Investigation into the circumstances surrounding the death of a man in October 2010 at HMP & YOI Norwich

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

The man was 72 years old when he died at HMP & YOI Norwich. He suffered from a number of complaints, including diabetes, heart disease, renal failure and, ultimately, presumed lung cancer. He was thought to have a malignant tumour in his lungs but there was no definitive diagnosis before he died.

In the last months of his life, he lost mobility and remained in his cell on the older prisoners' unit. He was given pain relief but no further treatment was pursued by the local hospital. Having received the last rites from a Roman Catholic chaplain, he died in his cell in October 2010. He had previously signed a form indicating that he did not want to be resuscitated.

Although none of his family have been traced, I know that he is much missed by the friends that he made whilst he lived in Kenya.

The investigation was completed by my colleague. One of my Family Liaison Officers was asked to contact the family on my behalf. However, his relatives live in Austria and could not be located by either the prison or the Austrian embassy.

The format of my report about the man's death differs from the previously established template. I have adopted a different approach to investigating deaths which were foreseeable (typically prisoners who die of cancer after receiving palliative care). The report does not contain a complete chronological account of his time in Norwich, but instead assesses the care he was given in nine different thematic sections. I welcome feedback about this new method of investigating from all of the office's stakeholders.

A clinical review of the treatment which he received in prison was undertaken by a clinical reviewer appointed by the local PCT. She is critical of the care the man received and makes a total of 40 recommendations in her review. I am grateful to her for her assistance. I have not repeated all of her recommendations, but I ask those responsible for healthcare at Norwich to carefully consider her comments.

I would like to express my thanks to the Governor and the staff and prisoners at Norwich for their cooperation whilst the investigation was completed. I particularly thank the liaison officer who liaised with the investigator and arranged the interviews.

As I have indicated, a large number of recommendations are contained in the clinical review. My investigation endorses the clinical reviewer's core findings. Given that Norwich has a reputation for pioneering work in the field of palliative care and specialises in holding older prisoners who may be near the end of their lives, I am concerned by some of the problems which the man's care has highlighted. In particular, the absence of properly trained staff able to deliver the best available form of pain relief (syringe drivers) is most worrying.

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 **July 2011**

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SUMMARY

1. The man was arrested in December 2008 at an airport. He was an Austrian citizen who had spent the last few decades living in Kenya. He was remanded into custody and taken to HMP Chelmsford. In March 2009, he transferred to HMP Norwich. In June, he received an eight year prison sentence. He was already unwell when he arrived in custody and suffered from a number of complaints, including diabetes, asthma and high blood pressure.

2. In April 2010, a doctor ordered tests because he was worried that the man might have cancer. (He had been losing weight and had pain in his chest.) In early May, x-rays confirmed the doctor's suspicions. In June, a computerised tomography (CT) scan showed a large mass in his right lung. Following further tests throughout the summer, he was thought to be suffering from late stage lung cancer, although he did not receive a definitive diagnosis before he died.

3. When he was admitted to hospital in September he underwent more tests. Sadly, he was not considered to be fit enough to cope with either surgery or chemotherapy. Radiotherapy was thought to be an option if the cancer spread to his brain, but his consultant recorded that this would not have improved his chances of survival.

4. The man returned to stay on the older prisoners' unit at Norwich (also known as L wing). He was referred to Priscilla Bacon Lodge, a specialist palliative care facility. His care was overseen by a consultant who visited him in the prison. His pain relief was increased towards the end of October as his condition deteriorated. He was treated according to the Liverpool Care Pathway (guidance for helping patients who are very close to dying) from 26 October and had signed a 'Do not resuscitate' form.

5. Having received the last rites from a Roman Catholic chaplain, the man died in his cell in October. Staff realised that he was close to death and tried to make him comfortable. A nurse stayed with him until he died. His funeral took place on 25 November.

THE INVESTIGATION PROCESS

6. The investigator was formally notified of the man's death on 29 October 2010. Notices were subsequently issued to both staff and prisoners at HMP & YOI Norwich, informing them of the investigation process and giving them the opportunity to contact the investigator with any relevant information.

7. He liaised with the Safer Custody Manager at Norwich throughout the investigation. His colleague visited Norwich on his behalf to open the investigation and collect all the documents relating to the man's time in custody.

8. The investigator wrote to the local Coroner's office to inform them of the nature and scope of the investigation. HM Coroner will be provided with a copy of the report of the Ombudsman's investigation.

9. The investigator also contacted the local PCT and asked that a review be carried out with regard to the clinical treatment which the man received at Norwich. The purpose of the review is to establish whether the care that he was offered in prison was comparable with that he would have expected in the community. The clinical reviewer completed the review. She and the investigator visited Norwich to interview four staff on 18 January 2011.

10. I asked one of my family liaison officers to contact the man's next of kin to tell them about my investigation. Sadly, prison staff were unable to contact any of his family, despite the assistance of the Austrian embassy. He had not lived permanently in his native country for many years and had not maintained contact with his relatives. Consequently, the family liaison officer was unable to get in touch with any members of the family to discuss either the investigation or the findings in the draft report.

HMP NORWICH

11. 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

12. The healthcare provision at Norwich changed in October 2010, very shortly before the man died. The local PCT 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 and came into post only shortly before the man died.

13. The man moved to L wing (the dedicated older prisoners' unit) as his health deteriorated. This wing is located 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 located nearby in Norwich which specialises in palliative care.

Her Majesty's Inspectorate of Prisons

14. The former HM 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'. As regards L wing, she 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

15. The most recent annual report published by the Independent Monitoring Board (IMB) at Norwich covers the year from March 2009 until February 2010. (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.) The Board commented on the difficulties that foreign national prisoners like the

man can face when trying to find out more about their status and the possibility of either repatriation or deportation:

> ‘Long delays, coupled with this lack of information, causes stress and anxiety and the Board asks that the Minister improves the system for advising prisoners of their current situation and deciding their future.
>
> ‘The Prison has a designated Foreign National Co-ordinator. The Board considers that more emphasis needs to be placed on the needs of foreign nationals ...’

16. As I go on to discuss, in the months before he died, two members of staff were trying separately to arrange for the man to return to either a prison or a clinic in Austria.

17. 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. These are both problems which were evident to my investigator and the clinical reviewer as they explored the man’s care.

Previous deaths at Norwich

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

Performance

19. The most recent prison quarterly ratings published by the Ministry of Justice show that Norwich scored 3 overall, indicating a good performance. The prison achieved the same score in the previous quarter. The minimum score is 1 (serious concerns) and the maximum is 4 (exceptional performance). The rating takes into account 34 different aspects of the way the prison is currently operating.

ISSUES

The diagnosis of the man's terminal illness

20. The man had numerous health problems from the time he arrived in prison in late 2008. However, he was not suspected of having cancer until April 2010. This section of the report outlines the way in which his health declined and the manner in which his presumed tumour was discovered.

21. In December 2008, he was arrested at an airport. He was remanded into custody and initially taken to HMP Chelmsford. In March 2009, he transferred to HMP & YOI Norwich. He was assessed by a nurse and a doctor during the reception process.

22. The nurse recorded that she had received his clinical record from Chelmsford. However, since he died, the healthcare managers at Norwich have been unable to provide my investigator with a copy of the earlier clinical record. Staff at Chelmsford told the investigator that the record would have been handwritten and that they did not keep a copy. I endorse the clinical reviewer's recommendation in her clinical review:

    Norfolk Community Health and Care NHS Trust should ensure that any written clinical notes transferred with a patient are scanned and added to the electronic clinical record within 48 hours.

23. The clinical reviewer expresses some concern that the man may not have been fit to transfer from Chelmsford in the first place. Without a copy of the earlier clinical record, she cannot be sure about what treatment he was receiving at Chelmsford, how unwell he was there or whether he should have been subject to medical hold (a prisoner can be held at a particular prison if they have outstanding treatment needs).

24. Although he had not been diagnosed with cancer when he arrived at Norwich, he had a considerable number of health problems. He was short of breath, diabetic and overweight. He was a smoker and suffered from asthma. Staff thought that he might have chronic obstructive pulmonary disease (COPD). He had high blood pressure and high cholesterol and experienced pain in his hips when he walked. He was prescribed a significant number of different medications for his ailments and located in a single cell because of his health problems.

25. He told staff that he had outstanding medical appointments, but he did not know who he was meant to see or why. (There is no evidence in the clinical record of staff checking whether he needed to go to hospital for treatment.) I endorse the clinical reviewer's recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that newly arrived prisoners' clinical records are checked for outstanding hospital appointments and that the appropriate enquiries are made.

26. Although he had a number of health problems, he was not allocated a key worker and no care plan was drawn up. I endorse the clinical reviewer's recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that a care plan is drawn up for, and a key worker allocated to, each prisoner with complex long term needs.

27. After he arrived at Norwich, his health continued to be poor. He was unsteady on his feet and would fall out of bed, injuring himself. He told the nursing staff that he was experiencing a lot of pain and was reminded to take his pain killers. He was referred for x-rays on his hips but it is not clear from the clinical record that the results were ever received by the prison healthcare team. He continued to smoke heavily.

28. He was admitted to the prison's healthcare centre between 30 June and 10 July for assessment and observation. He was prescribed medication to treat problems with his heart. He continued to complain of feeling dizzy when he coughed and was unsteady on his legs. He told staff that he had trouble communicating due to language difficulties. He asked for a translator, but when an officer offered to talk to him using a telephone based translation service, he declined. Nonetheless, I reiterate the recommendation I made at paragraph 34.

29. In September, he was diagnosed with osteoarthritis in both hips. Later in the month, he requested a wheelchair. However, staff recorded that they were reluctant to provide one because they thought that his obesity would only worsen if he relied on a wheelchair. He told the education officer that he felt isolated and frustrated because he was forced to miss classes due to health problems. By the middle of October, he was spending most of his day confined to his cell and a wheelchair assessment was requested. I am concerned that an assessment was not completed when he first enquired. I make the following recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that all staff are aware of the correct assessment and referral procedures when a prisoner requests a wheelchair.

30. In late October, he was prescribed a glyceryl trinitrate (GTN) spray on the advice of the local hospital's cardiology department. (GTN spray provides relief from angina pain.)

31. In December, discipline staff asked a nurse to assess him because they were concerned about a 'noticeable deterioration' in his condition. The nurse asked Prison Doctor A to examine him. He recorded that the man was progressively deteriorating and was having difficulty caring for himself. He ascribed the man's mobility problems to his arthritis. The doctor recorded his angina, diabetes and unsteadiness. He arranged for him to be given a wheelchair and to move to the healthcare centre, because he was at risk of injuring himself in a fall.

32. At the end of December, Prison Doctor B assessed the man and noted that he was suffering from kidney damage. The doctor told the investigator that the man was examined for possible renal failure, but the specialist determined that no further treatment was needed at the time and discharged him. The doctor spoke German, which allowed him to communicate freely with him.

33. In early January 2010, the man told Prison Doctor B that he had lost 10kg in weight. He had been smoking heavily but was trying to cut down. The doctor recorded that there were no masses in his abdomen but that he had chronic congestive heart failure.

34. The man had a chest x-ray taken in January. The doctor assessed the results. He told my investigator that there was no indication from these x-rays that he might be suffering from lung cancer.

35. In February, the doctor ordered blood tests. Later in the month, the man complained to staff that he had lost his appetite. At the end of February, the doctor recorded that his 'general malaise' was worsening. He became unmotivated and did not leave his cell.

36. Near the end of March, the doctor considered that the man might soon be fit enough to be discharged from the healthcare centre. He continued to report a loss of appetite at the start of April. (His weight had declined since he arrived in Norwich. It was recorded as 108kg on 21 July 2009, 100kg on 19 December 2009 and 5 January 2010, 99kg on 7 January, 98kg on 9 February, 93kg on 24 March, 92kg on 28 March and 90kg on 3 April.)

37. In late April, he complained to nursing staff about right sided chest pain. It hurt when he took a deep breath in and out and when he coughed. He scored his pain as 7/10 and said that it was affecting his appetite. He said that he felt the pain when he got up from either a lying or sitting position and he was referred to a doctor.

38. Prison Doctor C assessed the man the next day. The doctor attributed his pain to a recent fall from his bed. He wrote that his chest was clear and he prescribed pain killers. The following day, he complained to a nurse about his chest pain. She told him that he probably still had some bruising from his fall.

39. Prison Doctor B assessed him a few days later. The doctor noted that he had complained of chest pain for three weeks and ordered chest x-rays as a matter of urgency. On 5 May, the hospital contacted the healthcare staff at Norwich to advise that the recent x-rays showed a mass in his lungs. Consequently, he needed to undergo a CT scan as a matter of urgency.

40. On 6 May, the doctor referred him to the hospital for a computerised tomography (CT) scan of his lungs. The request was faxed the next day. The doctor told the investigator that, after earlier x-rays in January had not shown any sign of a tumour, he was surprised that the presumed cancer in his lungs had progressed so quickly and there was now an identifiable large mass.

41. The doctor made a further request to the hospital on 27 May requesting the CT scan. The doctor told my investigator that he had to pursue the appointment himself. He said that this proved difficult because he had no administrative support and could not easily access the office containing the fax machine. On 8 June he faxed a 'two week wait' referral form to the hospital. I endorse the clinical reviewer's recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that doctors are allocated adequate administrative support to facilitate hospital referrals in a timely manner.

42. The CT scan which eventually took place on 16 June revealed a large 11cm by 8cm mass in the man's right lung. This was presumed to be lung cancer. As the clinical reviewer comments in her review, neither Prison Doctor B nor the palliative care specialist based at the Priscilla Bacon Lodge who would treat him in the weeks before he died thought that the diagnosis could have been made much earlier.

43. However, there was a delay of approximately six weeks between Prison Doctor B's referral for a CT scan in early May and the scan taking place. I commend the doctor for his repeated efforts to organise the scan. It is not within my remit to comment on the processes at the local hospital, but I draw the attention of managers at NHS Norfolk to the delay which the man experienced.

44. In the event, although it was presumed that the man had lung cancer, a definitive diagnosis was never actually made. The clinical reviewer notes that the diagnosis was problematic because he had so many things wrong with him. She writes that a number of tests provided 'inconclusive and complex' results.

Informing the man about his condition

45. Two days after the CT scan, one of the nurses at Norwich learnt from a prisoner that the man had been told at the hospital that he probably had lung cancer. The prison healthcare staff had not yet been given this confirmation themselves. The nursing staff reassured him that a letter with an official diagnosis would be sent from the hospital soon.

46. A couple of days later, the nursing staff at the prison requested and received by fax a report from the hospital about the CT scan results. It confirmed that he had a mass in his lung that was likely to be a tumour. One of the nurses relayed this information to him and arranged for him to speak to a doctor the next day to get a better understanding of his condition. Because Prison Doctor B spoke German, he could communicate properly with him about his condition and any decisions regarding his treatment.

47. Although the actions of hospital staff are not within my remit, I draw the attention of managers at NHS Norfolk to the way in which the CT scan results

seem to have been communicated firstly to the man and then to the prison healthcare staff.

48. I note that, until he fortuitously came under the care of Prison Doctor B, the man was not provided with an interpreter during his medical consultations. Accounts of his ability to speak English varied, but interpreters were certainly required to deliver medical information when he spent time in hospital as his condition deteriorated.

The man's subsequent medical appointments and treatment

49. The man was treated both in the prison healthcare centre and the local hospital in the months that followed. Prison Doctor B immediately referred him to the chest specialist, in accordance with the instructions in the CT scan report. He underwent a further CT scan at the hospital on 2 July. The results showed that the cancer had not yet spread to his brain. However, by the middle of July, he was noticeably confused and disorientated. He was unsteady on his feet and prone to falling over.

50. An outpatient appointment booked for him on 15 July was cancelled by the hospital because they had overbooked and did not have sufficient beds available. The appointment was rescheduled for 28 July, almost two weeks later. However, on 24 July, he was taken to hospital in an emergency ambulance on the advice of an out-of-hours doctor. He was diagnosed with acute renal (kidney) failure, received treatment and returned to the prison on 31 July.

51. Whist at hospital, he needed to undergo a lung biopsy (a further exploration of his presumed tumour). The prison arranged for an interpreter to attend the hospital to help staff obtain consent for the operation. However, the interpreter did not arrive in time and, without consent, hospital staff were unwilling to proceed. The biopsy was rescheduled. Another interpreter was booked for 30 July to assist hospital staff with informing him about his condition, but once again they did not arrive.

52. He was due to go to hospital for an outpatient appointment on 11 August, but did not go because healthcare staff were unaware of the appointment and had not organised an escort for him. The hospital had booked an interpreter and reserved a bed. He was due to be assessed by a radiologist. The appointment was rescheduled for 16 August. I make the following recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that all outpatient appointments are clearly recorded in the clinical record and that prisoners are given the opportunity to go to all such scheduled appointments.

53. On 16 August, he was admitted to hospital, returning to the prison on 18 August. A CT guided ultrasound lung biopsy on 17 August proved

inconclusive. A malignant tumour was suspected but could not be definitively diagnosed.

54. He was supposed to go to an appointment at the respiratory medicine clinic on 13 September. However, the doctor wrote to healthcare staff indicating that he was aware of his probable diagnosis and that he would not benefit from the proposed treatment. The doctor asked healthcare staff to discuss the matter with him and to cancel the appointment if he agreed. Prison Doctor B discussed his prognosis with him. The doctor noted that he seemed to understand that no curative treatment could be offered. The appointment at the respiratory clinic was cancelled with the man's agreement.

55. However, because of his declining health, he was then admitted to hospital between 8 and 29 September. The prison arranged for an interpreter to meet him and help him understand what was happening.

56. He underwent MRI scans on his brain and spine to check if the suspected lung cancer had spread. A subsequent discharge letter recorded that there was no evidence that his likely lung cancer had spread to either his brain or spine. His doctor wrote that staff had had some difficulty communicating with him.

57. He underwent a bone scan on 23 September. The scan gave no indication that the suspected cancer had spread to his bones. The same day, hospital staff used an interpreter to inform him of his likely, presumed diagnosis of late stage lung cancer and explain his test results.

58. He had developed hypercalcaemia (a high level of calcium in the blood which is associated with late stage cancer). His likely prognosis was assessed as being either weeks or months. He was not thought fit enough to undergo either surgery or chemotherapy. He was discharged back to the older prisoners' unit at Norwich. Hospital staff contacted staff at Priscilla Bacon Lodge to discuss his palliative care needs.

The man's location in the prison

59. Because of his declining health and presumed diagnosis of lung cancer, the man was given a more comfortable bed in late June and subsequently also received an air mattress to relieve pressure sores.

60. In total, staff recorded that he fell over in his cell eight times at Norwich. There is no evidence in the clinical record that staff carried out regular risk assessments or ever properly explored why he kept falling over and hurting himself.

61. In her review, the clinical reviewer expresses concern about the use of co-codamol as a pain killer without consideration for its possible side effects. She considers that some of his symptoms, such as dizziness and becoming unsteady on his feet, could have been caused or aggravated by this drug.

62. Although he needed regular treatment for diabetes, this was not always accurately and fully recorded in the clinical record. The clinical reviewer highlights the link between diabetes and potential falls or blackouts. His blood sugar levels were only tested twice after a fall.

63. As the clinical reviewer writes in her review, staff recorded that he had a tendency to fall, yet no care plan to address the problem was implemented. I endorse her recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that staff are trained in the management of falls and subsequent care planning.

64. Prison Doctor B told the investigator that the man was admitted as an inpatient in the healthcare centre partly because he kept having falls. He transferred to the older prisoners' unit on 3 July and, aside from trips to hospital, remained there until he died.

65. Just over a week before he died, on 20 October, Prison Doctor D advised staff to keep his cell door open at all times because there was a risk that he might choke if left alone. The duty governor gave permission for the cell door to remain open. I endorse the clinical reviewer's commendation of this course of action.

Restraints, security and bed watch

66. I consider that appropriate arrangements were made for the man when he had to spend three periods in hospital in July, August and September. Because of his lack of mobility, age and poor health, he was not handcuffed and was only accompanied by one officer. He was escorted using a wheelchair and transported in a taxi.

Liaison with the man's family

67. The man had no address in the UK. He was arrested at the airport and had no real connections with this country. His main links were to Austria and Kenya. He did not provide the prison with current details of his next of kin, despite several requests.

68. As his condition deteriorated, he told staff that he did not want any of his next-of-kin in Austria to be contacted. He said that he had been married and had had two children, but was divorced and did not know how to get in touch with them. Although he had been living in Kenya for most of the last 30 years, he did not want to provide any contact details for any of his friends there. He only provided a telephone number for a friend in the UK.

69. Although no next of kin were involved when he died, he was visited by the Roman Catholic chaplain who gave him the last rites. After his death, prison staff were still unable to locate his next of kin, despite assistance from the Austrian Embassy. He was cremated at a crematorium with a full Roman Catholic Service on November 25.

The possibility of compassionate release

70. My investigator has found that whilst the immigration clerk was trying to repatriate the man to an Austrian prison at his request, Prison Doctor B was simultaneously trying to repatriate him to a clinic in Austria on compassionate grounds. Unfortunately, neither party made the other aware of their actions.

The immigration clerk's efforts

71. In spring 2010, the man applied to be repatriated to Austria to serve the rest of his sentence. He received a reply in early May, informing him that the immigration clerk would be in touch. He was advised that the process might take some time. The immigration clerk wrote to him in late May, asking him to complete an application for repatriation, so that the process could move forward. He immediately returned the signed form.

72. During interview, she told the investigator that she was asked to arrange his repatriation to an Austrian prison only because he was a foreign national (rather than for health reasons). She said that repatriation is a relatively rare procedure and that this was the first time she had been asked to organise it. She told the investigator that most foreign national prisoners choose to serve their sentences in Norwich.

73. She confirmed that the repatriation process can take many months whilst the various parties involved submit information. She contacted the police, prison discipline staff and HM Revenue and Customs during the next few months. The process was still ongoing when he died.

74. Until very shortly before he died, she did not know that he was terminally ill. She was not copied into any of Prison Doctor B's correspondence with the Austrian Embassy. At no stage was she asked by the doctor to help him arrange the man's return to an Austrian clinic on compassionate grounds.

The prison doctor's efforts

75. The man told Prison Doctor B that he wanted to die in Austria. He asked to be released on compassionate grounds. In late March 2010, the doctor noted in the clinical record that the Austrian authorities were considering whether to agree to his repatriation.

76. The doctor wrote to the Governor of Norwich on 22 June about the man's possible release. At the end of June, a probation officer working in Norwich completed a report about his early release on compassionate grounds.

77. In early July, the doctor attempted to telephone social services in Austria to identify a clinic that the man could be released to and the name of a supervising clinician. He was unable to make international telephone calls from the prison, a problem that continued to delay his efforts in the months to come. Around this time, the man told the doctor that he wished to persevere

with the process of compassionate release. However, there is nothing in his records to indicate that any progress was made between July and September.

78. In early September, the man again asked the doctor if he could be repatriated to Austria. The doctor spoke to an official at the Austrian Embassy later in the month. She asked the doctor for a medical report before the Embassy could consider repatriation. A condition of possible release on compassionate grounds was that a clinician would need to be found in Austria who was willing to take responsibility for the man's care. The address of a clinic where he could be cared for was also needed.

79. The official asked the doctor to arrange for the man to sign a form confirming that he wanted to return to Austria to be cared for. After the man prevaricated for several days, the doctor arranged for an interpreter to help him understand the form. He signed it on 30 September.

80. The doctor advised the Austrian Embassy that the man was only expected to live for weeks or months. In his medical report, he recommended that a qualified nurse would need to accompany the man on the flight back to Austria, because he tended to become confused.

81. The official subsequently informed the doctor that the Embassy had identified a clinician who was willing to take over the man's care in Austria. She indicated that they would be able to confirm a place of treatment once his release from custody was underway.

82. The doctor wrote to the management team at Norwich more than once towards the end of September, asking for the man to be released on compassionate grounds as soon as possible. He stressed the urgency of compassionate release and noted that funding would need to be secured for his repatriation. Unfortunately, the man's own bank accounts had been frozen following his imprisonment.

83. The Acting Governor of Norwich approved the man's request for release on compassionate grounds on 30 September. The doctor explained to the investigator that a prison officer had by this time volunteered to escort him back to Austria by plane. However, the practicalities and cost of arranging a plane flight proved to be an obstacle. In the event, his health deteriorated quickly, no definite arrangements were ever made and the Ministry of Justice never actually agreed to his release.

84. On 21 October, the doctor recorded that the man's plan to return home to Austria for the end of his life had to be abandoned. He could no longer travel anywhere because he was so unwell. Similarly, the process of repatriation which the immigration clerk initiated was a slow one, and was still ongoing when he became too frail to travel.

85. I am concerned about the lack of liaison between the healthcare department and the immigration clerk in the prisoner administration department. Two repatriation processes were continuing alongside one another. Had the

immigration clerk known about the doctor's efforts and the urgency of the situation, she could have abandoned her own endeavours and relieved him of a bureaucratic and time intensive process. I make the following recommendation:

The Governor should ensure that the role of the immigration clerk is communicated to all staff in Norwich. The prison management should consider how to improve the channels of communication between the prison administration and healthcare departments regarding foreign national prisoners.

Palliative care plans

86. The clinical record seems to indicate that healthcare staff notified a nurse at Priscilla Bacon Lodge (a local NHS facility specialising in palliative care) about the man's CT scan result in June and the nurse agreed to visit him the following week. However, the consultant in palliative medicine who oversaw the man's care in the last few weeks of his life told the investigator that her staff did not become involved with him until September.

87. Prison Doctor B spoke to the man about the issue of resuscitation on 23 August. However, the doctor did not think that he understood their conversation, so he decided that he should still be given resuscitation if he stopped breathing.

88. Staff at Priscilla Bacon Lodge were initially asked for advice and guidance about his palliative care on 23 September. The referral was made by staff at the hospital. The palliative care specialist was allocated as his palliative care keyworker. This was an advisory role in which she offered guidance only. The healthcare staff at Norwich continued to deliver his daily care and medication.

89. The man's palliative care plan was discussed at a meeting at Priscilla Bacon Lodge on 30 September. Both his keyworker and healthcare staff from Norwich attended. Because he did not have specialist palliative care needs, she told the investigator that it was agreed that he would return to the older prisoners' unit at Norwich rather than move to Priscilla Bacon Lodge.

90. Later the same day, his keyworker went to Norwich to review his condition. She met him for the first time and spoke with him using the same interpreter who had attended the hospital a week earlier. She recorded that his ability to think and understand was deteriorating. However, she wrote that he was not experiencing many specific symptoms relating to the suspected tumour in his lung, such as chest pain and breathlessness.

91. She wrote to Prison Doctor B on 8 October to offer an outpatient's appointment for him to undergo treatment for his hypercalcaemia (a symptom of late stage cancer). He was supposed to receive the treatment at the Rowan Centre (the part of Priscilla Bacon Lodge where outpatients are

treated) on 11 October. However, because of problems with his escort, he went to the Rowan Centre for treatment the next day, 12 October.

92. He signed a 'Do not resuscitate' form on 20 October following a discussion with a doctor. The doctor and a nurse signed the form. The doctor thought that his health had deteriorated to such a degree as to prevent any quality of life.

93. The clinical reviewer expresses concern in her clinical review that there is no evidence in the clinical record of his involvement in the decision and no record of his mental capacity to understand the implications. He did not sign the form. I endorse the clinical reviewer's recommendation:

    Norfolk Community Health and Care NHS Trust should ensure that staff record clearly in the clinical record that the mental capacity of the patient has been considered when a 'Do Not Resuscitate Order' is signed.

94. The keyworker wrote to Prison Doctor B on 22 October. She advised that the man's condition seemed to be deteriorating and he would not be given any further treatment for his hypercalcaemia. She suggested that healthcare staff ensure that enough pain relief drugs were on site to help him through the forthcoming weekend. Because his condition was not deteriorating consistently, she wrote that it was difficult to know whether he was approaching the end of his life or whether his condition might improve again.

95. Nurse A discussed the possibility of implementing the Liverpool Care Pathway (LCP) for dying patients with a worker from Priscilla Bacon Lodge and Prison Doctor B. (The LCP guides staff in how to best manage the final days and hours of a patient's life.) They decided to delay beginning the LCP whilst the man was still able to take fluids and his condition remained changeable. The nurse recorded that the LCP could be started whenever staff thought it appropriate. Following the keyworker's advice, the doctor prescribed additional medication for the weekend in case his health deteriorated further.

96. The LCP was started on 26 October. The keyworker told the investigator that she was satisfied with the timing and implementation of the LCP. She explained that this was not completely predictable because the man's condition was fluctuating. The clinical reviewer is critical in her review of the 'limited detail' in the clinical record about the nursing care he was given under the LCP framework.

97. The keyworker visited the man on 28 October. He was sleeping much of the time and his condition continued to deteriorate. He was eating and drinking very little. He died the following day.

98. I am satisfied that appropriate consideration was given to the man's care in the final weeks of his life. The continuing liaison between Norwich and Priscilla Bacon Lodge is clearly a great source of support to the staff caring for men on the older prisoners' unit.

The man's pain relief and medication

99. The man died on 29 October. His pain seemed to increase in intensity from 23 October when nursing staff gave him oramorph (a pain killer containing morphine). He had pain all over his body. He could not swallow easily so his food had to be mashed.

100. One of the nurses completed an Abbey Pain Scale assessment on 25 October. She scored his pain as severe, acute and chronic. The same day, Prison Doctor B prescribed higher strength buprenorphine patches for pain relief. The clinical reviewer expresses concern that, although he was in considerable pain, he was only given one dose of diamorphine before he died, even though a doctor prescribed the drug a week before he died.

101. There is only one example in the clinical record of his level of pain being assessed. However, the keyworker told the investigator that his pain was being controlled and that she was not necessarily an advocate of this type of pain measurement. She thought that his pain was well contained and that appropriate pain relief had been prescribed.

102. When the keyworker visited him on 28 October (the day before he died) she recorded his pain relief, noting that his buprenorphine patch had been increased and that he was also being given oromorph and diamorphine for his pain. She thought that he appeared comfortable with his level of pain relief.

103. However, she did advise staff that he might require a syringe driver if his condition deteriorated further. (A syringe driver is a small pump which delivers a steady rate of pain relief to palliative care patients.) She wrote in a letter '... that the team on L wing do not feel competent at present to manage [a syringe driver]'. She advised Prison Doctor B to consult the local district nursing team, because they might be needed to deliver this type of treatment in the days to come. In the event, the man died the next day before this could be considered.

104. The doctor told my investigator that insufficient general nurses working on the older prisoners' unit (L wing) had been trained by staff at Priscilla Bacon Lodge to operate and maintain a syringe driver. He expressed concern about the situation and said that it was an ongoing issue. Given that the unit often looks after older prisoners who may well have palliative care needs, I am extremely concerned that there are insufficient nurses qualified to deliver this form of pain relief.

105. During interview, the doctor expressed his opinion that the man would probably have been given the option of a syringe driver at an earlier stage if he had been treated in the community. He thought that this would have been best practice. He explained that he was unable to offer equivalent care because of the lack of appropriately trained staff.

106. The keyworker confirmed that her staff have delivered training to healthcare staff at the prison in the past, but she reflected that suitably trained staff may well have moved on, as the management and staff at Norwich have recently changed considerably.

107. The clinical reviewer comments:

> 'Staffing should be appropriate to the situation and it would appear that best practice palliative care nursing was not delivered. Urgent help should be sought to enable the use of syringe drivers. This may involve re-planning of staffing rotas with appropriately qualified competent staff to deliver all aspects of palliative care. Urgent training should be sourced and urgently sought in order for the staff to attain the required competencies. Until this occurs, then a plan of care should be agreed between the healthcare provider and the Hospice to ensure the provision of optimal pain relief in end of life care.'

108. The issue was raised last year when the former Chief Inspector of Prisons conducted her most recent inspection of Norwich. She made the following recommendation:

> 'The skill mix on the inpatient unit should be appropriate to meet the needs of the population.'

109. I endorse the clinical reviewer's recommendations:

Norfolk Community Health and Care NHS Trust should undertake a staffing review to ensure that sufficient nurses are qualified to deliver all aspects of palliative care. They should be trained in the use of syringe drivers.

Norfolk Community Health and Care NHS Trust should ensure that the prison healthcare team and the palliative care specialists at Priscilla Bacon Lodge jointly devise a care plan to provide optimal pain relief for each patient at the end of life.

110. Because of his hypercalcaemia, the man became easily dehydrated. Prison Doctor B told the investigator that there are not enough nursing staff available on the older prisoners' unit to keep offering the patients sips of water. He explained that the prison officers often did this instead to help the nurses. The clinical reviewer also comments that healthcare staff did not assess the man's difficulty swallowing. I draw these comments to the attention of Norfolk Community Health and Care NHS Trust.

111. The clinical reviewer raises the issue of potential side effects that can be experienced when a patient is prescribed both oromorph and buprenorphine. However, the keyworker confirmed during interview that the combination was both safe and standard practice and that such reactions only happen when the patient is given a high dose of buprenorphine. He was not given a sufficiently high dose for side effects to occur.

CONCLUSION

112. This was a man with a unique and surprising background who, by virtue of his offending behaviour, found himself in a strange prison in an unfamiliar country. He was not a well man when he arrived in the UK and his health progressively declined as the months passed. Whilst I am pleased to see that the prison's healthcare department is working so closely with Priscilla Bacon Lodge, I am concerned by the staffing issues the investigation has highlighted. Given that Norwich has prided itself for some years now on the care it can offer the elderly and the dying, I am greatly concerned that its staff cannot administer syringe drivers.

113. The clinical reviewer makes a total of 40 recommendations in her clinical review. I have not repeated all of them in my report. Nonetheless, I draw the attention of Norfolk Community Health and Care NHS Trust to the clinical review.

114. Lastly, whilst the investigation has inevitably dwelt on problems that need to be addressed, I would like to take this opportunity to also highlight good practice. In her review, the clinical reviewer commends Prison Doctor B's professionalism and persistence in caring for the man. I fully endorse her comments.

RECOMMENDATIONS

Recommendation for the Governor

1. The Governor should ensure that the role of the immigration clerk is communicated to all staff in Norwich. The prison management should consider how to improve the channels of communication between the prison administration and healthcare departments regarding foreign national prisoners.

   The Governor accepted the recommendation and gave the following response:

   'A Governors Notice to All Staff will be issued outlining the role of the Immigration Clerk and the channels that the paperwork must go through for repatriation.'

Recommendations for the healthcare department

2. Norfolk Community Health and Care NHS Trust should ensure that any written clinical notes transferred with a patient are scanned and added to the electronic clinical record within 48 hours.

   Norfolk Community Health and Care NHS Trust partially accepted the recommendation and gave the following response:

   'Due to administration staff working Monday to Friday this may be not workable as a time frame over a weekend.'

3. Norfolk Community Health and Care NHS Trust should ensure that newly arrived prisoners' clinical records are checked for outstanding hospital appointments and that the appropriate enquiries are made.

   Norfolk Community Health and Care NHS Trust accepted the recommendation and gave the following response:

   'This should be addressed on arrival and /or in the secondary screening.'

4. Norfolk Community Health and Care NHS Trust should ensure that a care plan is drawn up for, and a key worker allocated to, each prisoner with complex long term needs.

   Norfolk Community Health and Care NHS Trust accepted the recommendation and gave the following response:

   'There is a large body of work ongoing with regard to careplanning, keyworkers and complex needs.'

5. Norfolk Community Health and Care NHS Trust should review the criteria for the provision of wheelchairs and communicate the outcome to all staff.

Norfolk Community Health and Care NHS Trust partially accepted the recommendation and gave the following response:

'Currently the need for a wheel chair is assessed via occupational therapy services. There are a number of restrictions on wheelchair use such as size and fitting through doors, access to lifts for exercise and association.'

The Trust also asked for greater clarity. My investigator agreed with the Modern Matron that the recommendation be reworded as follows:

Norfolk Community Health and Care NHS Trust should ensure that all staff are aware of the correct assessment and referral procedures when a prisoner requests a wheelchair.

6. Norfolk Community Health and Care NHS Trust should ensure that doctors are allocated adequate administrative support to facilitate hospital referrals in a timely manner.

   Norfolk Community Health and Care NHS Trust partially accepted the recommendation and gave the following response:

   'Doctors are employed by Serco and provide their own administration support.'

7. Norfolk Community Health and Care NHS Trust should ensure that all outpatient appointments are clearly recorded in the clinical record and that prisoners are given the opportunity to go to all such scheduled appointments.

   Norfolk Community Health and Care NHS Trust accepted the recommendation.

8. Norfolk Community Health and Care NHS Trust should ensure that staff are trained in the management of falls and subsequent care planning.

   Norfolk Community Health and Care NHS Trust accepted the recommendation.

9. Norfolk Community Health and Care NHS Trust should ensure that staff record clearly in the clinical record that the mental capacity of the patient has been considered when a 'Do Not Resuscitate Order' is signed.

   Norfolk Community Health and Care NHS Trust partially accepted the recommendation and gave the following response:

   'The recording of these details is the doctors' responsibility under the Gold Standard. The doctors are employed by Serco.

   'It should be made clear that the Mental Capacity Act says that it must be assumed that a person has capacity unless it is established otherwise.'

10. Norfolk Community Health and Care NHS Trust should undertake a staffing review to ensure that sufficient nurses are qualified to deliver all aspects of palliative care. They should be trained in the use of syringe drivers.

    Norfolk Community Health and Care NHS Trust accepted the recommendation.

11. Norfolk Community Health and Care NHS Trust should ensure that the prison healthcare team and the palliative care specialists at Priscilla Bacon Lodge jointly devise a care plan to provide optimal pain relief for each patient at the end of life.

    Norfolk Community Health and Care NHS Trust partially accepted the recommendation and gave the following response:

    'This is currently being looked at jointly with Priscilla Bacon Lodge.'