Investigation into the circumstances surrounding the death of a man at HMP Norwich in May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

The man at the centre of this report died in May 2007 at HMP Norwich, aged 56. A post mortem was not carried out, but the documented cause of death was a brain tumour.

The man had been diagnosed with such a tumour in November 2003. In December 2003, he had surgery to remove it, followed by a course of radiotherapy.

Throughout the remainder of his time in prison, and following his release to an Approved Premises, the man was seen by specialists who monitored his condition. In 2005, whilst at the Approved Premises, he began experiencing more headaches and poor co-ordination. In February 2006, tests showed that there was a recurrence of the tumour. The man was admitted to a specialist neurological care unit, but his behaviour became aggressive and the unit withdrew his bed.

He was subsequently recalled to prison. His care continued there, with good links to his palliative care nurses. Sadly, the man's health continued to deteriorate.

My colleagues and I would like to extend our condolences to the man's family.

This investigation was carried out on my behalf by one of my investigators. A review of the clinical care was carried out by the Head of Clinical Governance, on behalf of Norfolk Primary Care Trust (PCT), and I am grateful for her assistance. I asked the reviewer to look at the care given to the man and ensure that it was comparable to that which he might have received in the community. Both the reviewer and I are satisfied that the man's care was of a good standard, consistent with and, at times, possibly better than, that which he might have received in the community. It is clear that the nursing staff at HMP Norwich and the palliative care team treated the man with decency and sensitivity during his final months.

The clinical reviewer has made two recommendations which I endorse. I have also highlighted three areas of good practice that the Prison Service may wish to share across the prison estate.

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

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SUMMARY

The man in this report received a life sentence for murder in 1986.

In November 2003, staff at HMP Erlestoke noticed that he was unsteady on his feet and appeared disorientated. The man told staff that he was suffering from headaches and he was admitted to the local hospital where tests showed that he had a brain tumour. The man had surgery to remove the tumour in December 2003, followed by a course of radiotherapy.

As part of the conditions of his life licence, he was required to live in a Probation Approved Premises upon his release. He was granted several visits on temporary release to an Approved Premises in Norwich between November 2004 and February 2005, before being released there from prison in March 2005.

His medical condition varied over the following 11 months, but in February 2006 the man told staff that he was suffering from poor co-ordination and more headaches. As a result, he had a computed tomography (CT) scan which showed a significant recurrence of the brain tumour. The man was given various treatment options but initially declined all of them. He was supported by palliative care nurses from a specialist unit in Norwich.

Over the next few months, the man's condition deteriorated further, and in June 2006 he was admitted to Norfolk and Norwich Hospital for a course of chemotherapy. It was evident that the Approved Premises was no longer equipped to meet his health needs, and so when he was discharged from hospital on 3 July he was admitted to a local specialist neurological unit. However, in September 2006, the unit withdrew the man's place because he was abusing a member of staff and distressing other patients. With no follow on management plan or accommodation in place, the probation service recalled him to prison.

He went to HMP Norwich and, after a time in the healthcare unit, was located on the elderly patients' unit which has specialist facilities for prisoners with complex health needs. The palliative care nurses continued their contact with the man in prison. His health declined further and he was eventually bedridden. On 6 May 2007, the man was very unwell throughout the day and that night. At 6.35am the following morning, he died as staff were tending to him. As per his wishes, resuscitation was not attempted.

The clinical review acknowledges that, due to his medical illness and prognosis, the man required a significant level of nursing and medical care. The reviewer has found that the care the man received at Norwich was a co-ordinated multi-disciplinary approach, which was well planned and appropriate for a patient receiving end-of-life care. The reviewer has also credited the healthcare team at Norwich with the man's confidence in the care he received at the prison, choosing this as his preferred place to die.

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INVESTIGATION PROCESS

1. My investigator requested all the relevant documentation including medical records and core prison records. She and another of my investigators visited HMP Norwich during the course of their investigation.

2. Notices to staff and prisoners were displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.

3. Norfolk Primary Care Trust (PCT) was asked to carry out a clinical review and the Head of Clinical Governance, undertook this on their behalf.

4. HM Coroner for Greater Norfolk District was informed of my investigation. A post mortem was not carried out, but HM Coroner kindly provided my office with the official cause of death. He will receive a copy of this report to assist him with the inquest.

5. My investigator also contacted Norwich Probation Service and was given access to the man's probation records.

6. The man's parents are recorded as his next of kin. One of my Family Liaison Officers wrote to them in America to offer the opportunity of involvement in the investigation. Through the prison's Family Liaison Officer the man's parents have responded that they do not have any questions for the investigation, but would like a copy of my report.

HMP NORWICH

7. Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 824, holding remand and sentenced adult men and young offenders. The prison is divided into two sections. One area accommodates young offenders and the healthcare centre

8. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 32 in-patients. On the ground floor of the centre is a specialist elderly patients unit, Nelson unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.

9. Her Majesty's Chief Inspector of Prisons (HMCIP) last inspected HMP Norwich in November 2006. HMCIP recognised the good links with palliative care teams and good use of the Liverpool Care Pathway.

Liverpool Care Pathway

10. The Liverpool Care Pathway (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 for care for a dying patient. It has been developed to transfer the hospice model of care into other settings.

11. There is a multi-disciplinary document which provides an evidence-based framework for end-of-life care. The LCP provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions. Additionally, psychological and spiritual care and family support is included.

Release on licence

12. Prisoners sentenced to life imprisonment may only be released on life licence, which means they are supervised by the Probation Service. There are standard conditions for all licences, which include:

    - Keeping in touch with the probation officer in accordance with any instructions that may be given.
    - Residing at an address approved by the supervising officer.
    - Being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

13. Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person's risk.

Categorisation of prisoners

14. Prisoners are categorised according to their likelihood to attempt to escape and the risk they would pose to others should they do so. The Prison Service defines the categories as follows:

    - Category A – prisoners whose escape would be highly dangerous to the public or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible.

    - Category B – prisoners for who the highest conditions of security are not necessary, but for whom escape must be made very difficult.

    - Category C – prisoners who cannot be trusted in open conditions, but who do not have the resources and will to make a determined escape attempt.

    - Category D – prisoners who can be reasonably trusted in open conditions.

15. A life sentenced prisoner would be expected to progress from either Category A or B to a Category D prison prior to release.

PROBATION APPROVED PREMISES

16. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.

17. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the potentially most difficult and high-risk offenders in the community. They are not principally an accommodation resource.

An Approved Premises in Norwich

18. The Approved Premises where the man resided in Norwich currently has a capacity for 25 residents. The bedrooms are single occupancy. There is a ground floor bedroom for residents with physical disabilities which has its own toilet and shower.

19. Each resident has a dedicated key worker to assist in meeting their specific needs. Key workers hold regular one-to-one meetings with their residents. They also liaise with other agencies and the resident's probation officer to monitor and facilitate as appropriate the resident's reintegration back into the community and to address specific needs.

20. The Approved Premises is staffed 24 hours a day. There is a minimum requirement for two staff to be on duty at all times.

21. Residents' medication is securely stored within the office. It is handed to residents by staff according to the medication instructions. Each resident has a drug dispensing chart which a member of staff signs when the medication is dispensed. The Approved Premises has a contract with a local general practitioner (GP) to whom all residents have access. They also have links to specialist services when necessary.

KEY FINDINGS

22. The man at the centre of this report was sentenced to life imprisonment in June 1986 at Exeter Crown Court. During the first years of his sentence, he moved through several prisons as is normal practice. However, he did not engage in programmes to address his violent behaviour, and so the Parole Board did not deem that his risk of reoffending had sufficiently reduced to recommend his transfer to open conditions and subsequent release.

23. During the course of the man's progression through his sentence, he transferred to two Category C prisons, but did not settle at either, and returned to Category B conditions. In October 2000, the man transferred to another Category C prison, HMP Erlestoke.

24. In 2001, papers prepared for the man's lifer file show that he had been engaging well in the prison system. He was undertaking one to one sessions with psychology and probation staff. The man began to interact more with other prisoners and staff, which was a necessary step towards social re-integration in the community. He was also undertaking a psychology degree with the Open University. Staff felt that a combination of maturity, albeit within prison, and a long period without drugs and alcohol had led to this positive change.

25. However, in November 2003 staff noticed a change in the man's behaviour. He became unsteady, disorientated and experienced headaches. He was admitted to the local Accident and Emergency (A&E) unit and, after having a magnetic resonance imaging (MRI) scan, was diagnosed with a right sided brain tumour.

26. On 1 December 2003, the man underwent surgery to have the tumour removed at a hospital in Bristol, followed by a course of radiotherapy. Because there is only part time healthcare at Erlestoke, the man was temporarily transferred to HMP Bristol where they have 24 hour healthcare and where he was nearer the hospital for his radiotherapy treatment.

27. He returned to Erlestoke at the beginning of March 2004. On 19 March, a multi-disciplinary case conference took place. The meeting noted the man's diagnosis and treatment and set out a support plan for him. This included moving him to a unit where he knew prisoners so he would have peer support, and meetings with healthcare to discuss outstanding hospital appointments and further treatment options. The plan also included arrangements to keep his personal officer informed of the ongoing situation so that he could support and advise the man. The staff at the meeting wanted to ensure that the man had a support plan in place before being transferred to a Category D prison. However, until his prognosis was clear, the identified prisons would not accept him as they did not have the necessary healthcare services.

28. The consultant oncologist saw the man on 16 June 2004, three months after he completed the course of radiotherapy. A further MRI scan showed evidence of enhancement of the tumour which might have been as a result of

the recent surgery or signs of early recurrence. The oncologist was unable to come to a definite conclusion and recommended a repeat scan in two months when, if necessary, chemotherapy could be offered. The scan was repeated in August and the tumour showed no worsening. In fact, it showed a slight improvement so no further treatment was deemed necessary.

29. Lifer progress reports were prepared in August, and concentrated primarily on the man's release plans. The reports considered that he should be released, when appropriate, to a Probation Approved Premises. Although the man had not yet moved to Category D open conditions, this was because his health required him to be in a prison with 24 hour healthcare. It was also important that the man had people around him who could monitor his behaviour. The reports noted that there had been occasions when the man had been unsteady on his feet or had put his clothes on incorrectly and not noticed.

30. The downside of the plan was that he would not have the gradual re-integration into the community that open conditions allow for. The general recommendation was that he should remain at Erlestoke as a Category D prisoner and be released on temporary licence (ROTL) to attend an allocated Approved Premises. This would stage his return to the community and also provide an opportunity to monitor his responses and behaviour. The man's probation officer at the time contacted Norfolk Probation Area (although it is not clear why Norfolk was approached). They agreed in principle to accept the man as long as his supervision was transferred to the Norfolk Probation Area. They also requested a period of three months' home leave on temporary licence to enable the man to get used to hostel conditions and for the staff to get to know him.

31. A visit to the Approved Premises on temporary release was arranged for 10 - 12 November 2004. From subsequent letters between the man and the hostel manager, it appears that the visit was successful. Three further successful home visits to the hostel took place between December 2004 and February 2005. On 1 March 2005, the Parole Board wrote to the man notifying him that he was eligible for release to the hostel when a space was free. Two weeks later a space became available, and the man was released on life licence to the Approved Premises on 14 March.

32. The probation records show that the man spent the next two months trying to settle back into the community. He visited libraries and resource centres, and attended his probation supervision sessions with no problems. Due to his illness, the man was unable to take on full time employment or education. However, he did want to use the qualifications he gained in prison and to learn how to use the internet.

33. The man also continued to see his doctor and specialists regarding his health. There is conflicting evidence about the exact state of the man's health, and this caused him some anxiety as he wanted to know what his life expectancy was. However, one record suggests that, after an MRI scan in May 2005, there was no indication that the tumour was growing back.

34. In June, the man started experiencing headaches again, although he said that they felt different to those he had experienced when he had his tumour. Despite previously wanting to know his prognosis, he was apprehensive about seeing his doctor, fearing it would lead to more tests. By July, his headaches had become more severe but he shrugged this off as a virus going around or a change in his medication. Although the staff at the Approved Premises are not medically qualified, they continued to monitor him. In August, the man was reporting constant headaches but still did not feel ready to see the doctor.

35. The probation records show that the man made an appointment with a psychiatrist to discuss medication for cognitive impairment. The appointment took place in December 2005, and the psychiatrist recommended cognitive behavioural therapy (a course which aims to tackle the way people think about matters) rather than medication. The man went to see his doctor, who also declined to prescribe additional medication, but offered stronger painkillers for his headaches.

36. On 8 February 2006, the man told hostel staff that he had a headache and was suffering from poor co-ordination. His doctor was contacted and he was prescribed additional medication. The doctor also requested that the man's oncology appointment be brought forward from April. The hostel key worker noted the following day that the man had displayed signs of paranoia, accusing the key worker of withholding medication and demanding a call to his solicitor. He later apologised for the outburst.

37. The oncology appointment was brought forward to 17 February and he attended with his probation officer. The doctor concluded that the man would need a CT scan to clarify the situation, but his assessment was that the tumour was growing back. The scan took place on 22 February, and when the man returned to see the doctor two days later he was told that there was a significant recurrence of the brain tumour. Treatment options were discussed, but the man declined anything other than his current medication.

38. Over the next three months, his health deteriorated further. He experienced dizziness, drowsiness, headaches and slurred speech. On several occasions hostel staff found him asleep in the communal areas or in a disorientated state, at times losing his balance and falling over. The staff had cause to contact the out-of-hours doctors to attend to the man more than once. However, the man was still not ready to accept further treatment.

39. At an oncology appointment on 13 June 2006, again accompanied by his probation officer, the man was told that surgery and/or radiotherapy were no longer an option due to the size and location of the tumour. He was given the option of commencing chemotherapy but declined.

40. The man's health deteriorated further over the next two days and he was admitted to Norfolk and Norwich Hospital on 15 June. His probation officer visited him in hospital and they both agreed that the hostel could not meet his medical needs or provide appropriate support. The man spoke about

returning to prison, and his probation officer advised him not to reoffend to get recalled.

41. The records do not make it clear why the man changed his mind about accepting treatment, but on 22 June he started another course of chemotherapy. He remained in hospital until 3 July, when he was transferred to a local neurological unit. The original arrangement was that he would stay at the unit for a few weeks. There is no record of any plans for his future accommodation or an explanation of why he remained longer than planned.

42. On 24 July, the man's probation officer received a telephone call from his solicitor. The solicitor had received a letter from the man in which he requested that his licence be revoked so he could be recalled to prison. The solicitor was of the opinion that the request was due to his client's deteriorating health, and his desire to return to a familiar environment.

43. The man's probation officer telephoned him at the neurological unit later that day. In her contact record she noted that the man appeared confused. He was saying that the staff had withheld his 5.00pm medication, and she had had to explain that it was only 4.20pm and he would receive his medication with his dinner. The man went on to say that he had contacted his solicitor and the Home Office to request that his licence be revoked. He had heard that HMP Norwich had a specialist unit for dying prisoners. His probation officer explained that Norwich had a medical unit and specialist unit for elderly prisoners, but not necessarily those who were dying. She said that the man then became quite defensive with her.

44. Two days later, the Assistant Chief Officer (ACO) in the Norfolk Probation Area, received a telephone call from the Home Office lifer unit. They had received two letters from the man saying that he could not cope with his condition. The lifer unit wanted to know if his inability to cope would increase the risk of offending in order to be recalled. The following day, the man's probation officer discussed the issue with him again. He was adamant that he would not reoffend and said that he had been 'homesick' (referring to prison). He told his probation officer that he was settling into the neurological unit because it was like an 'institution', something his records show he was most comfortable with.

45. There are not many entries in the probation contact record for August 2006, but one entry shows that the man had had an aggressive outburst at his probation officer. She noted that he had been very agitated and defensive that day and would not understand that the nurses administering his medication were following the doctors' orders and were not withholding his treatments. The man became aggressive and threatening, but soon calmed down and asked the probation officer to take him to the coffee shop. It is clear from the other entries that the man was also becoming aggressive towards a nurse at the neurological unit. This was reported to the Home Office lifer unit.

46. On 6 September, the lifer unit contacted the ACO again. They wanted to know if the aggressive behaviour was linked to the man's tumour. They were reluctant to recall him to prison on the basis of medically induced behaviour and queried whether he could be separated from the member of staff he had been aggressive towards. The ACO explained that, regardless of the cause of the behaviour, if it was deemed as a sufficient risk then consideration would have to be given to recalling him to prison.

47. The same day, the man followed a female member of staff at the unit and verbally abused her. He was also swearing at staff and patients and grinding his teeth. This was understandably causing concern for the other patients. The unit staff were concerned because the man would usually calm down quickly after any outburst, but on this occasion he had not.

48. Due to the concerns raised by the manager at the unit, two Senior Probation Officers (SPO) agreed to go and see the man. Prior to this, they contacted various agencies involved with him to look at appropriate alternative interventions, including mental health services.

49. One of the SPOs spoke to a probation colleague at HMP Norwich who was by chance with one of the prison governors. He queried whether the man could be accommodated in the elderly patients unit. The response was that, although he did not fit the age criteria, he could be assessed if necessary as the unit would be able to deal with his personal care.

50. That SPO and a colleague, also an SPO, went to the neurological unit to see the man. When they arrived, the manager told them that the man had calmed down when he was told they would be visiting. The officers saw the man and discussed how his behaviour was causing concern. The man said he did not know how he was causing problems, and that he had been calm and reading all day. He then changed his mind and said 'they would have to learn to cope with it'. The probation staff told him of the risk of recall if his placement became untenable. He was reportedly neutral about this and said he would 'go quietly' if recalled.

51. They also discussed the man's letters to the Home Office lifer unit requesting recall. The man then alternated between saying he liked the environment of the unit to saying that he 'hated' it and wanted to be in custody. He appeared able to change his behaviour with different individuals and situations. It was difficult to attribute his behaviour solely to his medical condition or medication. The probation staff gave him a verbal warning and told the unit manager that they wanted to monitor his behaviour overnight and review the situation in the morning.

52. However, the unit manager was not prepared to accept this course of action due to the perceived risk and distress to other staff and residents. The neurological unit has reduced staffing levels at night and they did not want to take any risks. The senior probation officers told the manager that, on their observed behaviour of the man, unless there was a further incident they did

not have sufficient grounds to recall him to prison. The unit manager then took the decision to withdraw the man's place with immediate effect.

53. One of the SPOs spoke to the man's social worker and her manager. With no suitable move on arrangements in place for him, no effective risk management plan was in place. Because he would have been of no fixed abode and therefore presenting a heightened risk, the Probation Service had to request that the man's licence be revoked.

54. He was taken to HMP Norwich and accommodated in their healthcare unit. His medical care continued at the prison. Links were maintained with his palliative care nurses who continued to visit him in the prison. The nurses contributed to the records in the man's medical file and these show that his health continued to deteriorate.

55. Although the man asked to appeal against his recall to prison, the records show that he felt he was in the best place at Norwich. This is confirmed by the palliative care team who had discussed his preferred place of care with him. His appeal was heard, but re-release was refused. The response from the Parole Board refers to his wish to stay in prison, and thus it is clear that he was in fact content to be there.

56. Over the next four months, the man's condition deteriorated further and he was moved to the specialist elderly patient unit within the prison. He was not able to see out of his left eye and frequently struggled with mobility. There are many documented occasions when he was found to have fallen from his chair or bed or when he was trying to move around his cell. He became unable to keep his cell tidy and staff often arranged for it to be cleaned so that there were fewer hazards. They also arranged to purchase slippers that would reduce his risk of falling. As his mobility reduced, arrangements were made to move the man's furniture to make the cell safer and for specialist equipment to be brought in. This included a mobile commode, use of a wheelchair and a hoist to help him into his chair and bed.

57. On 29 March 2007, the man saw his palliative consultant. The prison records show that the consultant told the man that there was no further treatment possible for his illness. She also discussed the issue of resuscitation, although felt it would be unsuccessful due to the severity of his condition. The man gave his permission for doctors to withhold resuscitation. The appropriate form was completed by the consultant and witnessed by two other members of staff. The man kept a copy and another was retained in his file. He was reassured that all other symptoms would be treated and he would continue to be cared for by prison medical staff and the palliative care nurses.

58. Over the following few weeks, the man's condition varied. At times he was confused and unable to attend to his personal care. At other times he was settled and more mobile.

59. The clinical reviewer found that, from 22 April 2007 onwards, entries in the man's care plans and records became more regular, which she felt

demonstrated that care requirements were increasing to meet his needs. On 23 April, the man had a tense abdomen and full bladder that was causing incontinence. A catheter was inserted later in the day. The following day an air mattress was supplied to help alleviate his pain in pressure areas.

60. A friend of the man's visited him on 24 April 2007. For his ease, the prison arranged for the visit to take place in his cell on the unit. The prison also arranged for him to telephone his father in America. The Head of Healthcare telephoned the man's father and explained the seriousness of his son's health. The man's friend visited on two more occasions that week and, as previously, the visits took place in his cell.

61. When the palliative care nurse visited on 26 April, she noted that the man's condition was still deteriorating. He was experiencing more headaches, reduced mobility and incontinence. The nurse noted that his condition varied and he had been alert and had spoken about his condition and current situation. The nurse discussed his preferred place of care again and noted that the man felt that prison was the best place for him. However, he did want to consider the option of moving to a care home in the future to be nearer his friend.

62. The records show that, by 28 April, the man had become bedbound but was sleeping without medication, and eating and drinking well. He had another visit from his friend, again in his cell, but under the supervision of staff.

63. On 4 May, the prison's lifer officer received a letter from the man's solicitors. The letter requested an update on the man's condition so that they could apply for his release on compassionate grounds as his condition deteriorated. (A reply was not sent until a month later, following the man's death.)

64. Over the weekend of 5 and 6 May, the man needed diamorphine medication. This is a controlled drug and stored under strict conditions. Although it is kept in stock in the prison pharmacy, legally it can only be accessed by a pharmacist. As the pharmacist was not on duty, the Head of Healthcare took the prescription to a specialist registrar at a local palliative care unit and then to the local hospital to be dispensed.

65. The man's condition remained poor and, on the evening of the 6 May, it was noted that he had deteriorated considerably over the previous 24 hours. The Head of Healthcare contacted the man's friend, who was able to visit him in his cell that evening. During the night, the man began to vomit and was incontinent, and it was agreed that his door would remain unlocked so that staff would be able to monitor him more easily and regularly.

66. Staff continued to monitor and tend to the man through the night. During a check at 6.25am the following morning (7 May), the healthcare assistant noticed that he had vomited again. When staff rolled him onto his side he continued to cough fluid. The healthcare assistant had just left the cell to call the Head of Healthcare for advice when another nurse called her back. The

man was no longer breathing. In accordance with his decision about resuscitation, no attempt was made to revive him.

67. The Head of Healthcare arrived at the prison at 7.15am and went straight to the man's cell. She pronounced his death at 7.20am and then contacted his friend and invited her to come into the prison to say goodbye to him.

68. The man's friend subsequently wrote to the Governor thanking him for allowing the visits and for the care and compassion staff gave to the man.

ISSUES

Clinical care in prison

69. The clinical reviews I commission as part of my investigations look at the care and treatment a prisoner receives in prison, ensuring that it is appropriate and comparable to that which is available in the community. In this case, the clinical reviewer has found that the nursing care and intervention the man received from the healthcare staff at HMP Norwich was of a consistently good standard.

70. Appropriate links were maintained with specialist and palliative care services. Care was delivered through the Liverpool Care Pathway as part of the Gold Standard Framework for End of Life Care.

71. It is clear from the prison medical records and entries made by the palliative care services that the man was treated with dignity and sensitivity and was in his preferred place of care.

Out-of-hours medication

72. There was one occasion, just before the man passed away, when healthcare staff were unable to get medication from the prison pharmacy. The Head of Healthcare took it upon herself to collect a prescription and have it dispensed from the local hospital so that it was available to the man. I commend the Head of Healthcare for her actions, but the clinical reviewer describes the arrangement as complex, and says that it involved considerable co-ordination to gain the necessary permissions and access to an out-of-hours pharmacy. There was inevitably some delay in the man receiving his medication.

73. Because of the rules governing controlled drugs, the clinical reviewer says prison should have a procedure to ensure that there are no avoidable delays for prisoners requiring end-of-life care and medication to relieve their pain.

    HMP Norwich healthcare service and Norfolk PCT should review the local systems in place for accessing out-of-hours medication for prisoners who are receiving end-of-life care, to ensure that the risk of delay in obtaining and administrating pain relief medication is reduced.

Correspondence

74. The clinical reviewer has highlighted a month's delay in responding to the letter from the man's solicitors that was received by the prison on Friday 4 May. The letter was not received directly by healthcare and would therefore not have been actioned until Monday 7 May at the earliest.

75. I am satisfied in this case that the man was happy to remain in prison to receive his care. I am also satisfied that the process for compassionate release would not have been started before he passed away, so the delay in responding made no material difference. However, I endorse the clinical

reviewer's recommendation that any similar requests on behalf of terminally ill prisoners should be dealt with promptly.

The Healthcare Manager should consider putting in place a process for responding to urgent requests made on behalf of prisoners receiving end-of-life care.

RECOMMENDATIONS

1. HMP Norwich healthcare service and Norfolk PCT should review the local systems in place for accessing out-of-hours medication for prisoners who are receiving end-of-life care, to ensure that the risk of delay in obtaining and administrating pain relief medication is reduced.

   HMP Norwich have partially accepted this recommendation. They have responded that under predicted circumstances, medication is available as needed. The man however, deteriorated rapidly over a short period of time.

2. The Healthcare Manager should consider putting in place a process for responding to urgent requests made on behalf of prisoners receiving end-of- life care.

   HMP Norwich have accepted this recommendation. A system has been put in place to highlight correspondence requiring urgent responses.

GOOD PRACTICE

Visits in cell

3. As his condition deteriorated, the man was allowed to see his friend in his cell on the healthcare unit. This showed decency and compassion. Security implications permitting, this is a practice that the Prison Service may wish to share across the prison estate.

Open door

4. The night before the man died, staff were authorised to leave his cell door unlocked. This allowed nursing staff quick, easy and regular access to deal with his needs. Whilst again I am mindful of security risks, this is good practice that the Prison Service may wish to share.

Specialist links

5. Prison healthcare staff maintained good links with the man's palliative care nurses. This resulted in good continuity of care and a multi-disciplinary approach to the man's care and support. This is also a practice that should be shared across the prison estate.