

A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at hospital in  
October 2012, while a prisoner at HMP Norwich**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report into the death of a man, a prisoner at HMP Norwich. He died from liver cancer at hospital in October 2012. He was 61 years old. I offer my condolences to his family and friends.

An investigator carried out the investigation and a clinical reviewer conducted a review of the man's clinical care at both HMP Norwich and HMP Wayland.

The man was diagnosed with liver cancer in June 2012 while he was a prisoner at HMP Wayland and started chemotherapy shortly afterwards. His condition deteriorated in the following months. On 12 October 2012, he transferred to the Older Prisoners' Unit at HMP Norwich, as Wayland does not have 24 hour health care. After spending a short time at Norwich, he was admitted to hospital on 25 October, where he died a few days later.

The clinical reviewer found that neither Norwich nor Wayland prisons provided appropriate end of life care for the man. Healthcare staff did not effectively involve him in his care plans and there was a lack of clarity among the staff about their individual roles. There was poor communication between prison healthcare staff and hospital personnel responsible for his care. The investigation also identified a need for improvement in the application process for compassionate release. Finally, despite being incapacitated and assessed as low risk, he was held in restraints until the morning of his death. This was not justified by a properly considered risk assessment and the process was poorly understood.

Overall, I do not consider that end of life care provided to the man was of a sufficient standard. This is particularly disappointing as it appears to reflect a decline in these services at Norwich, which we have previously commended.

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.

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

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## SUMMARY

1. The man died of liver cancer at hospital in October. He had been convicted of actual bodily harm (ABH) in December 2008 when he received a discretionary life sentence. In prison, he was diagnosed with hepatitis C and cirrhosis of the liver and received regular treatment.
2. On 25 May 2011, the man transferred to HMP Wayland. When he arrived, he had an outstanding appointment for a bladder biopsy. After an initial delay in following this up, his care was transferred to another hospital, where he attended frequent outpatient appointments. Tests, in April 2012, indicated that he had liver cancer. Prison healthcare were informed of the outcome but the doctor did not tell him, who did not find out about his diagnosis until a further hospital appointment on 13 June.
3. The man underwent a relatively new treatment of chemotherapy in an attempt to slow down the progression of the illness. However, his condition deteriorated and he transferred to the Older Prisoners' Unit at HMP Norwich on 12 October. The aim was to assist his difficulty with swallowing and provide intravenous treatment, which was unavailable at Wayland. We found that some staff were unclear about the reasons for his transfer, the expected treatment was not available at Norwich and the palliative care provision was poor. Previous good links with community services were no longer in place.
4. The man's condition deteriorated further and, at around midday on 25 October, a prison doctor arranged for him to be admitted to the Acute Medical Unit at hospital, but he did not leave the prison until about 6.00pm. Before he left the prison, staff completed a risk assessment and concluded that he should be escorted by two staff and restrained by a single handcuff (subsequently reduced to an escort chain). No medical information was considered as part of the risk assessment and it was not reviewed during his time in hospital, although his condition continued to deteriorate. The restraints were eventually removed on the morning of his death, at the request of hospital staff. His family remained with him throughout the day and he died at 6.45.
5. The investigation found that there was a lack of palliative care resources to manage appropriately those at the end of their lives. There was inadequate communication between the two prisons and with the hospital. The process for compassionate release applications was poor. Procedures for the use of restraints were inadequate and the level of restraint used was not justified by properly informed risk assessments. We made recommendations about these matters to both Wayland and Norwich prisons and all were accepted.

## THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 31 October 2012. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact him with any relevant information. No responses were received.
8. The investigator obtained copies of the man's medical record and relevant prison records. The local PCT conducted a review of the clinical care he received at Norwich and HMP Wayland.
9. The investigator visited Norwich and Wayland in December to conduct interviews with prison staff. The clinical reviewer joined him for interviews with clinicians.
10. The investigator informed HM Coroner for Norfolk of the investigation. A copy of this report has been sent to the coroner to assist his enquiries.
11. One of the Ombudsman's family liaison officers contacted the man's partner to outline the purpose of the investigation and ask if there were any issues she wished the investigation to consider. She was particularly concerned about the length of time it appeared to take before her partner was taken to hospital.
12. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.
13. Following a consultation period, the man's family responded to the findings of the investigation, set out in the draft report. They said that they were satisfied that all issues had been considered and that recommendations made had been accepted by the Prison Service. They hoped that changes would be made that meant other families would be spared the same distress which they themselves experienced from seeing him in restraints at the end of his life.

## HMP & YOI NORWICH

13. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison accepts adult and young adult men under 21, both convicted and on remand. It holds up to 767 prisoners. The prison's health services are commissioned by the NHS and provided by a private healthcare company and their subcontractors. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

### HM Inspectorate of Prisons (HMIP)

14. Her Majesty's Inspectorate of Prisons carried out an unannounced follow-up inspection of Norwich in February 2012. The previous inspection, in February 2010, found that the healthcare provision was improving but inpatient services were insufficient. The 2010 report commented about the Older Prisoners' Unit:

'... 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 ...'

15. This investigation has found that since the change in healthcare provider, the links with outside agencies, mentioned by the inspectorate in their 2010 report, no longer appear to be in place.
16. In their most recent report, the inspectorate commented:

"Prisoners were dissatisfied with some aspects of health care, particularly the appointments system, although health services had improved since our last inspection. Service commissioning and provider arrangements were overly complex and in transition. The standard of clinical facilities and treatment rooms ranged from high to very poor. There was a reasonable range of primary care clinics and opportunities for the care of lifelong conditions ... The inpatient unit and older prisoner unit offered good standards of care but in dated, and often, very poor environments."

### Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor standards to help ensure prisoners are treated fairly and decently. In their most recent annual report, the IMB at Norwich said:

'... In last year's report we stated that "The Board is of the opinion that healthcare provision in HMP Norwich continues to be deficient following the awarding of the contract to Serco in September 2010, this in spite of sterling and caring efforts by the inadequate number of permanent healthcare staff". Despite continued dedicated work by some of the healthcare staff, this situation has remained basically the same to the extent that we are worried that some practices are

clinically unsound. The Governor and Senior Management Team (SMT) persistently question Serco, highlighting their own concerns at the shortcomings and deficiencies within this provision, but are powerless to manage the contract themselves. The Serco managers on site appear to find themselves in the unenviable position of trying to meet the clinical needs of the prisoners, managing a variety of sub-contracts and working within the constraints placed upon them by their company. The latest Healthcare Manager and her clinical lead have just resigned ...'

18. Norwich has had a high number of deaths in custody, mostly of prisoners in the Older Prisoners' Unit which also provides palliative care for the terminally ill. The man's death was the sixth cancer-related death at this unit since June 2010. Previous investigations found the care provided in the Older Prisoners' Unit was of a high standard, which was not evident in this case.

### **HMP WAYLAND**

19. HMP Wayland is a category C prison (medium security) in Norfolk holding over 1,000 prisoners in 13 residential units. There is nursing cover in the prison between 7.30am and 7.30pm. A local out-of-hours service is used if medical attention is required at other times.

### **Her Majesty's Inspectorate of Prisons**

20. The last report published on HMP Wayland by HM Chief Inspector of Prisons followed an announced inspection in June 2011. About healthcare the report said:

"The strategic management of health care was weak and ineffective partnership arrangements meant that poor outcomes for prisoners were not robustly addressed... Primary care services were affected by staff shortages and contractual changes, although there was a new and effective nurse practitioner service. Access to the range of services was inadequate for the needs of the population. GP services were reliant on locum staff. The application process for health care services was poorly managed and there were long waiting lists for many of them. Medicines management was poor... Secondary mental health services were good... Palliative care, although rarely required, was supported with the cooperation of local services."

### **Independent Monitoring Board (IMB) report**

21. The last report published by the IMB for Wayland in May 2012, concluded that:

"... HMP Wayland remains a first rate prison due to strong management led the Governor and his team. We do have grave concerns regarding budget cuts and how they impinge on staff recruitment, and how a safe environment can be maintained. We are pleased to report that further to our criticism in last year's annual report, and a poor HMCIP inspection on IDTS delivery, this service has now been turned around and the process is safe, meaningful and proactive in detoxifying drug addicted prisoners ..."

## ISSUES

### **The diagnosis of the man's terminal illness**

28. The man was born in September 1951. He had been convicted of actual bodily harm (ABH) in December 2008 and sentenced to discretionary life imprisonment. While he was remanded in custody, he was diagnosed with hepatitis C and cirrhosis of the liver, and began regular treatment.
29. The man transferred to HMP Wayland from HMP Gartree on 25 May 2011, and told a nurse when he arrived that he had an outstanding appointment for a bladder biopsy. Despite this, he did not see a GP until 6 June 2011 and there is no explanation for this delay. The GP then referred him, under the "two-week rule", to the urology department at hospital. (There is a target for NHS patients with suspected cancer to see a specialist within two weeks of a GP referral). He attended an appointment on 13 June 2011. The biopsy indicated nothing sinister.
30. The man's hepatitis C and cirrhosis of the liver meant he was at greater risk of hepatocellular carcinoma (liver cancer) and therefore attended frequent hospital appointments for blood tests and ultrasound scans. At an appointment on 3 April 2012, it was noted that he had an irregular liver shape and a magnetic resonance imaging (MRI) scan was requested. The MRI took place on 20 April 2012 and indicated that he had three cancerous lesions on his liver.
31. We are satisfied that the man's healthcare was handled promptly after he was first seen by the prison doctor and his diagnosis was timely. The delay seeing the doctor when he arrived at Wayland did not affect his diagnosis as his biopsy on 13 June was clear. However, it is a concern that healthcare staff did not arrange a priority appointment for him to see the GP about his outstanding hospital appointment when he first arrived. In other cases such a delay could be crucial.

**The Head of Healthcare at Wayland should ensure that prisoners arriving with outstanding hospital appointments for investigative tests are referred to the prison doctor as a priority.**

### **Informing the man about his condition and treatment**

28. The man asked a doctor at Wayland on 25 May about the results of his MRI scan. She told him that they were not available. On 13 June, he had a further appointment at hospital for a computerised tomography (CT) scan to assess whether the cancer had spread to other areas. At the appointment, a specialist spoke to him about his diagnosis and was surprised that healthcare staff at the prison had not informed him. When he returned to the prison, he told a nurse about the conversation. The prison medical notes indicate that his diagnosis was known and recorded before his hospital appointment on 13 June.
29. The clinical reviewer concluded that communication between healthcare staff at Wayland and secondary care services at the hospital had not been good. This in turn led to delays in informing the man of his condition and the treatment options available. The delay in informing him fully of his diagnosis was

unsatisfactory and should have been avoided through better links with secondary care services in the community. As there is no evidence of a discussion with him about his treatment options and prognosis we make the following recommendation:

**The Head of Healthcare at Wayland should ensure that prisoners with serious illnesses are informed of their diagnosis and treatment options promptly.**

### **The man's appointments and medical treatment**

30. Because of the man's existing medical conditions, he had regular tests as an outpatient at hospital, which continued after his diagnosis. Prison healthcare staff interviewed during the investigation were unclear about his treatment plan and there was no correspondence about this from the hospital.
31. The man was due to attend a hospital appointment hospital, on 18 July 2011, for a cystoscopy (an examination of the bladder with a small camera) and bladder biopsy. Because the hospital had informed him of the date of the appointment in advance the prison cancelled it for security reasons. It was rescheduled for 28 July. This appears to have been the only appointment that was cancelled. The biopsy did not indicate any cancer in his bladder and he was discharged from the care of the urology team at the hospital.
32. The Prison Service's National Security Framework, which governs prisons' security arrangements, does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that this is often the case. The security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when taking a decision. In view of the man's serious medical condition, the need for regular monitoring and treatment and his low risk, we consider the appointment on 18 July should not have been cancelled.

**The Governor and Head of Healthcare at Wayland should ensure that a prisoner's health is fully taken into account before hospital appointments are cancelled and that when appointments are cancelled, fully justified and overriding security reasons are documented.**

33. The man underwent a new medical procedure on 30 July 2012, known as transarterial chemoembolization (TACE). This involves blocking blood vessels to cut off the blood supply to the tumour while injecting it with chemotherapy. The nurses at Wayland had no knowledge of this specialist procedure. However, the liver specialist nurse from the hospital conducts clinics at Wayland and during one of her visits, a nurse asked her for advice about his treatment and to act as a point of contact for the prison.
34. The man had a named nurse at Wayland to act as first point of contact and lead on his care plan. However, the clinical reviewer considered that the healthcare team was not sufficiently proactive in liaising with hospital staff for information and they should have considered attending a multidisciplinary meeting about him, held at the hospital on 28 June 2012. Although he received appropriate treatment through the hospital, we agree that active contact between the prison

healthcare team and secondary services is needed to ensure that the needs of seriously ill prisoners are met.

**The Head of Healthcare at HMP Wayland should ensure that there is effective liaison with secondary care services to gain a clear understanding of hospital treatment plans and patient needs.**

35. After the man transferred to Norwich on 12 October, he continued to receive medication and his condition appeared to settle. From 19 October, he began to feel increasingly unwell. He had chest pain and found it difficult to sleep. On 24 October, a nurse recorded that he had been suffering from hiccups for three days. That day a doctor noted that the hiccups were likely to be a side effect of antibiotics but he should continue the course unless he found the hiccups intolerable. There is no evidence that the doctor examined him.
36. On 25 October, a nurse recorded that during routine night observations, at 1.30am and 3.00am, the man had been heard in his toilet, retching and hiccupping. He told the nurse that he had diarrhoea and had been vomiting. He was helped back to bed and his observations, pulse and temperature were recorded. There is no record of any other treatment or intervention that night.
37. At 12.27pm on 25 October, a prison doctor discussed his condition with a gastroenterology registrar at the hospital, who advised her to refer him for assessment at the hospital's Acute Medical Unit. As this was not an emergency admission, initially staff booked a taxi, which arrived at around 4.00pm. It was then decided that he needed a non-emergency ambulance to take him to hospital and had to wait until around 6pm. While it would have been preferable for the transfer to hospital to have taken place more quickly, we do not consider that this was an undue delay and it did not impact on his treatment.

**The man's location**

38. The man's condition deteriorated between July and October 2012. Healthcare staff at Wayland had planned to move him to the Older Prisoners' Unit at Norwich when they could no longer facilitate his required level of care. He did not want to move and told staff that he preferred to remain at Wayland, where he knew people and felt settled. However, his condition deteriorated quickly and the move to Norwich took place on 12 October, sooner than planned. His medical record suggests that the reason for the move was that he needed 24-hour healthcare so that he could receive intravenous antibiotics and assistance at mealtimes.
39. Although Norwich offers 24 hour health cover, the investigation found that prisoners on the Older Prisoners' Unit receive no more general supervision than the man had received at Wayland. Prisoners are locked in their cells at mealtimes so he did not have the help with meals that Wayland staff had expected. Nor was Norwich able to facilitate the administration of intravenous antibiotics.
40. The admission criteria for the Older Prisoners' Unit, includes a requirement for a referral form to be completed by the sending prison. In the man's case this was not done and the investigator was told that the arrangements were made

by email and telephone. Prison staff, outside the healthcare team, told the investigator that they were not aware of the reasons for his transfer or his prognosis.

41. It does not appear that the care the man required was available in the Norwich unit to which he was allocated or that the operational staff on the unit understood the reasons for his transfer. In addition, there is no evidence that his own wishes about his location were fully considered before deciding to transfer him to Norwich.

**The Head of Healthcare at Norwich should provide clear information for healthcare staff in the Norfolk cluster, on the referral process, admission criteria and services available for prisoners who need inpatient healthcare, including in the Older Prisoners' Unit.**

### **Palliative care plans**

42. The healthcare manager at Wayland said that she had been in discussion with staff at HMP Norwich for some time to inform them that the man would have to move to the Older Prisoners' Unit for palliative care at some point. However, she said these arrangements were pre-empted by the need to transfer him for the intravenous antibiotic treatment and help with his food (neither of which were delivered).
43. The NHS document 'The route to success in end of life care – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. It helps carers to plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. It does not appear from the records that any plans had been made for the man's end of life care. The clinical matron at Norwich explained that he had only been at the prison for a short time. Had he been there longer, she would have held a multidisciplinary team meeting to discuss his care. She accepted that there was no end of life nor palliative care pathway in place since the healthcare provider had changed and that previous good links with local palliative care services, such as a local hospice, had been lost. She said she had started to develop relevant pathways.
44. Although previous investigations into the deaths of terminally ill patients on the Older Prisoners' Unit at Norwich found that palliative care was good, this was not the case with the man. The respective roles and responsibilities of healthcare and prison staff were unclear. Many of the latter were not even aware of the reasons for his transfer to Norwich and Wayland did not develop any end of life care plan to pass to Norwich.

**The Heads of Healthcare at Wayland and Norwich should implement multidisciplinary end of life care plans for terminally ill prisoners in line with national guidance.**

### **Compassionate release**

45. Early release on compassionate grounds (ERCG) is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for

indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700 and prisoners are usually expected to have less than three months to live. The criteria include that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) within the National Offender Management Service (NOMS).

46. After his diagnosis, the man discussed the possibility of early release with his offender supervisor at Wayland. She told the investigator that when he was diagnosed she was in the process of compiling his parole report to pursue both compassionate release and to expedite his parole hearing on the grounds of ill-health. She had explained to him that, in view of his prognosis, she would need to speak to both the healthcare team and his offender manager to discuss the best way of moving forward.
47. Applications for early release on compassionate grounds must be submitted with supporting letters from those who have been involved in the patient's care. The offender supervisor tried to obtain these and had spoken to the healthcare manager, who told her that a supporting letter had been requested from the liver specialist nurse at the end of August 2012. She had also tried to obtain supporting documentation from the prison doctor. Her efforts continued after the man transferred to Norwich but the documents had still not been received before his death. There is no evidence that any other member of staff from either prison attempted to pursue compassionate early release.
48. The clinical reviewer considered that the approach of the healthcare team at Wayland to supplying information for early release appeared muddled and could not be identified in the medical record. At Norwich it was unclear what, if any, discussions had been held about early release. Although the offender supervisor had attempted to progress an application, there is no evidence of any management input or coordination of an application for early release.

**The Governors of Wayland and Norwich should ensure that the possibility of early release on compassionate grounds is considered and documented for terminally ill prisoners.**

#### **Escort, restraints and bedwatch**

49. The Prison Service has a duty to protect the public when escorting prisoners to hospital and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition.
50. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It is deemed

that handcuffing a prisoner receiving chemotherapy (and, by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations. During the investigation it was apparent that none of the staff interviewed were fully aware of this judgement or the impact on Prison Service policy and procedures. The clinical reviewer also commented that the healthcare team seemed unclear about their role in the risk assessment process.

47. When the decision was taken to send the man to hospital from Norwich on 25 October, a Senior Officer (SO) completed an escort risk assessment. He told the investigator that he did not know why the man was going to hospital when he completed the form. He incorrectly recorded his offence as 'murder' and said that he believed he obtained the information from the electronic records. However, during previous hospital visits from Wayland his offence details had been recorded correctly and copies of previous escort forms were available in his record.
48. The investigator reviewed the risk assessment documents for the October admission, as well as those completed at Wayland for previous hospital visits. There is a requirement for medical information to be included, but no one from the healthcare department completed or signed the relevant section of the form. The man's risk of escape was assessed as low on each of the assessments, as was his risk of hostage taking and risk to the public. The October risk assessment indicated no security concerns in any of the areas covered. Despite this, it was concluded that he should be escorted by two officers and handcuffed to one of them
49. The SO explained that if the transfer to hospital was an emergency it could be quite difficult to find a nurse who knows the prisoner to complete the form. If it was a pre-planned escort, the medical information would be completed first and then sent to the security department where it would be taken into account during the assessment. At around 12.30pm on 25 October, it was agreed that the man had to go to hospital but he did not leave the prison until around 6.00pm. This suggests that there was sufficient time to collate the required information.
50. The Head of Security and Operations countersigned the assessment. The investigator asked her about the procedures and drew her attention to the fact that the healthcare section of the form was incomplete. She said she did not know whether it was an emergency or not and dealt with it the same as any other risk assessment. She said there was nothing of real concern and the normal procedure would be to ensure that this prisoner is handcuffed at all times. She added that improvements had been made to the risk assessment process since January 2012, but as the man went to hospital in October 2012, this does not suggest that the arrangements took appropriate account of Prison Service guidance for escorts to hospital.
51. The escort staff were given a standard escort risk assessment form, rather than one for a hospital admission (known in prisons as a bedwatch). Norwich's local policy says:

“... Should an escort turn into a bedwatch the escorting officer should immediately inform the orderly officer. The orderly officer must arrange

for a bedwatch risk assessment to be completed, signed by the governor, deputy governor, or governor in charge in their absence. The completed document must be sent with the relieving escort staff or within 24 hours, whichever is sooner ...”

52. The documents for hospital admission were not given to the officers escorting the man until mid-morning on 27 October and no revised risk assessment had been completed, taking account of changes to his medical condition. The log completed by escort staff indicates that he continued to receive treatment and experience problems with his breathing.
53. A prison manager visits the hospital daily to check the welfare of the prisoner and review the risk assessment. Management checks were completed on 28, 29 and 30 October. During the checks on 28 and 29 October, the visiting managers recorded, ‘no change to current assessment’. There was nothing to indicate what had been checked, why they considered there was no need to change the risk assessment or whether they had spoken to medical staff about the man’s prognosis. During this time, he was restrained by an escort chain, (a length of chain with a single handcuff at each end, one attached to his wrist and the other to one of the escorting officers).
54. A Principal Officer (PO) conducted the management check on 28 October. The investigator asked him about the purpose of a management check. He replied he would check security precautions, protocols and equipment and that staff were correctly dressed. He would also consider the room, facilities, the prisoner’s demeanour and would talk to the prisoner to find out if they had any needs. He added that he did not have the authority to make any changes to the risk assessment, but if he had concerns he would speak to the duty governor at the prison.
55. Escort staff recorded that medical staff had continuing concerns about the man’s respiratory and cardiac function, but no changes were made to the original risk assessment and he remained attached to the escort chain. At 6.30 on 30 October, hospital staff told the escort officers that they were becoming increasingly concerned about his condition and asked for the restraints to be removed as they were intrusive. Although the risk assessment clearly stated that restraints could be removed at the request of medical staff, the officers told them that they would first have to check with the duty governor.
56. An operational manager was also the duty governor on 30 October. He told the investigator that a member of staff at the prison had telephoned him at home at around 7.30am, to tell him that the man’s health had deteriorated overnight and the hospital staff had concerns about how long he had to live and had contacted his family. He then went to the hospital. The investigator asked him why he had not authorised that the restraints should be removed when he was contacted. He was unable to comment, other than to say that the escort staff had an expectation that such a decision would need to be made by a competent manager. When he arrived at the hospital, he recorded that, ‘The man is a low risk cat C prisoner serving life for murder. He has limited mobility and considering decency as this part of his illness, mechanical restraints have been removed ...’ The investigator pointed out to him that the man had not been convicted of murder and that he had been considered a ‘low risk’ prisoner in a poor physical condition at the outset.

57. The man's condition continued to deteriorate and, sadly, he died. His family were with him at the time.
59. British Medical Association guidance is that there should be a presumption that prisoners are examined and treated without restraints, unless there is a high risk of escape or the prisoner represents a threat to himself, the health team, or others. We acknowledge that public protection is paramount, but security measures must be proportionate to a prisoner's individual circumstances. The man had been diagnosed with a terminal illness and assessed as a low risk of escape and a low risk to the public should he do so. When he was taken to hospital on 25 October, he was very seriously ill, yet restraints were still used. They were not removed until the morning of his death despite the deterioration of his condition in the preceding days. It is apparent that staff at Norwich had little knowledge of current Prison Service guidance on the use of restraints for prisoners being taken to hospital. The man's physical health and medical information were not sufficiently taken into account in the escort risk assessments and the level of restraints used was not appropriately justified.

**The Governor of Norwich should ensure that risk assessments for hospital escorts take into account accurate, up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.**

#### **Liaison with the man's family**

60. The man was in contact with his partner throughout his time in prison, and she visited him often. When he was admitted to hospital on 25 October 2012, he was able to telephone to tell her of his admission. His partner visited him in hospital and was with him when he died.
61. The prison's family liaison officer contacted the man's partner on 31 October and arranged to visit his family on 1 November. She explained her role and told them that the prison would assist with the funeral. She remained in contact with the partner over the next few weeks, and provided practical support in organising the funeral, which took place on 16 November.
62. Prison Service Instruction (PSI) 64/2011 states, "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill". It also suggests that if a prisoner is in hospital, a member of staff should meet the prisoner's family to provide information as this might reduce the distress for the family. In the man's case, the prison did not assign anyone to liaise with his family until after his death, which might have happened had there been appropriate end of life care planning. We are satisfied that, once appointed, the family liaison officer provided good support.

**The Governors of Wayland and Norwich should appoint a member of staff to liaise with families, provide information and act as a point of contact when a prisoner is diagnosed with a terminal illness.**

## RECOMMENDATIONS

### HMP Wayland

1. The Head of Healthcare at Wayland should ensure that prisoners arriving with outstanding hospital appointments for investigative tests are referred to the prison doctor as a priority.

*The Prison accepted this recommendation and has said:*

*'This will be picked up at the point of reception and all outstanding appointments will be reviewed as a matter of urgency at the doctors' appointment that is given as a priority. This is now in place.'*

2. The Head of Healthcare at Wayland should ensure that prisoners with serious illnesses are informed of their diagnosis and treatment options promptly.

*The Prison accepted this recommendation and has said:*

*'Diagnosis, treatment options and prognosis should be discussed with the patient promptly. In the event that the hospital has not shared the initial information with the patient, more liaisons with the hospital must take place between prison healthcare and hospital to avoid delays in information being given to the patient. The Junior Sister for Wayland has been given the responsibility for case managing all patients with complex needs and this will fall in her remit. This is now in place.'*

3. The Governor and Head of Healthcare at Wayland should ensure that a prisoner's health is fully taken into account before hospital appointments are cancelled and that when appointments are cancelled, fully justified and overriding security reasons are documented.

*The Prison accepted this recommendation and has said:*

*'All hospital appointments should take place unless reason for cancellation is fully justified and at all times the health needs of the patient is given priority. Any cancellations should have the justification documented. This is now in place.'*

4. The Head of Healthcare at HMP Wayland should ensure that there is effective liaison with secondary care services to gain a clear understanding of hospital treatment plans and patient needs.

*The Prison accepted this recommendation and has said:*

*'Liaison with secondary care services needs to take place as a matter of course and with regulatory. The Junior Sister that manages the patients with complex health needs will ensure that effective communication occurs with all services involved with the patient's care. In addition the Liver Specialist Nurse will be informed of all patients that present with any form of liver condition/involvement as she wishes to be involved in the case management of these patients. This is now in place.'*

## **HMP Norwich**

5. The Head of Healthcare at Norwich should provide clear information for healthcare staff in the Norfolk cluster, on the referral process, admission criteria and services available for prisoners who need inpatient healthcare, including in the Older Prisoners' Unit.

*The Prison accepted this recommendation and has said:*

*'The Admissions Policy was reviewed in March 2013 and this current policy covers Admission Criteria to HCC for HMP Bure, Wayland and Norwich, Admission to HMP Norwich in-patient beds, Admission criteria, Exclusion criteria, Procedure for Admission, Admission form Acute Hospital, Referrals, Transfer to Secondary Care Hospital, Monitoring and Reviewing.'*

6. The Governor of Norwich should ensure that risk assessments for hospital escorts take into account accurate, up to date and relevant information, including age, state of health and mobility as well as a meaningful assessment by healthcare staff.

*The Prison accepted this recommendation and has said:*

*'Security staff completing the initial documents should ensure the correct information is contained. This should be checked again by the discharging Custodial Manager. Healthcare to offer full input to the risk assessment both at initial escort and any subsequent review. Risk assessment will be reviewed regularly by visiting manager conducting escort checks, and take account of any change/deterioration in health.'*

*All prisoners who require escorting to hospital have System1 clinical notes with up to date data which can be shared with escorting/discipline staff.'*

## **HMP Wayland and HMP Norwich**

7. The Heads of Healthcare at Wayland and Norwich should implement multidisciplinary end of life care plans for terminally ill prisoners in line with national guidance.

*Both prisons accepted this recommendation and have said:*

*'All terminally patients will be placed upon End of Life Pathway in line with National Guidelines. Presently all prisoners at HMP Norwich who come under this remit have a preferred priorities of care document which informs the prisoner with regards to their end of life circumstances. Any prisoner who has a palliative condition is on the Gold Standard Register which is reviewed monthly. The Liverpool Care Pathway is implemented where appropriate. This is now in place.'*

8. The Governors of Wayland and Norwich should ensure that the possibility of early release on compassionate grounds is considered and documented for terminally ill prisoners.

*Both prisons accepted this recommendation and have said:*

*'All due consideration for possibility for early release will be raised at the point of diagnosis and at any subsequent case review (or significant change of circumstances). This process will be considered as a multi-disciplinary case review including Healthcare, Probation, Offender Management and Security. The process will be facilitated by the Safer Prison and Equalities Manager. As part of the regular GSF meetings, consideration is given to applications for compassionate release and updates to this will be reviewed monthly. This is now in place.'*

9. The Governors of Wayland and Norwich should appoint a member of staff to liaise with families, provide information and act as a point of contact when a prisoner is diagnosed with a terminal illness.

*Both prisons accepted this recommendation and have said:*

*'Any offender that is diagnosed with a terminal illness will be designated a family liaison officer. The FLO will provide a consistent point of contact supported by the Safer Custody team. Regular GSF meetings take place between Safer Custody and Healthcare. Prisoners identified with a terminal illness will be allocated a FLO and a member of Healthcare staff as contact point for medical in confidence information. This is now in place.'*