

**Investigation into the circumstances surrounding the
death of a man who was a prisoner at HMP Norwich, who
died at Norfolk and Norwich University Hospital April 2007**

**Prisons and Probation Ombudsman
for England and Wales**

January 2008

This is the report of an investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Norwich. The man died on 11 April 2007 whilst a patient at Norfolk and Norwich University Hospital. The post mortem report says that the man died of pneumonia as a consequence of his oesophageal cancer, heart disease and chronic obstructive pulmonary disease. The man was 78 years of age when he died.

The man had no known next of kin, having spent much of his early years under the care of the National Society for the Prevention of Cruelty to Children. Files indicate that he had a sister but contact with her had been lost in the 1950s or 1960s. He struck up a relationship with a woman whilst on home leave from prison but in 1993 contact with this lady seems to have faltered too.

One of my investigators conducted this investigation. I am grateful to the Norfolk Primary Care Trust who undertook the clinical review into the care and treatment afforded the man whilst he was in prison. I would also like to thank the Governor of HMP Norwich, and his staff for their help and co-operation during the investigation.

As when I have investigated the deaths of other very elderly prisoners, I have asked myself why they were still in custody. I should emphasise that the man received good care from prison staff, and was heavily institutionalised. However, the reviews that were undertaken appear not to have addressed the man's offending risk in a proportionate and timely manner. This may have resulted in him spending longer in custody than was necessary or reasonable to protect the public.

I make five recommendations in my report and note one point of good practice.

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January 2008

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SUMMARY

The man died in April 2007 in the Norfolk and Norwich University Hospital whilst a prisoner at HMP Norwich.

The man was convicted of murder in 1972 and received a life sentence at Liverpool Crown Court. In 1982, he was released on life licence into the care of a probation hostel. However, in 1988 he was found to be in breach of his licence conditions and was recalled to prison. He was held in a number of prisons in the nineteen years after his recall in 1988, and arrived at Norwich in November 2005.

Whilst at Norwich, the man was located on a special unit (the Nelson Unit) for elderly lifer prisoners. The man suffered from many chronic health conditions but during his time on the Nelson Unit he was well looked after by nursing staff.

In November 2006, cancer of the oesophagus was diagnosed. The man was referred to the local palliative care services who worked with the prison healthcare team to give good care to him. The man was too unwell for radical surgery but consideration was given to alternative treatment (endoscopic mucosal resectioning of the tumour) that might have been effective for him.

The man was scheduled for the resectioning early April 2007 but this had to be postponed because there were no beds available at the hospital. The man was admitted to the Norfolk and Norwich Hospital due to his deteriorating condition in early April. He died before he could receive the surgery.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Norwich on 8 May 2007. He was given access to the man's prison records. He visited the Nelson Unit where the man was resident prior to his admission to hospital. He was met there by the Head of Healthcare at Norwich, and spoke informally to several members of staff. Notices of my investigation for staff and prisoners were already on display around the prison. No members of the Prison Officers' Association (POA) or the Independent Monitoring Board (IMB) were present or expressed a wish to see my investigator at this time. The Governor did ask to see my investigator and was keen to ensure My investigator received all the assistance he required, for which I am most grateful.
2. Norfolk Primary Care Trust was asked to undertake a clinical review of the care the man received while in custody. The Head of Clinical Governance and Quality for Norfolk PCT, undertook the review. She was asked to look at the entries in the man's clinical record and their quality. The clinical reviewer was also invited to judge whether the care the man received at HMP Norwich was the same as he could have expected to have received in the community.
3. The man was raised in children's homes and it is not thought he had any contactable next of kin. Certainly his prison record shows no next of kin. My Family Liaison Officers were therefore unable to make their usual contact with family members following the man's death.
4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, a copy of my report will be sent to the Coroner to assist in his enquiries into the man's death.

HMP NORWICH

5. Norwich was first opened in August 1887 on its present site on Mousehold Heath, overlooking the city. It is a multi-functional prison on two separate but adjacent sites holding up to 823 prisoners. The Victorian prison is a local prison serving the needs of the local courts. There is also newer accommodation built on the former barracks that acts as a category C training prison.
6. The Young Offender Institution (YOI) was developed in the mid 1960s. It is on this site that the healthcare inpatient unit is located. The healthcare unit covers two floors, the lower level of which is the Nelson unit (L wing).
7. The Nelson unit opened in 2004 and provides specialist care akin to that in a nursing home. It has been specially designed and equipped to enable older prisoners to live a relatively normal life within a custodial environment. Additionally, there is a medical in-patient unit on the floor above the Nelson unit.
8. The Nelson unit has a dedicated team of healthcare workers and prison officers. There are partnership arrangements in place between primary care and secondary care staff both within and external to the prison. In addition, the prison works closely with palliative care services in Norfolk.
9. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, last reported on Norwich in November 2006. Her report commented on the good standard of clinical care provided on the Nelson unit although she criticised the unit's lack of purposeful activity. Ms Owers' report said that, "There were good local links to palliative and Macmillan nurse teams, and good use had been made of the Liverpool Care Pathway for the dying."

KEY FINDINGS

The man's clinical care

10. The clinical review reports on the man's medical history from the time of his return to prison in 1988. The man developed chronic arthritis to such an extent that HMP Lindholme made him a permanent in-patient in their healthcare unit in 1993. In 1997, the man was transferred to HMP Kingston where he developed further health problems. In 2002, he was diagnosed as having Type II diabetes (controlled by tablets) and in 2004 as suffering from Chronic Obstructive Pulmonary Disease (COPD) which is a breathing difficulty condition. In 2004, the man suffered mild heart attacks and angina. In 2005, he developed mild congestive heart failure (an inability of the heart to perform properly) and dementia. In November 2005, the man was transferred to HMP Norwich because it was felt he required 24 hour medical care. The Nelson unit has the appropriate resources to support patients with chronic and palliative care needs. When the man arrived at Norwich, he did not have a diagnosis of terminal illness but was considered chronically unwell.
11. The man was admitted to the Norfolk and Norwich University Hospital in June 2006 with a chest infection. He was discharged later the same day after treatment. He was again admitted in late October 2006 with symptoms of chest pain and abdominal pain, but was discharged after only a few days with a diagnosis of constipation. He returned to Norwich prison on 25 October but was sent back to the hospital on 26 October due to continued pain and vomiting blood (haematemesis). This was later discovered to be due to an intestinal bleed caused by non-steroidal anti-inflammatory drugs. The man was given a blood transfusion and underwent other investigations before being discharged back to prison on 30 October.
12. On 21 November, the man was seen at an outpatients clinic at Norfolk and Norwich University Hospital. He was given the news that his earlier investigations showed he had cancer of the oesophagus. There was some concern over whether the man understood the diagnosis. When the prison doctor saw the man on 22 November, he commented in the clinical notes that he was still unsure if the man had understood his diagnosis.
13. On 3 January 2007, the man was referred to the palliative care team at Priscilla Bacon Lodge (the local hospice care unit) for community palliative care by Macmillan nurses. A nurse from this team made her initial assessment visit on 5 February 2007. The Macmillan nursing team continued to support the man and the nursing team at Norwich prison throughout the coming months.
14. On 5 January, the man was in severe pain and having breathing difficulties. He was sent to hospital but was returned to prison again the same day. On 6 January, the man again returned to the hospital with the same symptoms. This time he remained in hospital for three days, receiving treatment for pneumonia.
15. On 12 January, the healthcare team at Norwich prison discussed the matter of resuscitation for the man. It was decided that, because the man was being

considered for cancer treatment, he should be resuscitated if the need arose. This was well documented in the clinical notes.

16. On 19 January, the man appeared still to be suffering from pneumonia with shortness of breath, delirium and crepitation sounds at the base of the lungs (a 'crackling' noise heard through a stethoscope). He was readmitted to Norfolk and Norwich University Hospital for treatment.
17. When the man was discharged on 25 January, he remained out of hospital despite generally being in poor health until April 2007. He was suffering from slight confusion due to mild renal failure and shortness of breath caused by mild heart failure and oedematous (swollen) ankles, but was carefully monitored and treated by staff at the prison. However, on the day after he was originally scheduled for a resectioning of his tumour the man was re-admitted to hospital. He was suffering from chest pain, nursing staff could not record his blood pressure, and his pulse was weak.
18. During this last stay in hospital the man was treated for heart arrhythmias and respiratory failure. He was discovered to have a pleural effusion (a build up of fluid between the lung and the chest wall) which was treated by inserting a chest drain. He was also given intravenous antibiotics, physiotherapy, pain relief and sleeping tablets. In short, he was made as comfortable as possible before his death later on in April 2007.

The man's life licence

19. In 1988, the man was returned to prison following the revocation of his life licence.
20. In 1989, the man's prison and probation assessments resulted in a recommendation to the Parole Board that he should be released back into the community with a condition of residency at a hostel under supervision. I have been unable to ascertain what occurred in consequence, if anything.
21. In 1997, when he was 69 years old, the recommendation to the Parole Board was that the man should be sent to an open prison. The aim was to test his resolve to abstain from alcohol, with a view to release into the care of a hostel. For reasons that are not entirely clear from the files, the man never reached open conditions.
22. In 2004, the Parole Board was minded to release the man, providing there was a suitable plan in place for his release. The Board postponed its review until a release plan could be drawn up in conjunction with the man's home probation area.
23. As the man had originally been recalled to prison from around Newcastle, the Prison Service endeavoured to forge links with that area. There followed a two year delay in establishing who would take responsibility and fund the release plans for the man.

ISSUES

24. The clinical review shows that the man was transferred to Norwich with the specific aim of improving the care resources available to him. The Nelson unit provides 24 hour healthcare in an environment designed to support the ongoing needs of patients with chronic conditions. It endeavours to provide an environment where the independence, privacy and dignity of individual patients is respected. According to the clinical review, the man received a mainly good standard of care during his stay at Norwich. I am pleased to note from the clinical review that the healthcare team worked collaboratively alongside members of the Specialist Palliative Care Team and staff at Norfolk and Norwich University Hospital to ensure that the man's complex care needs were met and that he was allowed to die with dignity.
25. There are a couple of exceptions to this good provision of care highlighted by the clinical review. On 5 January 2007, according to the clinical notes, the man continued to shout out in pain throughout the night. It was not until 8.00 am the following morning that staff were able to gain access to his cell. They found him to be 'pale, cold to the touch and not responding to verbal stimuli. Blood pressure was 120/50 [low], pulse 120 and respiratory rate 36 [high indicating he was having difficulty breathing]. Oxygen saturation levels were 77% [again, low].' An ambulance was called and the man was admitted to hospital for the next three days.

The Governor should ensure that processes for out of hours entry to rooms on the Nelson unit allow staff ready access to patients.

26. The clinical review also indicates some difficulties with the Liverpool Care Pathway (LCP), a nursing tool for the management of people in the terminal phase of a condition. It is clear from the review that at the time of the man's deterioration, there was some debate as to whether he had reached a terminal phase. Staff on the unit were also in a transitional period of training and implementation of the LCP model.

Practice within the healthcare team at HMP Norwich should be reviewed and audited by the PCT to ensure it is in line with the Protocol for Palliative Care. The findings of this audit should be reported to the PCT Clinical Governance Group and the Partnership Board.

27. The question of whether the man received equitable care from secondary care services after his diagnosis of cancer is raised by the clinical reviewer. She concludes that the time taken from diagnosis to treatment should have been less than one month. However, the man was scheduled for further treatment in early April 2007. Matters are complicated in that he was assessed as being a high risk for ordinary surgery of his carcinoma. It was thought that an endoscopic mucosal resection of his tumour might be feasible. This latter treatment was not scheduled for some three months.

The Head of Healthcare should discuss with the PCT commissioners waiting times for cancer patients and whether the case of this man demonstrates inequity of service.

28. One final area of concern highlighted by the clinical reviewer was referrals to other health services, such as dieticians and speech and language therapists. The reviewer suggested that referrals to both these services would have been beneficial to the man. In one instance, this referral was never made (the dietician), in the other (speech and language therapy) the referral was made but never followed through. Whilst neither of these omissions would have prevented the man's death, they may well have resulted in improved care for him.

PCT commissioners should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multidisciplinary health team members.

29. The other issue raised by my investigation concerns the very fact that he remained in prison for nineteen years after his recall from life licence. He had no relatives with whom he was in touch and had become institutionalised, but I wonder if more could have been done to secure his release. It is unlikely that being in prison directly contributed to his death but I am far from clear that the protection of the public required that he should have died while still in custody.
30. The clinical review says that a geriatric assessment was carried out in September 2005 as part of the parole process. The additional health problems that this assessment identified showed the man to be suffering from mild congestive heart failure, restricted mobility, night time falls and a degree of confusion and verbal aggression. The recommendation was that a medium secure, all male Elderly Mentally Infirm (EMI) placement with 24 hour care should be found. This indicates the extent to which the man had deteriorated during his time in prison.
31. I am conscious that there is a growing number of elderly prisoners, many convicted of very serious offences but who grow increasingly enfeebled while in prison. This case appears to demonstrate a lack of urgency in securing the man's release on licence and the practical impediments that are encountered. My final recommendation is intended to inject some new thinking into what will become an increasingly common problem.

NOMS should review the number of elderly prisoners and any impediments to their release on licence.

RECOMMENDATIONS

The following recommendations were made in the draft version of the report. The Prison Service's and PCT's responses are included in italics following each recommendation:

The Governor should ensure that processes for out of hours entry to rooms on the Nelson unit allow staff ready access to patients.

Recommendation accepted: There is already in place a night routine for accessing patients on the unit including, for those who are at the end-stage of terminal illness, an 'open-door' policy. It is unclear from records from the night mentioned why/whether access was not gained as procedures allow for the Night Manager to attend as required. Staff will be reminded to access the Night Manager as required in order to deliver care to patients. A Healthcare Notice to staff was issued on 19/11/07.

Practice within the healthcare team at HMP Norwich should be reviewed and audited by the PCT to ensure it is in line with the Protocol for Palliative Care. The findings of this audit should be reported to the PCT Clinical Governance Group and the Partnership Board.

Recommendation accepted: The PCT responded: an audit will be undertaken by the end of the financial year to establish the level of care currently provided against the Protocol for Palliative Care. The Prison Service responded: Further training has already taken place and the Liverpool Care Pathway adapted to the needs of this patient group. The audit process will form part of the overall PCT audit strategy.

The Head of Healthcare should discuss with the PCT commissioners waiting times for cancer patients and whether the case of this man demonstrates inequity of service.

Recommendation accepted: The PCT responded: it is appropriate for a representative of our service to discuss this with the PCT commissioners before the new financial year. The Prison Service responded: To be discussed at the next Prison Health Operational forum by the end of April 2008.

PCT commissioners should ensure there is a robust system in place for appropriate prisoner-patient referrals to other multidisciplinary health team members.

Recommendation accepted: The PCT responded: there will be implemented a robust, auditable referral system to other healthcare providers both within the prison and the PCT. The Prison Service responded: This will form part of the SLA between the Prison and the PCT. The timetable for this is scheduled to be before the end April 2008.

NOMS should review the number of elderly prisoners and any impediments to their release on licence.

Recommendation accepted: Together with the Dept of Health, the Prison Service is looking at all issues surrounding the health and social care of older prisoners. An Older Prisoners Action Group has been set up by the Dept of Health to target the problems identified with meeting the particular needs of older prisoner in the Criminal Justice System. The principle aims of the group are to address the health and social care needs of older prisoners through specific partnership with the Prison Service, stakeholders and other networks. This will be ongoing.

Good Practice

I am pleased to note from the clinical review that the healthcare team worked collaboratively alongside members of the Specialist Palliative Care Team and staff at Norfolk and Norwich University Hospital to ensure that the man's complex care needs were met and that he was allowed to die with dignity.