitation' form on the grounds of medical futility.

21. The man continued to deteriorate. On the morning of 19 January, the Head of Healthcare contacted the man's wife who came to the prison with a family friend. The man's wife sat with her husband until 3.30pm when he died.

ISSUES CONSIDERED DURING THE INVESTIGATION

22. The clinical review concluded that all the man's needs in terms of treatment and care were met by the healthcare team at Norwich. The man had regular monthly review meetings with a member of the palliative care team until his condition deteriorated when he received more regular input. His medication was monitored and changed when necessary to try to alleviate his symptoms. When it became obvious that the man had entered the final phase of his terminal illness, permission was granted by the Governor to leave his cell door open to facilitate one to one nursing care. In accordance with the protocol for facilitation of visits to terminally ill prisoners, his wife was given more flexible visiting rights so she could be with her husband during his last day. I note that the Head of Healthcare personally helped the man's wife complete a visiting order on one occasion. Working with terminally ill prisoners is an area in which the Norwich healthcare team do particularly well. I have had cause to praise it in every one of my previous reports into natural cause deaths at the prison. I am happy to do so once again and I endorse the clinical reviewer's note of good practice:

    Good practice: The healthcare team worked collaboratively alongside members of the specialist palliative care team to ensure that the man's care needs were met and that he was allowed to die with dignity with his wife present.

23. The clinical reviewer commented that she had seen limited evidence that the Liverpool Care Pathway (LCP) had been implemented in this case. The LCP for the dying patient has been developed to transfer the hospice model of care into other settings. It is a key recommendation in the NICE guidelines for supportive and palliative care and provides an evidence based framework for end of life care. Its application is stipulated in Norwich's protocol for palliative care. The clinical reviewer found that the documents which related to the care plans implemented in this case were not filed in a particularly structured way. Some of the documentation did not appear to have been completed. I know from my previous investigations into expected deaths at Norwich that the LCP has been successfully implemented and followed by healthcare staff. It is important that this good work is evidenced by proper documentation. I therefore endorse the clinical reviewer's recommendation and expand it slightly:

    I recommend that, within three months of the publication of this report, the Head of Healthcare completes a review of training and practice to ensure that all staff are able to properly document the implementation of the LCP for all patients identified as being in the terminal phase of a disease. Following the review, the implementation of the LCP should be monitored through audit against the protocol for palliative care by the PCT clinical governance team.

24. In accordance with the Norwich healthcare resuscitation policy and the protocol for palliative care, the man was asked whether he wished to be resuscitated in the event of cardiac or respiratory failure. Staff spoke to the man in the week before he died and he said that he would like to be resuscitated. Unfortunately, he deteriorated rapidly in his last days and staff were unable to ask him if his

wishes remained the same and if he wanted to go to hospital for further treatment. Advice was sought from a specialist in palliative care and she made the decision not to transfer the man to hospital and to complete a 'Not for Resuscitation form'. The aim of the Norwich policy is to help prisoners die with dignity and not to resuscitate them when it will only cause them further unnecessary suffering. The decision should normally be taken with the involvement of the dying person. Although the man was not involved in this decision, and although his previous wish had been to be resuscitated, I consider that the actions of staff were appropriate and within the spirit of their guidance to allow people to die with dignity. Once the decision had been taken, a clear note to that effect was written in the healthcare observation book so that staff who would subsequently come on duty would be aware of what to do. The man's wife was contacted personally and told of the decision.

Good practice: The decision not to resuscitate the man was communicated to staff who would come on duty later and the man's wife was informed immediately.

25. The man expressed a wish to die at Priscilla Bacon Lodge on two occasions in September and October 2006. Priscilla Bacon Lodge is a specialist palliative care unit which concentrates on people needing complex palliative care. It is not a hospice. I am satisfied that, on the occasions the man asked to go there, his illness was not at a sufficiently advanced stage to fit the admission criteria. Understandably, the man did not wish to die in prison. His deterioration in the last 48 hours of his life was rapid and staff decided not to put him through the anxiety and disruption of moving him. The Head of Healthcare told my investigator that another consideration for keeping the man at Norwich was that he would continue to be cared for by people with whom he was familiar. I am satisfied that this was both a reasonable and compassionate decision.

26. The clinical reviewer has commented the man had three falls between June 2006 and January 2007. She said she had seen no evidence that a risk assessment had been conducted on the likelihood of falls, or that any preventative measures had been taken after the first to reduce the chance of it happening again. I endorse her recommendation.

Patients deemed at risk of falling should be properly assessed using the PCT falls risk assessment tool. Training for healthcare staff in the use of this tool should be facilitated by the Clinical Governance department and provided by the Moving and Handling Adviser. The team may need to consider further preventative measures such as sensor pads and the use of cot sides.

27. Norwich prison has comprehensive contingency plans for dealing with deaths in custody and clear guidance to staff on what to do in the case of expected deaths. The guidance was followed appropriately. The prison appointed a family liaison officer and financial assistance was offered for the funeral expenses. The man's property was returned to his wife in a sensitive manner.

28. I am pleased that the man's wife was able to speak so highly of the efforts made by all of the staff she came into contact with at Norwich.

RECOMMENDATIONS

1. **I recommend that, within three months of the publication of this report, the Head of Healthcare completes a review of training and practice to ensure that all staff are able to properly document the implementation of the LCP for all patients identified as being in the terminal phase of a disease. Following the review, the implementation of the LCP should be monitored through audit against the protocol for palliative care by the PCT clinical governance team.**

   The Prison Service accepted this recommendation in their response to my draft report. They said that training in the LCP and the Gold Standard Framework was underway. The first training sessions were held on 15 and 22 March 2007.

2. **Patients deemed at risk of falling should be properly assessed using the PCT falls risk assessment tool. Training for healthcare staff in the use of this tool should be facilitated by the Clinical Governance department and provided by the Moving and Handling Adviser. The team may need to consider further preventative measures such as sensor pads and the use of cot sides.**

   The Prison Service accepted this recommendation in response to my draft report. The PCT policy for the use of cot sides was in place but training for assessors was required. A copy of the PCT risk assessment for those at risk of falling had been requested. Clinical Governance and the training department had been asked for dates for training in both areas.

Good practice:

3. **The healthcare team worked collaboratively alongside members of the specialist palliative care team to ensure that the man's care needs were met and that he was allowed to die with dignity with his wife present.**

   The Governor agreed to personally ensure that this good practice was recognised and will make an award to the staff involved.

4. **The decision not to resuscitate the man was communicated to staff who would come on duty later and the man's wife was informed immediately.**

   The Governor agreed to personally thank the healthcare staff involved in the care of the man.