# Investigation into the death of a man whilst in the custody of HMP & YOI Norwich, in June 2010

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

**November 2011**

This is the report of an investigation into the death of a man at HMP & YOI Norwich. The man died at the Priscilla Bacon Lodge. He was 60 years old. The cause of his death was metastatic small cell carcinoma (lung cancer).

I offer my sincere sympathy and condolences to his family, and to all who have been affected by his loss. I apologise for the delay in issuing this report and any additional distress this may have caused.

The investigation was carried out by my investigator. A review of the man's medical care was led by the clinical reviewer on behalf of NHS Norfolk. I am grateful to the clinical reviewer for her assistance. I would also like to thank the Deputy Safety Custody Manager, for his work liaising with the investigator.

My report finds that the man received an equivalent level of care to that he could have expected in the community. I do however make five recommendations in respect of areas where improvements are needed. These relate to the clinical care for prisoners on L wing at Norwich and escort arrangements.

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

**Thea Walton**
**Acting Deputy Ombudsman** **November 2011**

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## SUMMARY

1. The man was given an indeterminate public protection sentence with a four year tariff on 9 December 2005 and arrived at HMP Gartree in July 2006. Whilst at Gartree the man re-established contact with his two brothers. In June 2009 he spent a period of time in HMP Durham on accumulated visits to enable him to receive visits from his family.

2. On 10 December 2009 the results of a chest x-ray showed an upper lobe mass on the man's right lung. The man was moved to the prison's healthcare wing on 15 December.

3. The man was given a diagnosis of small cell carcinoma of the lung[1] on 6 January 2010. The following week he had his first session of chemotherapy[2] treatment. On 27 January he was re-categorised from category B to category C [3]due to his deteriorating health. It was also decided that he would be moved to a suitable category C prison that could support his healthcare needs. On 5 March the man decided that he did not wish to continue with the chemotherapy treatment.

4. The man was moved to HMP and YOI Norwich on 6 March for end of life care. He was located in L wing which is the dedicated elderly prisoners unit. On 18 May the man was referred to the palliative care team. Following a comprehensive assessment by a palliative care consultant the man was placed on the waiting list for the Priscilla Bacon Lodge, a local facility which provides specialist palliative care[4] and support for patients with advanced diseases.

5. On 3 June the man was moved to the Priscilla Bacon Lodge. He was placed in a single cuff restraint and escorted by two officers. The escort risk assessment remained in place until 7 June when the man's restraints were removed.

6. This report contains five recommendations. These relate to the use of locum doctors at Norwich, End of Life Care pathways and the support offered to prisoners receiving palliative care. I also criticise the lack of a formal assessment of the man' mental capacity to refuse treatment and make a recommendation regarding risk assessments for escort arrangements.

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[1]Small cell carcinoma (sometimes rendered as "small-cell carcinoma") is a type of highly malignant cancer that most commonly arises within the lung.

[2] Chemotherapy is the use of anti-cancer drugs to destroy cancer cells. There are different groups of anti-cancer drugs that can be used.

[3] There are four security categories for adult male prisoners. Prisoners who are categorised as Category C cannot be trusted in open conditions but do not have the resources or will to make a determined escape attempt.

[4] Palliative care is a specialised area of healthcare that focuses on relieving and preventing the suffering of patients.

## THE INVESTIGATION PROCESS

7. The investigation was opened on 14 June 2010 by my investigator. She was met by the prison's liaison officer and reviewed the man's prison and medical files. Copies of documents from those files were given to the investigator. My investigator met with the Chair of the Independent Monitoring Board (IMB) and a representative from the Prison Officers Association. She also spoke the Head of Healthcare at the time of the man's death.

8. NHS Norfolk commissioned the clinical reviewer to undertake a clinical review into the man' medical care prior to his death. The clinical review panel met on 10 September 2010. This meeting was attended by the investigator and the clinical reviewer. Following this meeting a clinical review report was written, which I include with this report as Annex 1. The review was received on 10 December 2010.

9. My investigator visited the prison on 20 September and interviewed three members of prison staff and the head of healthcare. The interview with the Head of Healthcare was also attended by the clinical reviewer.

10. The Ombudsman's family liaison officer wrote to the man's brother on 6 July to inform him of the investigation and determine whether he had any issues he wished it to address. The man's brother did not raise any issues. The Ombudsman's family liaison officer wrote to the man's brother again on 18 April 2011 to inform him that the Ombudsman's family liaison officer had been changed to another one. I hope that the findings of my report help to clarify the circumstances of the man' death for his family.

11. The second Ombudsman's family liaison officer wrote to the man's brother on 28 July to inform him that the draft report was ready and to ask if he wished to receive a copy. The man's brother did not respond to her letter. The draft report was issued to the National Offender Management Service (NOMS). NOMS' responses to my recommendations are included at the end of this report.

## THE MAN

12. The man was born in January 1950 and was the youngest of three brothers. After leaving school he enrolled in the Army in 1970 but left two years later with a dishonourable discharge. The man gained a City and Guilds qualification in catering which he used to gain employment as a chef for Butlins. He married twice but did not have any children.

13. The man had an extensive history of offending behaviour which dated back to the 1960s. He received his first custodial sentence aged 19 when he spent three months in a detention centre. On 9 December 2005 the man was convicted of a serious offence and received an indeterminate public protection sentence with a four year tariff.[5]

14. The man started his sentence at HMP Blakenhurst before being transferred to HMP Gartree in July 2006. During his time at Gartree he completed several offending behaviour programmes and was participating well in the regime of the prison. He also re-established contact with his two brothers which resulted in him being transferred in June 2009 to HMP Durham for accumulated visits.[6]

[5] Indeterminate public protection sentences were introduced by the Criminal Justice Act 2003. The purpose of these sentences is to detain in prison people who pose a significant risk to members of the public until their risk is reduced. In sentencing the courts will impose a minimum term that the prisoner must serve before they can be considered for release by the Parole Board.

[6] If a prisoner is in a prison a long way from home and family they can save up their visiting time. This enables the prisoner to be transferred on a temporary basis to undertake the visits at a prison closer to their family.

## HMP & YOI NORWICH

15. Norwich is a large prison built on a site close to the city centre. The original buildings date back to the Victorian era. The prison holds a maximum of 767 men, both adults and young offenders. Some men have been convicted and some are being held on remand. The prison largely receives men from courts in Norfolk and Suffolk. The site is geographically split and the prison has to deliver a number of different functions.

## Healthcare

16. The healthcare provision at Norwich changed in October 2010. NHS Norfolk now commissions a private company, Serco Health, to provide the healthcare at Norwich and two other nearby prisons. However, although Serco Health is the provider, they deliver the care in association with a number of partners, including Norfolk Community Health and Care NHS Trust (NCH&C). The three managers overseeing healthcare at Norwich (one on behalf of Serco, two for NCH&C) were appointed late last year.

17. The man was transferred from Gartree to Norwich on 6 April 2010 and went to L wing. This is a dedicated older prisoners unit. L wing is on the ground floor of the healthcare centre at Norwich. It used to be referred to as the Nelson Unit. Staff on L wing often work closely with colleagues at Priscilla Bacon Lodge, an NHS facility nearby in Norwich which specialises in palliative care.

## Her Majesty's Inspectorate of Prisons

18. The former Her Majesty's Chief Inspector of Prisons completed an unannounced inspection of Norwich in February 2010. She judged that Norwich was an improved and safer prison since her last inspection. She found that the provision of healthcare was improving, but that the facilities offered to those prisoners staying in the healthcare centre were 'insufficient'. With regard to L wing, Her Majesty's Chief Inspector of Prisons commented:

    'Many of the patients required full nursing care and staff were hard pushed to provide the required level of care despite their best efforts ...

    'The unit had excellent links with outside agencies, including the local palliative care team.'

## Independent Monitoring Board

19. The most recent annual report published by the Independent Monitoring Board (IMB)[7] at Norwich covers the year from March 2009 until February 2010. The Board identified difficulties with the provision of healthcare. They were critical of staff shortages and a lack of care plans for the chronically ill.

## Previous deaths at Norwich

20. Norwich has specialised in recent years in caring for older prisoners whose lives may well end lives whilst still serving a prison sentence. The prison has established links with a palliative care provider in the local community. L wing is a dedicated unit for older prisoners with chronic or terminal illnesses. Since assuming responsibility for investigating deaths in custody in 2004, I have investigated a significant number of deaths at Norwich resulting from illness, primarily diseases such as cancer.

[7] The IMB at each prison is made up of members of the public who are both independent and unpaid. They monitor the day-to-day life in their local prison and ensure that proper standards of care and decency are maintained.

## KEY EVENTS

21. The man was convicted of a violent offence on 9 December 2005 and received an indeterminate public protection sentence with a four year tariff. He spent most of his sentence at HMP Gartree before being moved to HMP Norwich in April 2010 on the grounds of his deteriorating health.

22. The man arrived at Gartree on 27 July 2006 and received the appropriate medical assessments. His medical records showed a history of asthma and dermatitis for which he was prescribed the appropriate medication. The man had also made use of the prison's primary healthcare facilities including general practice, practice nursing, podiatry [8]and dentistry.

23. On 21 September 2009 the man was seen at Gartree by Dr A. He complained of experiencing occasional hot flushes with cold hands and feet. The prison doctor referred the man for blood and urine tests. The test results were received on 25 September and were within normal ranges.

24. On 9 October the man complained of feeling anxious when he participated in the cognitive self change programme (CSCP).[9] Dr B suggested that the man should be referred to the mental health team and prescribed propranolol.[10]

25. The man was seen by Dr C on 19 October to discuss his anxiety. He said he had not taken the propranolol because he was worried the medication could have an adverse effect on his asthma. The following day he was admitted to healthcare for overnight observation while starting propranolol. The man was discharged back to the wing on the following day.

26. A mental health assessment took place on 7 November. The assessment concluded that there was no evidence of physical or mental signs of anxiety. The man told Nurse A at Gartree that his problems related to his attendance on the CSCP.

27. On 12 November the man complained of feeling breathless and was seen on the wing by Nurse B. He complained that he had been

[8] Podiatry is a branch of medicine devoted to the study, diagnosis, and treatment of disorders of the foot, ankle, and lower leg.

[9] The cognitive self change programme is an offending behaviour course which targets high risk violent offenders. It equips prisoners with skills to help them control their violence and avoid reconviction. It is aimed at offenders with a history of violent behaviour and is suitable for those whose violence is reactive and/or instrumental.

[10]Propranolol is a beta blocker mainly used in the treatment of hypertension (high blood pressure).

coughing up green phlegm for the past few days. He was reviewed again on 15 November by Nurse C. The man said he was experiencing a shortness of breath after little exertion. He was advised to ask for help from prisoners or staff on the wing.

28. On 23 November 2009 the man was seen in healthcare by Dr C. He complained of a persistent cough and said he was worried that he had lost weight over the past few months. The doctor referred the man for a chest x-ray. The appointment took place on 8 December at Market Harborough Hospital.

29. The results of the chest x-ray were sent to Dr C by fax on 10 December. The results showed an abnormality on the man's right lung. This was identified as a right upper lobe lung mass. The hospital advised that the man should be referred to Leicester Royal Infirmary department of Oncology[11] for further investigation into possible lung cancer. The referral form was completed by Dr D, on 10 December. The doctor said that the man had been told that the x-ray had shown a shadow on his lung.

30. On 15 December the man was seen on the wing by Nurse C. The man was very upset about the deterioration in his physical health and weight loss. In view of the chest x-ray results the man agreed to be moved to the healthcare wing at Gartree. This would allow healthcare staff to offer him support and to facilitate his visits to hospital for treatment.

31. Nurse C noted on the man' medical record that the man 'had been hinted that there were some abnormalities on his last chest x-ray'. It is not clear if the man was told that he had been referred to the Oncology Department for further investigation into possible lung cancer.

32. On 19 December the man was referred to the mental health team at the prison because he was feeling depressed and anxious about his health.

33. On 22 December the man attended the Respiratory Clinic[12] at Glenfield Hospital. On his return to Gartree he was seen by Nurse D, a mental health nurse. The nurse noted in his medical records that the man told her he believed he had lung cancer. The nurse reassured the man that he would be offered support by healthcare staff. The man said he was very anxious because he had experienced a 'funny turn' that morning and fallen to the floor. He told the nurse that the clinic doctor had told him he would need a brain scan to see if the cancer had spread.

34. A consultant respiratory physician wrote to Dr D on 23 December. He said it was likely that the man had lung cancer. The consultant respiratory physician said he had explained to the man that more information was required before his condition could be confirmed. For

[11] Oncology is the field of medicine that deals with the diagnosis and treatment of cancer.

[12] Respiratory clinics see patients who are suffering from common chest illnesses.

this reason the man would be given an ultrasound[13] of his neck lymph nodes.[14] A further discussion of his case would take place on 24 December.

35. On 24 December a nurse, a lung clinical nurse specialist from the Oncology Department at Leicester Royal Infirmary, contacted the prison healthcare department to discuss the man' diagnosis and treatment. The nurse said they had been given a diagnosis of small cell carcinoma of the lung. The man would be offered chemotherapy.

36. The same day the man was seen in his cell by Nurse F and Nurse D. They told the man he would be going out to hospital the following week to discuss his diagnosis and treatment options. Nurse D noted in the man's medical records that he appeared to be convinced that he was suffering from a virus that was affecting his lung and perhaps his brain. Nurse D wrote that she needed to confirm with the man how much the man knew about his condition. She decided that it would be more sensitive not to tell the man any further information about his condition on Christmas Eve.

37. On 31 December the man was seen by Nurse D. He expressed concern about his weight loss and asked about the possibility of having some build up drinks. Nurse D said it was clear that the man was very worried about his health and anxious about the appointment to discuss his diagnosis and treatment options.

38. Nurse D saw the man again on 4 January 2010. She agreed to accompany him to his appointment at the Oncology Department on 6 January. The man said he was looking forward to finding out what was wrong so he could 'get back to normal'. Nurse D noted that she believed that the man was aware that he was seriously ill.

39. On 6 January 2010 the man was seen at Leicester Royal Infirmary by a doctor, a consultant oncologist. He was accompanied to the appointment by Nurse D. During the appointment the man was told that he had been diagnosed with lung cancer. His treatment plan was outlined. The man was extremely upset by his diagnosis, in particular the effect that it would have on his seventy year old brother.

40. The man had his first session of chemotherapy treatment on 15 January. On 22 January a MacMillan nurse, contacted healthcare and said she had received the man's referral and was happy to be contacted for guidance and advice.

41. A sentence planning board was held on 27 January to discuss the man's security categorisation. The Board noted that whilst the man needed to

[13] An ultrasound scan is a painless test that uses sound waves to create images of organs and structures inside the body.

[14] A lymph node is a small ball or an oval-shaped organ of the immune system.

reduce his risk of re-offending, he would need to complete further offending behaviour programmes and this would not be possible due to the seriousness of his illness. For this reason a long term objective was made that the man should be transferred to a suitable category C prison that could support his healthcare needs. A recommendation was made that the man should be re-categorised from category B to category C due to his deteriorating health.

42. The man had his second chemotherapy session on 5 February. On 10 February healthcare staff observed the man lying on his bed. He told staff that he was feeling dizzy.

43. On 25 February the man told Nurse C, that he had been told by the consultant that the results of one of the scans had indicated that the cancer was spreading to his liver. Nurse C noted that he believed the man had not been fully informed of his prognosis.

44. The same day the man was seen in his cell by Dr B and Nurse C. Dr B noted that the man was aware of his diagnosis, in particular that he was unlikely to be cured of his condition. The man had not wished to discuss his specific prognosis with the consultant.

45. Nurse D saw the man again on 5 March. He expressed concern about having his next session of chemotherapy treatment. He said the treatment was making him feel physically very ill. The man was also expressing depressive thoughts and feelings. The man said he had decided to stop having his treatment and asked for his decision to be noted in his medical notes. He asked healthcare staff to respect his wishes in wanting to discontinue the treatment. The nurse asked the man if he would consider talking to the doctor and taking an antidepressant. The man said he that he did not wish to do so.

46. On 8 March the man discussed his decision to stop having treatment with Nurse C. The man said he was finding his decision difficult to cope with. He was pleased to have been recategorised to category C and said he would prefer to be moved to a prison with similar healthcare facilities to Gartree.

47. The next day the man was seen by the Head of Healthcare and Nurse F, the nurse manager. The man was told that a referral had been made to the healthcare department at Norwich.

48. The man completed a treatment disclaimer form on 12 March 2010. This said he had refused chemotherapy at Leicester General Infirmary and he recognised that the refusal was against medical advice.

49. A nurse from the chemotherapy suite at Leicester General Infirmary contacted Gartree on 18 March to ask if the man would be attending for his chemotherapy. The man said he did not wish to receive his treatment. On the same day a consultant in clinical oncology, wrote to

healthcare regarding the man' decision to refuse chemotherapy treatment. The consultant said the man had a chemo-sensitive tumour and following several cycles of chemotherapy could have a remission which sometimes lasted over a year. The consultant went on to say that the man needed to come and have a discussion about his situation without committing to any treatment.

50. Nurse D reviewed the man on 25 March. He said he felt much better than when he was having chemotherapy treatment. The man was also regularly in contact with his brothers by telephone.

51. On 29 March the man was seen by a healthcare practise manager in order to complete a treatment disclaimer form. The man confirmed that he did not wish to attend an out patients appointment to discuss his treatment options with the consultant. There is no evidence that a formal assessment of the man's mental capacity to refuse treatment was carried out at this time.

52. The man was accepted by Norwich on 30 March. On 5 April he was reviewed by Nurse D and discharged from her care. Nurse D noted in the man's care plan that they had discussed his expectations and anxieties. On 6 April the man moved to Norwich for end of life care.

53. On arrival at Norwich the man underwent a first reception health screen. The man felt unable to discuss his 'do not resuscitate' (DNR) status with the doctor. However, he was aware that his suitability for this policy was being discussed with the palliative care team. [15]

54. On 10 May the man was seen by Nurse A at Norwich. The man complained of feeling short of breath when he walked around and said that he felt like he was experiencing flu-like symptoms. Later the same day the man was reviewed by Dr A at Norwich. He was prescribed amoxicillin[16] for a suspected chest infection. The following day the man refused to take his medication because he believed he did not have a chest infection. The man asked for a doctor's appointment to discuss his constipation.

55. Dr A at Norwich saw the man again on 14 May. He noted that the man was aware that his cancer was growing rapidly. The doctor described the man as being anxious with a 'demanding demeanour'. He reviewed the man again on 18 May. The man complained that he was experiencing indigestion and hot flushes and was also tearful.

56. On 18 May the man was referred to the palliative care team.

[15] A DNR order on a patient's file means that a doctor is not required to resuscitate a patient if their heart stops and is designed to prevent unnecessary suffering.

[16] Amoxicillin is an antibiotic medication used to treat infections.

57. Nurse A at Norwich reviewed the man on 21 May. She said the man was experiencing some nausea and vomiting. Whilst the man denied that he was anxious regarding his prognosis he asked for a mental health assessment. The following day the man was seen by Nurse B at Norwich. He said he felt agitated and asked to be taken to hospital.

58. On 23 May the man said he was feeling increasingly agitated and felt that staff were not taking him seriously. Nurse A at Norwich described the man as being confrontational and very restless. However, she felt that this could be attributed to an increase in the dosage of morphine sulphate.

59. The man was assessed by a palliative care consultant, on 25 May. The palliative care consultant noted that the man had been feeling more unwell over recent days. It was recorded in the assessment that the man was aware that his condition was incurable and he was comfortable with his decision not to pursue any more treatment. The palliative care consultant went on to say that the man agreed with the decision to complete a DNR order. Once completed the DNR order would be considered by healthcare.

60. The palliative care consultant completed the DNR later that day. The reasons for the order were because the man's condition had indicated that CPR was not likely to be successful in event of him experiencing a cardiac arrest. The man had also made it known that he did not wish to be resuscitated. The DNR order said the man was judged to be mentally competent of making this decision. The order was countersigned by Nurse A and Dr A at Norwich.

61. On 27 May a drug error is recorded in the man's medical record. On investigation the clinical reviewer found that the error appeared to have been made because the locum doctor did not know how to prescribe medication using the electronic medical information system.

62. The palliative care consultant undertook a further review of the man's condition on 1 June. During this review the man acknowledged that he was feeling less well. The palliative care consultant said that she considered that the man's condition was deteriorating. The suggested plan of action was to place the man on the waiting list for the Priscilla Bacon Lodge.[17]

63. On the same day the man's medical record shows that the Head of Healthcare at the time, contacted the man's brother by telephone. During her interview with the investigator, she said she had first contacted the man's brother by telephone when it was clear his condition was deteriorating. During their conversation she told the man's brother about his move to the Priscilla Bacon Lodge. The Head of Healthcare at

[17] The Priscilla Bacon Lodge provides specialist palliative care advice and support for patients with advanced diseases, and for those close to them. The centre incorporates an inpatient unit and day centre.

the time said the man had asked her to keep his brother informed. She had agreed with the man's brother that she would contact him if there were any other changes.

64. An outpatient escort log dated 1 June was completed by Senior Officer (SO) A. A risk assessment is carried out for all prisoners who are leaving the prison for any reason. The assessment takes account of the risk the prisoner poses to the public and therefore what arrangements should be in place to manage these risks. The man was placed in a single cuff restraint and escorted by two prison officers. [18] The escort risk assessment noted that the man's condition was life threatening and he was possibly not returning to Norwich. The acting Deputy Governor at the time authorised the risk assessment but said it should be reviewed for appropriateness if the man remained at the Priscilla Bacon Lodge. The man was moved to the Priscilla Bacon lodge two days later on 3 June.

65. The head of healthcare at the time contacted the acting Governor at the time, to express her concern that the man would be placed in a single cuff restraint. In her opinion the man was far too ill to be a risk and she asked for consideration to be given to the man being placed on an escort chain (a long chain with a single cuff at each end. One end is attached to the prisoner's wrist and the other the member of staff). In response, the acting governor at the time, asked the acting Governor at the time asked Governor A and Governor B to review the man's risk assessment.

66. On 4 June Governor A reviewed the man' risk assessment as requested by the acting governor at the time. He decided that the risk assessment should remain unchanged. During his interview with the investigator Governor A said as part of the risk assessment process he had visited the man at the Priscilla Bacon Lodge. He recalled that the man looked relatively fit and should therefore remain in single cuffs.

67. My investigator also spoke to Governor B who said he had visited the man on 5 June. Governor B said at this point the man was still able to walk around the Priscilla Bacon Lodge and he considered that the risk assessment in place was appropriate.

68. On 6 June the head of healthcare at the time contacted Governor C in the security department to express her concern that the man remained single cuffed. She described the man as 'a very frail, terminally ill man', with an extremely poor prognosis. She said for the purpose of dignity the man should be uncuffed with a discreet support officer. The following day the man's restraints were removed. During her interview with the investigator the head of healthcare at the time said that it was clear that

[18] Each time that a prisoner is escorted outside the prison to hospital, a risk assessment considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and the type of restraint to be used. In this case the man was escorted in a single cuff restraint and escorted by two prison officers.

the man was very unwell and his physical condition was such that he would be unable to present a risk of escaping.

69. The man died on 10 June. The same day the head of healthcare at the time was asked by the acting governor at the time to telephone the man's brother to let him know. He was also contacted by the prison's family liaison officer, Governor D. The man's funeral took place on 2 July in Newcastle. My investigator found that the prison's offered a contribution to the funeral costs in accordance with Prison Service Order (PSO) 2710.[19]

[19] PSO 2710 provides instructions on the action to be taken following a death in custody.

## ISSUES

### Clinical Care

### The man's clinical care at HMP Gartree

70. Following his conviction, the man spent the first 14 months of his sentence at HMP Blakenhurst. He was moved to Gartree on 27 July 2006. On arrival at Gartree he underwent the appropriate health assessments. The man's medical record shows he was prescribed seretide for asthma.20 He had reduced his cigarette intake from forty a day to between seven and ten. Between July 2006 and September 2009 the man received regular appointments with the dentist and chiropodist and was prescribed the appropriate medication.

71. The clinical reviewer described the End of Life Care Pathway Model (2009) that was in use at Gartree as 'comprehensive and developed in conjunction with local healthcare organisations'. She comments

> "The information in the clinical record for the man demonstrates that there was robust communication between the secondary care oncology multi-disciplinary team at Leicester Royal Infirmary and HMP Gartree healthcare department following the man's diagnosis. A referral was made in January 2010 to the McMillan nursing team in Market Harborough who agreed they would provide the healthcare team guidance and advice as required while caring for the man.

72. In December 2009 the man was moved to the healthcare department for observation and support. The clinical reviewer comments that the Primary Care Manager at Gartree was clear that there was no formal protocol for admission to the beds in healthcare and the man was originally admitted to facilitate his visits to hospital for chemotherapy and to allow him some peace and quiet which was not possible on the wing

73. The clinical reviewer has questioned the appropriateness of the man's move to Norwich when a comprehensive End of Life Pathway model was in place at Gartree. The man spent a period of time in HMP Durham on accumulated visits. The clinical reviewer has commented that consideration should have been given to moving the man to a prison closer to his family. I do not consider that the man's move to Norwich contributed to his death and for this reason I make no recommendation.

74. In early March the man took the decision to stop chemotherapy. There is no evidence that a formal assessment was undertaken to confirm that he had sufficient mental capacity to make this decision. This is a surprising omission, given that the treatment may have potentially prolonged the man's life. I discuss this issue further later in my report.

[20] Seretide is a combination inhaler prescribed to control the symptoms of asthma.

**The man's clinical care at HMP Norwich**

75. The man arrived at Norwich on 6 April and underwent a first reception health screen. Arrangements were made for the man to see a doctor the following day to re-write his medications. It was noted that he required assistance with cleaning his cell and bed making. The health screen says that there were no concerns about the man's psychological state, in particular his thinking, feelings or behaviour.

76. On 7 April the man was seen in his cell by Dr A at Norwich. He expressed concern about his move to Norwich and was described as being 'evasive about whether his chemotherapy would have been curative or not'.

77. The man had received support from the mental health team at Gartree to help him deal with his diagnosis. However, he did not receive a mental health assessment during his time at Norwich nor was he offered any support from the mental health team, despite his worsening condition. During her interview with my investigator the head of healthcare at the time said if there had been any concerns about the man's mental health he would have been referred to the mental health team.

78. The clinical reviewer found that mental health services for older prisoners at Norwich were not well developed. She comments that there is no evidence in the clinical record to suggest that any mental health assessment was undertaken. I consider that Norwich should have undertaken an assessment of the man's mental health. Despite receiving support from the mental health team at Gartree, I am concerned that no such assessment took place. I make the following recommendation:

    **Prisoners on L wing who are receiving palliative care should be offered support from the mental health team at the prison.**

79. The man was supported by a specialist outreach team from the Priscilla Bacon Lodge. The clinical reviewer has commented that there is not an agreed end of life care pathway in place at Norwich which clarifies the roles and responsibilities across healthcare and local health services. She writes that given the number of prisoners at Norwich that are receiving end of life care it is important that staff are fully aware of their responsibilities to ensure that prisoners experience a dignified and comfortable death. The clinical reviewer makes the following recommendation:

    **HMP Norwich should have an agreed End of Life Care pathway which reflects the care available in the wider community.**

80. During the man's time at Norwich he was seen by several doctors, all of who were locums. [21] The clinical reviewer considers that a reliance on locum doctors at Norwich has resulted in a lack of continuity and may have put pressure on local specialist services, such as palliative care. In addition she found no evidence of an induction plan for locum doctors which would include clinical pathways for specialist care in the outside community. The clinical reviewer has also referred to a drug error in the man's medical record that was made by a locum doctor. Although on investigation the error was found to have been made due to the doctor trying to prescribe a drug electronically, the clinical reviewer considers this illustrates the lack of a robust induction for locum doctors. I repeat the clinical reviewer's recommendation here:

**A locum and new doctors' induction pack should be developed to provide information about the complex health needs of the prisoners in HMP Norwich.**

81. The man suffered from asthma for many years. The clinical reviewer is critical of Norwich's approach to chronic disease management. She considers that their approach did not mirror what is available in the wider community. As it is not directly related to the man's death I make no recommendation in this regard. However, the Governor and Head of Healthcare will wish to carefully consider the contents of the clinical review, which includes the following:

> "Although HMP Norwich chronic disease management is provided on an in reach basis by nurse practioners to the general prison population there is no evidence to suggest that the man' asthma was assessed by a nurse practitioner. It is unclear how prisoners on L wing access the full range of primary care services."

**Communicating the man's diagnosis**

82. Dr C at Gartree received information regarding the man's diagnosis on 10 December. On 15 December the man told Nurse C at Gartree that he was aware the chest x-ray results had shown some abnormalities and he would undergo further scans and tests in the forthcoming weeks.

83. On 22 December the man told Nurse D at Gartree that he thought he had lung cancer. Nurse D offered him reassurance that he could discuss his condition with staff at any time. The man's medical record shows on 24 December healthcare staff were told that he was suffering from small cell carcinoma of the lung. During his meeting with Nurse D and Nurse F at Gartree, the man told them he believed he was suffering from a virus that was affecting his lung and perhaps brain.

[21] A locum doctor is not employed on a permanent basis by the PCT and will undertake duties on a contract basis.

84. Nurse D at Gartree concluded that Nurse The manon, a lung clinical nurse specialist from the Oncology Department at Leicester Royal Infirmary, should be asked how much the man knew about his diagnosis and that staff had decided it would be cruel to give him any further information on Christmas Eve. In the circumstances I consider this to be appropriate.

85. The man's medical record shows that Nurse D at Gartree contacted Nurse The manon on 30 December about the man's appointment to discuss his treatment plan. However, it is not clear if Nurse The manon was told of Nurse D's decision not to inform the man about his diagnosis because it was Christmas Eve.

86. Nurse D at Gartered accompanied the man to the Oncology Unit at Leicester Royal Infirmary on 6 January for an appointment with the consultant oncologist. During the appointment the consultant oncologist outlined the man's treatment plan. In his medical records Nurse D has noted that the consultant oncologist did not check how much the man had been told about his condition by the Glenfield Hospital. The doctor opened the appointment by telling the man he was there to discuss his treatment for lung cancer. The man was understandably shocked and burst into tears. It is very unfortunate that the man found out about his diagnosis in this way. I would urge the Head of Healthcare to consider if more could have been done to liaise with the Oncology Department to avoid this. However, the decision of Nurse D to accompany the man to the appointment was compassionate and allowed her to offer him support. I commend Nurse D for her actions.

**The man's refusal of treatment**

87. Following his diagnosis the man had his first chemotherapy session on 15 January 2010. This was followed by a second session on 5 February. The man discussed his diagnosis with Nurse D at Gartree on 21 February. He told Nurse D that he had decided to stop his chemotherapy treatment because it was making him physically ill. Nurse D noted that the man appeared to be very stressed about going out to the hospital for his treatment.

88. Nurse at Gartree met with the man again on 5 March to discuss his decision to stop the chemotherapy treatment. The man told the nurse that he was aware of his condition but felt that the treatment was worse than the disease. He said he felt as if 'the whole world was crashing down on his shoulders'. The nurse tried to persuade the man to discuss his decision with the doctor and to consider taking an anti-depressant. However, the man was adamant that he did not wish to do so. The man asked that the staff respected his wishes to discontinue the treatment.

89. On 8 March the man told Nurse C at Gartree that he was finding his decision to stop the treatment difficult to cope with. He advised the man to raise any concerns with healthcare staff. On 12 March the man

signed a treatment disclaimer form. The form said he recognised that his refusal was against medical advice.

90. In his letter to Gartree of 18 March, the consultant in clinical oncology explained that the man had a chemo-sensitive tumour and following several cycles of chemotherapy could have a remission which sometimes lasted over a year. The consultant in clinical oncology went on to say that the man needed to come and have a discussion about his situation without committing to any treatment. Nurse D discussed the consultant in clinical oncology's letter with the man on 25 March. The man said he was feeling much better than when he was having the treatment and did not wish to discuss his decision with the consultant in clinical oncology.

91. On arrival at Norwich on 6 April the man told the doctor he felt unable to discuss his 'do not resuscitate' (DNR) status. Following his referral to the palliative care team on 18 May the man underwent a comprehensive assessment with the palliative consultant. During this assessment the palliative consultant noted that the man was aware that his condition was incurable and he was comfortable with his decision not to have any further treatment.

92. The man's capacity to refuse treatment was not formally assessed at either Gartree or Norwich. Whilst at Gartree he discussed his decision with Nurse D on several occasions. He also spoke to a doctor at Norwich, who was confident that he understood and was comfortable with the decision he was making. Whilst I do not doubt that staff at both prisons considered the man's mental capacity to refuse treatment (and were satisfied that his capacity was intact) it is concerning that this is not documented.

**The Governors and Heads of Healthcare at both Gartree and Norwich should remind staff of the importance of assessing and recording mental capacity assessments where a prisoner is refusing treatment.**

**Use of restraints at the Priscilla Bacon Lodge**

93. The man was moved to the Priscilla Bacon Lodge for symptom control and a blood transfusion. It was initially hoped that he would be able to return to Norwich once his condition had been stabilised. On admission to the hospice he was escorted by two officers and cuffed to one of them by means of an escort chain. The Head of Healthcare at the time, told the investigator that whilst the man was able to move independently albeit with assistance, he was a very unwell man. In her opinion the man's condition meant that he was too ill to be able to escape from custody. The Head of Healthcare at the time emailed the acting Governor to ask him to consider the use of an escort chain only.

94. At the time of his admission to the Priscilla Bacon Lodge the man's condition had deteriorated and he was described by the palliative consultant as 'weak and breathless'. The risk assessment completed on 1 June described the man's medical condition as life threatening and he would probably not be returning to Norwich.

95. The man's risk assessment was reviewed on 4 June by Governor A. The risk assessment remained unchanged. Governor B visited the man on 5 June. He told my investigator that the man was still able to walk around the Priscilla Bacon Lodge and he considered that the risk assessment in place was appropriate.

96. The following day the Head of Healthcare expressed her concern about the risk assessment to Governor C in the security department. In her opinion the man was a very frail and terminally ill man with an extremely poor prognosis. The Head of Healthcare told Governor C that the man's cuffs should be removed and he should be supported by a discreet officer. She considered that the man's poor physical condition would prevent him from escaping. The man's restraints were removed on 7 June.

97. The decision on whether to restraint a prisoner in a hospice is a difficult one. The balance between decency and security can be hard to judge. As I have previously mentioned the man was initially moved to the Priscilla Bacon Lodge to stabilise his condition. I therefore consider the level of restraints used appropriate. However, once it was established that he would not be returning to Norwich I judge that the restraints should have been removed and the presence of the bedwatch officers would have provided adequate security at this time.

**The Governor should remind senior managers to seek advice from Healthcare colleagues on the medical condition and mobility levels of seriously ill prisoners when determining the cuffing levels for outside escorts**

**Breaking the news of the man's death to his next of kin**

98. The Head of Healthcare at the time told my Investigator that she had contacted the man' brother on 1 June. During their conversation she told the man' brother about his move to the Priscilla Bacon Lodge. She said the man had asked her to keep his brother informed. She had agreed with the man's brother that she would contact him if there were any other changes.

99. During her interview the Head of Healthcare at the time told my investigator that she had visited the man at the Priscilla Bacon Lodge on either the 6 or 7 June. She was aware that the man was in regular telephone contact with his brother at that time. Following the man's

death the Head of Healthcare at the time was asked by the acting Governor to contact his brother to break the news of his death. She said the role of informing the next of kin was usually undertaken by a trained family liaison officer but that she undertook it on this occasion as she had been in contact with the family previously.

100. The acting Governor confirmed to my investigator that, as the Head of Healthcare at the time was in regular telephone contact with the man's brother, he considered her to be the most appropriate person to contact.

101. There is specific guidance in Prison Service Order (PSO) 2710 (Follow up to Death in Custody) on how the news of a prisoner's death should be passed on to their next of kin. The PSO says that Governors must:

> "Arrange notification to the next of kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner, giving an accurate factual account of what has happened."
>
> The accompanying Family Liaison Officer (FLO) guidance recommends that:
>
> "The family should be informed face to face as soon as possible after the death. Wherever possible this should be done by a dedicated Family Liaison Officer working alongside the Chaplain, or Governor or most senior individual available together with the Chaplain.
>
> "If distance from the prison presents a problem, a dedicated Family Liaison Officer or chaplain based in the area nearest the family home could inform the family face to face.
>
> "The prison should demonstrate its duty of care and show that it is taking the death seriously by making a personal visit."

102. The man's brothers live in Newcastle so it would not have been unreasonable to have contacted a prison nearer to there to ask them to break the news in person. However, the Head of Healthcare at the time had already established a relationship with the man's brothers and they were already aware that he was terminally ill. In addition, it had also been agreed with the brothers that they were to receive updates to the man's condition over the telephone.

103. Governor D, a trained Family Liaison Officer, also made contact with the man's brothers and this was entirely appropriate under the circumstances. Although the guidance in PSO 2710 was not followed I do not consider that the way in which the news was broken to the man' family was unreasonable under the circumstances.

## CONCLUSION

1. The man was diagnosed with small cell carcinoma of the lung whilst at HMP Gartree. He began a course of palliative chemotherapy in order to achieve a period of remission. Unfortunately he found the treatment too physically demanding and he decided not to continue. On 6 April 2010 he was moved to HMP &YOI Norwich on the grounds of his deteriorating health.

2. The man was referred to the palliative care team and following a comprehensive assessment, he was moved to the Priscilla Bacon Lodge for symptom control and a blood transfusion on 3 June. However his condition further deteriorated and he sadly died on 10 June.

3. The clinical reviewer finds that the man that his overall medical management was satisfactory and his death could not have been prevented. Nevertheless there are some areas that could have been improved, most notably carrying out a formal assessment of the man's capacity to refuse treatment. The man received regular support from the mental health team. This support was not continued at Norwich and no mental health assessment was undertaken.

4. Despite his deteriorating physical condition the man's restraints were not removed until three days before his death.

## RECOMMENDATIONS

1. Prisoners on L wing who are receiving palliative care should be offered support from the mental health team at the prison.

   Accepted- An assessment is carried out by the Nurse in Charge on all palliative care patients and should they require a mental health assessment this will be actioned.

2. HMP Norwich should have an agreed End of Life Care pathway which reflects the care available in the wider community.

   Accepted- End of Life Care Pathway will be developed in conjunction with the Prison and Healthcare.

3. A locum and new doctors' induction pack should be developed to provide information about the complex health needs of the prisoners in HMP Norwich.

   Accepted- This has been added to the newly developed Doctors induction pack.

4. The Governors and Heads of Healthcare at both Gartree and Norwich should remind staff of the importance of assessing and recording mental capacity assessments where a prisoner is refusing treatment.

   Not accepted- The Mental Capacity Act makes it clear that a person must be assumed to have capacity unless it is established that he or she lacks capacity. The report states that the man spoke to a doctor at Norwich who was confident that he understood that he understood and was comfortable with the decision he was making.

5. The Governor should remind senior managers to seek advice from Healthcare colleagues on the medical condition and mobility levels of seriously ill prisoners when determining the cuffing levels for outside escorts.

   Accepted- This will be included in the End of Life Care Pathway, and communicated to Prison Managers. The External Escort Risk Assessment booklets require that medical information is provided – in particular, whether the prisoner has any medical condition to influence the application of cuffs or considerations of any medical factors in respect of the escort (to influence cuffing arrangements or staffing levels). A reminder will be issued to all operational Duty Managers of the need to ensure this information is obtained, entered within the booklet and taken into consideration when making their assessment.