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

Report by the Prisons and Probation Ombudsman for England and Wales

May 2008

This is the report of an investigation into the death of a man at HMP Norwich in July 2007. The man died of natural causes two weeks after transferring there from HMP Leyhill. He was 78 years old.

The man had a history of serious ill-health. In 1974, he was diagnosed with cancer of the bladder. More recently he had been treated for chronic obstructive pulmonary disease, heart disease and ventricular tachycardia (irregular heartbeats), and a recurrence of bladder cancer. In the month before he died, he was diagnosed with untreatable lung cancer.

Fatal incident investigations conducted by my office attempt, as far as possible, to address the concerns of family members and anyone to whom the person who died was close. Sadly, this man had lost contact with his remaining family over the course his lengthy prison sentence and it has not been possible to trace any next of kin.

The investigation was undertaken on my behalf by two of my investigators. I would like to thank the Governors and liaison officers at both Norwich and Leyhill for the help my investigators received. A representative of Norfolk Primary Care Trust carried out a review of the care the man received throughout his time in custody, and I also thank her for her invaluable contribution.

It is clear that the man had battled for some time with deteriorating health. Leyhill was not able to offer him inpatient care but did their best to care for him. He was afforded good multi-disciplinary support to address his needs. I was also pleased to find that at Norwich, in the weeks before he died, the man was evidently cared for with dignity and compassion. He was given the chance to contribute to the care plan devised to make his last days comfortable, and his wishes were respected. This reflects extremely well on the staff at Norwich and those working on the Nelson Unit in particular.

I make no formal recommendations, but highlight one housekeeping point and five areas of good practice.

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Prisons and Probation Ombudsman
May 2008

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SUMMARY

The man was sentenced to life imprisonment in February 1970. He had poor health during most of his sentence and was treated for various illnesses. During the 37 years the man was in prison, he moved through several establishments. He was transferred to open conditions in 2003 and arrived at HMP Leyhill on 26 March 2003.

In April 2003, the man was diagnosed with chronic obstructive pulmonary disease, a condition that makes breathing difficult. He was also diagnosed with heart disease and rapid, irregular heartbeats. He took a number of medications to control his symptoms.

In the first 15 months he spent at Leyhill, the man was found collapsed on the floor 30 times. After each incident he was checked by healthcare staff and, on a number of occasions, he was sent to hospital for further examination. Despite his various medical conditions, none was thought to be related to the falls and staff suspected it was a behavioural problem. He continued to fall right up until his death.

On 17 March 2007, the man collapsed again. He was seen by healthcare staff who carried out an assessment. During the assessment, a quantity of his medication was found concealed in a box of washing powder in his room. He explained that he had stopped taking it because he did not think it was working. He was therefore admitted to hospital as a precautionary measure. The prison also opened an Assessment, Care in Custody and Teamwork (ACCT) document, a form used to monitor and support prisoners who are considered to be at risk of serious self-harm or suicide. This was closed later that day when it was established that the man was not trying intentionally to hurt himself by not taking his medication.

The man remained in hospital for three days. Soon after returning to Leyhill, he collapsed again on 29 March. He was taken to hospital and admitted, being discharged two days later. Once again an ACCT form was opened in order to monitor his compliance with his medication. This was closed on 5 April 2007 when a new system of monitoring the man's behaviour, a multi-disciplinary care plan, was introduced.

On 17 June, the man complained that he was experiencing pains in his chest and numbness in his left arm. He was examined, taken to Southmead Hospital and admitted. He was subsequently diagnosed with lung cancer which the consultant considered untreatable. He was discharged nearly a month later, on 12 July, and transferred to the Nelson Unit at HMP Norwich for specialist palliative care. His health slowly deteriorated over the next two weeks and he died during the afternoon of 25 July 2007.

Despite the best efforts of prison staff, it was not possible to contact an appropriate next of kin to inform them. The man's funeral took place three weeks later and was attended by a number of staff from Norwich.

THE INVESTIGATION PROCESS

1. One of my investigators opened the investigation into the man's death on 29 August 2007 at HMP Norwich. He met the Safer Custody Manager, who provided the man's prison records. (The investigation was continued by another of my investigators after the first investigator completed his secondment with my office.)

2. Prior to the first investigator visiting Norwich, notices were issued to staff and prisoners announcing the investigation and inviting anyone who had information relevant to the man's death to make themself known to the investigator. No one came forward. Having assessed the man's documentation and spoken informally to the Safer Custody Manager, my first investigator decided it was not necessary to interview staff at the prison formally.

3. My first investigator also contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries.

4. After receiving the clinical review, my second investigator visited HMP Leyhill. She had the opportunity to look at more evidence and speak to several members of staff and a fellow prisoner who had regular contact with the man. She also visited the areas where the man lived and spent time.

HMP LEYHILL

4. Leyhill is an open prison for adult males in Gloucestershire. It has an operational capacity of 512 comprising a mixture of life and determinate-sentenced prisoners. Leyhill has had several refurbishments, and in 1986 prisoners were moved from the original accommodation into new units providing single room accommodation.

5. Leyhill does not have 24 hour healthcare or inpatient facilities. However, there is a disabled persons unit, which is more suited to those with disability needs. For instance, there is better wheelchair access, beds that can be lowered or raised, audible alarm systems and disability liaison officers. It is situated for easy access to the dining hall and other communal areas. There is a day care centre at Leyhill, primarily for elderly and less able prisoners. It is supervised by healthcare assistants and affords prisoners time out of their cells to interact with others and keep mobile.

6. Her Majesty's Chief Inspector of Prisons (HMCIP), last inspected Leyhill in March 2007. In her subsequent report, the Chief Inspector praised the day care centre. She also noted that a healthcare operational support grade was responsible for booking external NHS appointments, and had established excellent relationships with the local providers ensuring that every effort was made for prisoners to attend appointments.

HMP NORWICH

7. Norwich is a multi-function prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 557, 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 23 inpatients. On the ground floor of the centre is a specialist elderly patients unit, the Nelson Unit. The Nelson Unit opened in 2004 and has been designed and equipped to enable older and less able prisoners to live a relatively normal life within a custodial environment. A dedicated team of healthcare workers and prison officers work on the unit. There are partnership arrangements in place between primary care and secondary care staff both within and externally to the prison. In addition, the prison works closely with palliative care services within Norfolk.

9. The Chief Inspector last reported on Norwich in November 2006. Her report commented on the good standard of clinical care provided on the Nelson Unit, albeit that it criticised the lack of purposeful activity. The Chief Inspector's report said, "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

10. On 3 February 1970, the man was found guilty of two very serious offences at Lincoln City Assize and sentenced to life imprisonment.

11. In 1974, he was diagnosed with cancer of the bladder, which was treated successfully.

12. Between 1970 and 2003, the man secured progressive moves to and between category C establishments. In March 2003, his security category was downgraded and he was transferred to open conditions. He arrived at HMP Leyhill on 26 March 2003 and three days later was admitted to hospital. A chest x-ray was arranged although there is no evidence that it was followed up.

13. During his first 15 months at Leyhill, the man was found collapsed on his residential unit on 30 separate occasions. Each time he was seen by a nurse, and he was sent to hospital for further assessment on numerous occasions. No physical cause for the collapses was identified and no injuries related to a fall were observed. As none of the collapses was witnessed by either staff or prisoners, some medical professionals involved in his care speculated that the man deliberately put himself on the floor in order to draw attention. Incidences of him collapsing and being transferred to hospital for assessment and treatment continued until his death.

14. Whilst no direct cause for his collapses was identified, the man was diagnosed with chronic obstructive pulmonary disease (COPD) in April 2003. This condition makes breathing extremely difficult and painful, and seriously impacts on the affected person's quality of life. The man was also diagnosed with ischaemic heart disease and a fast heart rhythm. These conditions have less of an impact on a day-to-day basis, but can prove fatal if not managed properly.

15. The man took a combination of prescribed medications to treat these conditions. He kept the medicines in his own possession. In April 2003, a report for the Parole Board indicated that the man had been warned about not taking his medication and a blister pack was provided for him.

16. The man was taken from Leyhill and admitted, as an inpatient, to the healthcare unit at HMP Bristol for a week in May 2003. Whilst he was there, he complied with his medication and there were no occasions when he collapsed.

17. In July 2004, the head of Leyhill's healthcare unit wrote to the prison's lifer governor asking for the man to be transferred to a prison with 24 hour nursing care. The request was made because he continued to collapse, occasionally refused to eat, and did not comply with his medication regime. Some seven months later an application dated 12 December was completed, requesting a move to Norwich. However

there is no other reference to the application, and it does not appear to have been followed up.

18. The man was diagnosed in July 2005 with a tumour in his bladder and was operated upon. In September that year, his name was put on the waiting list for further surgery. He was admitted as an emergency patient in October 2005 because of symptoms of anaemia. The bladder surgery was twice postponed and eventually he was assessed to be unfit for surgery.

19. On 28 September 2006, the man complained to prison staff at Leyhill that he was experiencing chest pains. He was taken to the Accident and Emergency (A&E) Department of Frenchay Hospital in Bristol and admitted as an inpatient. He remained at the hospital for a month for treatment before being discharged on 26 October.

20. Two weeks later, on 9 November 2006, the man was again taken to A&E. He was assessed by medical staff and his condition stabilised. He returned to the prison later in the day. Further urgent visits to A&E took place on 28 November and 19 December. On both occasions, the man returned to the prison later the same day.

21. On 17 February 2007, the man's health deteriorated to the point where he required an assessment at the local hospital. He was taken to A&E and admitted overnight. He was discharged to Leyhill on 18 February after the hospital stabilised his condition. The following day he went to healthcare to request follow up of the bladder surgery, originally requested some 17 months earlier. Further emergency hospital visits took place on 27 February and 6 March, although the man was not admitted on these occasions.

22. A week and a half later, on 17 March 2007, the man collapsed on the wing. He was seen by healthcare staff who carried out an assessment. Whilst the assessment was taking place, a quantity of his medication was found concealed in a box of washing powder in his room. Staff asked him why he was not taking his medication as prescribed. The man said he did not think it was working. Due to the amount of medication that was found and his apparent collapse, the man was taken to A&E and admitted as an inpatient. At the same time, Leyhill opened an Assessment, Care in Custody and Teamwork (ACCT) document, a form used by the Prison Service to monitor and support prisoners at risk of self-harm or suicide. It was initially thought that his refusal to take his medication could have been a deliberate attempt to harm himself. The assessor completing the ACCT document liaised with prison colleagues escorting the man at the hospital and concluded that it was not his intention to self-harm. The ACCT was therefore closed later that evening. The man was discharged to Leyhill on 19 March.

23. The events of the following ten days are not clear in the man's records. His medical record suggests that he returned to Leyhill on 19 March, but

on 28 March it also shows that he was discharged from hospital. It does not specify when he returned to hospital. The man's prison movement sheets suggest that he transferred to Bristol prison for the period between 20 – 29 March.

24. During this time the lead primary care nurse at Leyhill wrote to one of the prison governors with her concerns that the man was not taking his medication and not looking after his personal hygiene. She wrote that he needed to be supervised on a more individual basis than the healthcare team at Leyhill could provide.

25. On 29 March 2007, having returned to Leyhill at midday, the man collapsed again. He was seen by healthcare staff who assessed him. The medical record notes that the healthcare centre at Bristol would not take him back and therefore the healthcare staff at Leyhill decided he needed an ambulance. The man was taken to Frenchay Hospital before being transferred to the nearby Southmead Hospital, where he was admitted as an inpatient.

26. The man was discharged again on 31 March. Upon his return to Leyhill, the ACCT document was reopened. Whilst the man had not expressed any thoughts of deliberately harming himself, his antipathy about his medication made him vulnerable. As part of the ACCT, a separate care plan was drawn up so that the man's compliance with his medication could be checked more closely. It ensured that there was a multi-disciplinary approach to the man's care, needs and medication compliance. I commend the staff involved for using their initiative to help keep the man safe from unintentional harm.

27. On 2 April, the man started being sick. He also complained to staff that he was suffering from pain in his lower back. He was examined by healthcare staff who advised that he needed to get out of bed more often in order to relieve the pressure on his back. No treatment was given for the sickness and nausea, and the symptoms abated the following day.

28. Three days later, on 5 April, the man's ACCT was reviewed. In the six days since it had been opened, staff had developed an observation booklet called a care plan that could be used to monitor his medication intake and his changing health and support needs. This meant it was no longer necessary to keep the man on the ACCT, which had been used for the same purpose. The ACCT was formally closed at 10.45am. On the same day, healthcare staff developed a needs plan for the man with the primary services, and liaised with the doctor to enable care to be delivered according to his needs. The clinical reviewer comments that the plan was evidence of good communication.

29. On 6 May, the man was found collapsed on the floor. As Leyhill does not have healthcare cover at evenings or weekends, officers arranged to have him temporarily transferred to HMP Gloucester which has an inpatient facility providing 24 hour care. The man was transferred that

day. He returned to Leyhill from Gloucester on 29 May. During the intervening three and a half weeks, he had only fallen once. However, it was recorded that he was eating very little.

30. Upon his return, staff at Leyhill opened another care plan. As a multi-disciplinary document, the man's medication intake could be monitored more closely by all staff, not just by healthcare. The document also ensured regular contact with the man's to assess his situation and needs.

31. My second investigator, visited Leyhill. She found that all the staff she spoke to knew and remembered the man well. The wing staff were aware of the extra support he needed and had tried to help with his personal hygiene. The healthcare assistant told my investigator that the man would attend the day care centre and, when he did not, staff would follow up so that they could get him out of his cell. There is good evidence of information sharing between healthcare staff and operational staff.

32. The prison doctor met with one of the prison governors on 30 May to discuss the man's health. The doctor had examined him that morning and found the man unable to get out of bed due to back pain. The doctor was waiting for some test results to confirm bone metastasis (cancer spread from a part of the body to the bones), but noted that he had lost a considerable amount of weight and did not appear to be eating and drinking. A special mattress to help with pressure pain was arranged. It was the doctor's opinion that, regardless of the test results, Leyhill no longer had the facilities to cope with the man's current condition and he needed more nursing care. An application for a transfer to HMP Norwich was made.

33. On 8 June, three members of staff including the senior doctor formally spoke to the man about what he would like to happen if he experienced a serious collapse requiring life-saving resuscitation. He said that he did not want to be resuscitated. His wishes were recorded in his medical notes. This was followed up on 14 June when he was examined by a doctor. The man confirmed he did not want to be resuscitated if he became unconscious. A 'do not resuscitate' form was completed and signed by the doctor.

34. A week later, on 17 June, the man complained that he was experiencing pains in his chest and numbness in his left arm. He was examined and taken to Southmead Hospital where he was admitted as an inpatient.

35. Over the next few weeks, the man had a number of medical examinations and tests. Healthcare staff at Leyhill maintained contact with their colleagues at Southmead throughout and, on 6 July, the hospital confirmed that the man had lung cancer. The consultant at Southmead determined that the man was too frail for cancer treatment,

and thereafter only palliative care was delivered to make him as comfortable as possible.

36. Confirmation that a space was available at HMP Norwich was received on 25 June. Southmead Hospital provided Norwich with a discharge summary of the man's care and history before he was transferred from hospital on 12 July.

37. After arriving at the Nelson Unit, healthcare staff drew up a comprehensive plan to manage the man's deteriorating health. The plan covered numerous aspects of his well-being, including hygiene, pressure area care, weight, nutrition, bowel movements, manual handling, medication, pain relief and activities to keep him occupied. It was a multi-disciplinary assessment and a continuous care plan was put in place. The clinical reviewer comments that there was good liaison and the man's own wishes were at the centre of the care he received.

38. The following day (13 July 2007), the man was assessed by a visiting specialist palliative care nurse from the Priscilla Bacon Centre in Norwich. In a follow-up letter to the healthcare team at Norwich, the specialist made four recommendations to make the man as comfortable as possible. These were carrying out a comprehensive pain assessment, monitoring his blood pressure, undertaking blood tests, and giving consideration to implementing the Liverpool Care Pathway. (The latter is a system widely used in hospices and other specialist care environments to look after dying patients.) At this point Norwich also started making efforts to contact next of kin (a friend named by the man).

39. Between 16 July and the early hours of 20 July, the man was found on the floor by Nelson Unit staff seven times. On each occasion he was checked for injuries before being helped back to bed. Around 10.30am on 20 July, he was thoroughly examined by healthcare staff and it was recorded in his medical notes that he was drowsy and slipping in and out of consciousness. Later in the day, the man was seen again by the specialist palliative care nurse who noted that he was dying. As a result, the Liverpool Care Pathway document was opened. This described in detail how the man should be cared for and also gave the man the opportunity to make any last requests. He asked to see a chaplain and this was arranged in accordance with his wishes.

40. The man slept for the majority of the next few days. Morphine was started on 22 July and this was steadily increased over time in order to make him as comfortable as possible. On 24 July, oxygen was given.

41. At 2.44pm on 25 July, whilst asleep and in the company of two members of staff, the man's breathing stopped. At 3.07pm, an appropriately qualified medical practitioner formally pronounced death. The man was 78 years old.

42. Prior to his death, the man had said he wanted a friend to be his next of kin. After checking, the Safer Custody Manager, found out that the friend had died a few years previously. The Safer Custody Manager then attempted to contact the man's nephew, whom he had identified as his next of kin earlier in his sentence. Despite checking a variety of sources, including the electoral rolls and probation records, these efforts were unsuccessful.

43. The man's funeral took place on 16 August and the service was led jointly by two chaplains from Norwich. The Healthcare Manager, the Head of Offender Management, and the Safer Custody Manager attended to pay their respects, accompanied by other members of the chaplaincy team.

ISSUES CONSIDERED

Clinical care

44. The man had a long history of poor health. Whilst at Leyhill he fell frequently without becoming unconscious or suffering any injuries. His records contain references to the falls being a means of getting attention, but he would always be assessed and sent to hospital if deemed necessary because there was no other clear cause.

45. Due to the number of collapses and hospital admissions, the clinical reviewer found it difficult to track the records and monitor the man's passage through the prison and healthcare systems.

46. The clinical reviewer has found that communication between Leyhill's healthcare team and the hospital was insufficient. Not only was further surgery on the man's bladder not followed up, but there was no follow up after the shadow on his lung was confirmed. The clinical reviewer comments that communications were inconsistent and resulted in disjointed care. This said, Leyhill now operates a computerised record system that should highlight any overdue consultations and appointments. These of course then need to be followed up.

47. The clinical reviewer found more recent evidence of good communication between Leyhill and primary care district nurse teams. There was also good communication between both Leyhill and Norwich prisons and Southmead Hospital during June and July 2007 prior to the man being transferred to Norwich. I also note what the Chief Inspector of Prisons has said about the good links being made by Leyhill with the local NHS.

48. I do not make any formal recommendation regarding follow up appointments or communication, both which seem to have improved. Nevertheless, I suggest that the Governor and Healthcare Manager at Leyhill consider what needs to be done to ensure that the improvements are maintained.

Medication Management

49. The first report that the man failed to take his medication properly was in March 2002, but there is no evidence that the risk was assessed at the time. Similar reports continued throughout his time at Leyhill, yet there did not appear to be an effective system to manage this. However, in March 2007, healthcare staff were concerned when they found a quantity of medication hidden in the man's cell. As a result, a care plan - separate to that in the medical record - was devised so that prison and healthcare staff could monitor his medication intake and general health needs. The 'care plan' is now regularly used at Leyhill to support and monitor prisoners who need it.

Transfer to HMP Norwich

50. The first request for the man to be transferred to a prison with 24 hour healthcare was made in July 2004, but there is no evidence that this was taken forward.

51. At the end of March 2007, a senior nurse told one of the governors at Leyhill that the man needed more individual care. This was followed up in May by the prison doctor who felt that the man's health was deteriorating. The man was assessed for the Nelson Unit at Norwich and arrangements were made for his transfer. A space became available on 25 June, but the man was still in hospital. Upon his discharge from hospital on 12 July, he went straight to Norwich.

52. The clinical reviewer has noted that, whilst a quicker move might not have extended the man's life, he would have been seen by experienced palliative care nurses. My investigator discussed this with the Governor of Leyhill who said that consideration was given to the wider perspective of the man's care.

53. From accounts by prison managers, wing staff and another prisoner, the man was happy and well looked after at Leyhill. He knew the people around him and was closely monitored. The physical environment of Leyhill is pleasant and less constraining than that of a closed prison where the man would have returned for inpatient care. There is a daycare centre, primarily for older prisoners, that the man made use of. The healthcare assistant told my investigator that, if the man did not attend, somebody would check to see if he was alright. On the day that my investigator visited, she spoke to one elderly prisoner who told her that he himself regularly used the daycare centre. A prison officer had woken him after lunch to check that he wanted to attend because he was later going than usual.

54. When the man felt unable to get his meals or medication, arrangements were made for them to be brought to him. The prisoner whom my investigator met also told her that, if the man did not want anything from the menu, he would share his canteen food.

55. The Governor of Leyhill told my investigator that some days the man was physically better and more able than on others. It was a judgement call what was in his best interests. I have no doubt that the judgements were made with the best intentions for the man in mind. When the healthcare team at Leyhill could not provide adequate care, the man spent time at other prisons with inpatient facilities and in hospital. In May 2007, the prison doctor advised the Governor that Leyhill healthcare staff were no longer able to offer adequate support and arrangements were made to secure him a place at Norwich.

56. I am satisfied that the decision to keep the man at Leyhill took into consideration his wider care and support. The decision was reassessed due to medical need and appropriate action taken.

Record Keeping

57. The clinical reviewer found that the entries in the man's medical record were at times very difficult to read and follow. Reasons included illegible handwriting and undated entries. Leyhill now operates a computerised record system that should remedy these problems.

58. There was one inappropriate entry in the man's medical record. This was made in 2002 when he was at HMP Littlehey. My investigator has spoken to the Head of Healthcare at Littlehey about this. Given the period of time that has elapsed since the entry was made, and that the person who wrote it no longer works for the Prison Service, I do not think there is a need for a formal recommendation or that I should take the matter further.

RECOMMENDATIONS

1. I do not make any formal recommendations but draw the housekeeping point at paragraph 48 to the attention of the Governor of Leyhill.

GOOD PRACTICE

1. The man collapsed on numerous occasions, particularly in Leyhill. Although, it was suspected that this was a behavioural problem the collapses were dealt with appropriately.

2. Leyhill put in place a multi-disciplinary system to monitor and support the man. This allowed non-confidential medical information to be shared appropriately.

3. The man's doctor discussed his failing health with him. This allowed him to make an informed choice not to be resuscitated should such a situation arise.

4. There were good communication links between both Leyhill and Norwich prisons and Southmead Hospital which enabled Norwich to prepare for the man's transfer.

5. At Norwich, the man received equitable end of life care. The staff followed best practice with the necessary pathways and ensured that the man died in comfort and with dignity.