PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in September 2013, 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 investigation report into the death of a man in September 2013, a prisoner at HMP Norwich. The man died of multi-organ failure, as a result of liver cancer. He was 69 years old. I offer my condolences to the man's family and friends.

The man was sentenced to 18 years imprisonment on 21 November 2007, and transferred to the elderly prisoners' unit at HMP Norwich in April 2010. He was in poor physical health and suffered from a number of chronic medical conditions. In February 2013, the man was diagnosed with gallstones, but a follow up appointment planned for three weeks later did not take place. It seems the prison cancelled this but did not rearrange it. In June, the hospital informed the prison that they had booked an appointment in October to remove the man's gallbladder. On 3 September, the man was admitted to hospital with nausea, increasing tiredness and a general decline in health. Tests showed that the man had inoperable liver cancer, and he returned to the prison on 24 September for palliative care.

At 3.30am on 29 September, a healthcare assistant found the man unresponsive in his cell. He and other staff who attended were satisfied that the man had died, but no one knew whether a 'do not attempt resuscitation order' was in place, resulting in confusion about what to do. At the request of an operational manager, staff started futile attempts at resuscitation some time later. Paramedics arrived and immediately confirmed that the man had died

I am concerned that the man was not taken for a hospital appointment which could have led to an earlier diagnosis of his illness. In other respects he received a satisfactory standard of care at Norwich. It is unsatisfactory that there was no readily available care plan which resulted in a lack of clarity about what to do when the man was found unresponsive. While it would not have changed the outcome for the man, the governor needs to ensure that all staff working with elderly and terminally ill prisoners have a clear understanding of their roles and responsibilities in an emergency.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2014**

CONTENTS

SUMMARY

1. The man was sentenced to 18 years imprisonment for sexual offences on 21 November 2007. He transferred to HMP Norwich on 23 April 2010, and lived on L Wing, the elderly care unit. The man had an extensive medical history of complex long term conditions and was reviewed frequently by healthcare staff.

2. In February 2013, the man was admitted to the Norfolk and Norwich University Hospital and diagnosed with large gallstones. He was due to be reviewed, for possible surgery, three weeks later but this did not happen, despite him repeatedly asking the prison doctor why he had not been reviewed. The man was again admitted to Norfolk and Norwich University Hospital on 3 September 2013, after a general decline in his health. On 16 September the man was diagnosed with inoperable liver cancer and returned to the prison on 24 September**,** for palliative care.

3. On 29 September at 3.30am, a healthcare assistant found the man unresponsive in his cell. He understood that the man had agreed that resuscitation should not be attempted and was sure that he had died. The healthcare assistant did not immediately inform the nurse in charge of L wing that night and there was some confusion about the man's wishes. The duty governor later instructed the staff to attempt resuscitation. As this was over twenty minutes after the man had first been discovered and the healthcare staff were clear that the man had died, it should have been apparent that this was futile.

4. An emergency ambulance was not requested until 4.08am. Paramedics arrived at Norwich at 4.16am, but went to the wrong entrance, and did not get to the man until 4.26am. At 4.28am the paramedics confirmed that the man had died.

5. In light of the clinical reviewer's findings, we are satisfied that the man was treated appropriately after his diagnosis, but we are concerned that an important hospital appointment was cancelled by the prison. This is the second recent death at Norwich where confusion about resuscitation led to this being attempted when someone had clearly died. Although it would not have affected the outcome for the man, appropriate emergency protocols were not followed, which resulted in a delay in calling an ambulance.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Norwich of the investigation and asking anyone with relevant information to contact her. No one responded.

7. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

8. The investigator obtained copies of the man's prison and prison medical records. The investigator and clinical reviewer interviewed staff at HMP Norwich on 31 October, and visited the healthcare centre and wing where the man had lived. The investigator gave initial feedback to the Governor's representative during the investigation and followed this up in writing. The clinical reviewer subsequently interviewed two healthcare staff by telephone and the investigator interviewed the healthcare administrator by telephone.

9. The investigator informed HM Coroner for Greater Norfolk District of the investigation and the Coroner provided the cause of death. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers wrote to the man's friend, his nominated emergency contact, to explain the investigation process. His friend did not raise any issues he wanted the investigation to cover.

11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, whether palliative care was provided, liaison with his friend, his location and security arrangements and whether compassionate release was considered.

12. The man's next of kin was informed the draft report was available, but did not wish to receive a copy or make any comment. The prison considered our draft report and recommendations and has accepted these. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP NORWICH

13. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison holds up to 767 male prisoners. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Norwich was in August 2013. The Inspectorate found there was uncertainty around future healthcare provision and no clear strategy. While the nurse practitioner service was very good, the high use of locum GPs led to inconsistencies in treatment, care and prescribing. The Inspectorate noted that the inpatient and older prisoner units provided good care and there were plans to develop the palliative care arrangements.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to February 2013, the IMB noted that they had major concerns with regard to healthcare provision. In some areas the IMB regarded the service as inadequate to meet the complex needs of prisoners. The Board was concerned about the lack of permanent GPs and many other temporary healthcare staff which caused a lack of continuity of care. The IMB was positive about the permanent healthcare staff who the Board believed provided an excellent service in difficult and challenging circumstances.

16. The IMB noted that improvements had been made to the unit for elderly prisoners which was now a much friendlier and more homely place than previously. Although the cells remained outdated the prisoners there had a better quality of life for their final years. The IMB was concerned about the timeliness of applications for compassionate release for prisoners diagnosed with a terminal illness.

Previous deaths at Norwich

17. The man was the tenth prisoner to die from natural causes at Norwich since the start of 2011. In three other cases we have identified the management of Do Not Attempt Resuscitation (DNAR) notices as an issue. In another recent case we made recommendations on following up hospital appointments and guidance on resuscitation.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

18. The man was sentenced to 18 years imprisonment on 21 November 2007 and transferred to HMP Norwich on 23 April 2010. He had a number of complex medical conditions, including a history of heart attacks, gallstones, asthma, insulin controlled diabetes and rheumatoid arthritis. The man was obese and was registered blind. He used a wheelchair to get about. There were care plans to ensure effective management of his diabetes, and he was assisted with his personal hygiene. Healthcare staff reviewed the man regularly.

19. On 12 February 2013, the man told a nurse that he had been vomiting and had severe stomach pains. A prison doctor, examined the man, who told him that he had a history of gallstones. The man was admitted later that day to Norfolk and Norwich University Hospital and was diagnosed with very large gallstones. He was treated with pain relief and antibiotics. The man was discharged back to the prison on 22 February. His discharge letter said he would be seen again in three weeks, to decide whether surgery was necessary.

20. The man did not go to the hospital for this follow up appointment and there is no record to explain why. A prison officer working in the security department, told the investigator that the prison had probably cancelled the appointment as the man was aware of the date and this breached security. Other staff thought this had been the case, although this was not recorded anywhere. The healthcare administrator said that it was common practice to cancel hospital appointments when a prisoner is aware of the date.

21. No one has been able to tell us for certain what happened about the man's follow up appointment, but it is a concern that a number of staff believed it had been cancelled automatically because he was aware of the date. 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 prisons often do this without sufficient reason. The national security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision and, if necessary, additional security arrangements can be put in place rather than cancelling appointments.

22. The man's risk assessment at the time indicated that he was considered a low risk of escape, low risk to the public and his mobility and sight were limited. It is therefore difficult to see how cancelling the original appointment would have been justified on security grounds.

23. The man frequently told healthcare staff that he wanted surgery to remove his gallstones and was unhappy at the delay. The doctor asked the healthcare administrator to chase up the appointment on 12 April.

24. The healthcare administrator told the investigator that he would have accessed the prison electronic record to see if an appointment had been booked, but would not have contacted the hospital, as he was not a clinician. The healthcare administrator was unable to say whether he had reported back to the prison GP and there is nothing in the records. The healthcare administrator said that Norfolk and Norwich University Hospital contacted him on 19 June, and booked an appointment for 11 October for the man to have his gallbladder removed.

25. On 29 August, the man said the pain in his abdomen was worse, he had vomited, was unable to eat, and it was painful when passing urine. He told the GP that he was worried that he had prostate cancer and wanted to be referred to hospital. The GP requested an outpatient review as soon as possible.

26. Over the next few days, the GP and nurses frequently reviewed the man. Urine tests showed that he had raised billirubin (an indication of a possible obstruction that can cause jaundice) but there was no sign of infection. The man's urine was tested over the next few days and there was no worsening of his symptoms. The GP received blood test results on 2 September, and noted that the man had stage three kidney failure which signifies deteriorating kidney function. His blood results were abnormal. The GP made an urgent referral to a urologist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The doctor also requested further blood tests to test the man's liver function.

27. On 3 September 2013, the results of the blood tests showed that the man's condition had worsened, and he had developed jaundice (yellowing of the skin and eyes due to a build up of billirubin). The man was admitted to the Norfolk and Norwich University Hospital, where he was initially diagnosed with obstructive jaundice, caused by a gallstone.

28. On 13 September, the man had a scan which showed that he had multiple liver metastasises, although the primary source of cancer could not be detected. It was thought to be the gallbladder. A liver biopsy showed that his condition was inoperable. The hospital consultant informed him of this diagnosis and that he would receive palliative care to ease his symptoms.

29. We are concerned that the man was not taken for his original appointment and the prison did not urgently rearrange a further appointment for a review of his gallstones, even when the man reminded staff. The clinical reviewer notes that the presence of cancer within the gallbladder is often difficult to diagnose in its early stages due to the hidden position in the body, but it could have been present when the man's gallstones were found in February. It is possible that this could have been identified at an appointment in March, had this happened. We make the following recommendation:

The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the

prisoner's health. When appointments are cancelled, active efforts should be made to rearrange then urgently.

30. The clinical reviewer found that in other respects the man's treatment was reasonable. Healthcare staff noted the re-occurrence of biliary colic and jaundice and appropriately referred him to hospital.

31. We are satisfied that the man was fully informed of his diagnosis of liver cancer, along with its incurable and inoperable nature while in hospital.

The man's medical treatment

32. After his diagnosis the man remained in hospital until 24 September. He then returned to Norwich prison for palliative care.

33. 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.

34. After the man was diagnosed with cancer, Norwich healthcare staff liaised with a Macmillan palliative nursing care specialist at the local hospice. This helped ensure that the man received appropriate treatment and pain relief. His cell door was left open at all times to allow nurses easy access to attend to his needs. The man was a Muslim and the prison Imam visited him in hospital and when he returned to L wing to give him spiritual comfort.

35. It appears that healthcare and prison staff provided a good overall standard of palliative care, with attention to the man's physical, emotional and spiritual needs. However there was no clear, well documented care plan in place setting out these needs and how they would be met.

36. When prisoners are admitted to L wing at Norwich,(the elderly prisoner unit) a care plan should be completed which includes an assessment of their mental health to see if they are capable of discussing their future care arrangements. This should include whether they want a Do Not Attempt Resuscitation order (DNAR). A DNAR means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.

37. When the man was discharged from hospital on 24 September no formal decision about resuscitation had been agreed. The GP reviewed the man on 26 and 27 September, but did not discuss a DNAR. He said that he did not know if one had been discussed with the man in hospital, and he did not think it would be empathetic to discuss this so soon after the man had received the news of his cancer diagnosis. A multi-disciplinary meeting had been arranged for 30 September, the day after the man died at which when the man's DNAR status was to be discussed.

38. On 29 September, the night healthcare assistant (HCA) checked the man hourly. The HCA had checked the man at 2.45am, but when he next went to the man's cell at 3.30am, he said he was unresponsive, cool to the touch and was not breathing. The HCA did not attempt resuscitation. He understood the man was for 'full palliative care' and he believed this meant that the man did not wish to be resuscitated. He was satisfied that the man had died.

39. The HCA did not immediately inform the nurse in charge of L wing that he thought the man had died. He told the investigator that he was unclear of the management structure at night. However he telephoned a nurse, who was on night duty on the main site of Norwich and told him. During the conversation the nurse realised that the HCA had not informed the nurse in charge of L wing. He told the HCA that he needed to tell him immediately, as well as inform the night orderly officer (the most senior person in charge of the prison), the senior nurse and the police. The HCA then went upstairs to the inpatient office and told the nurse in charge of L wing, and an Officer that he thought the man had died.

40. All three went to the man's cell and the nurse in charge confirmed there were no signs of life. The nurse in charge went back to the inpatient office to check the man's DNAR status but could not find this on his medical record. The HCA telephoned the orderly officer at around 3.40am and informed him that the man had died. The orderly officer contacted the duty governor at home at 3.48am. The duty governor asked if a DNAR was in place and the orderly officer said he understood that one could not be found. The duty governor then instructed that staff should begin resuscitation and should request an ambulance.

41. It is a concern that there was a lack of clarity about whether the man had a DNAR and if not, whether there was a duty to attempt resuscitation when he was found unresponsive and not breathing. The healthcare provider's policy states that the GP has responsibility for coordinating a consultation between the multidisciplinary team and patient and it is unfortunate that this had not been done. We understand that the man's condition deteriorated more quickly than expected, and a meeting to discuss his care had been arranged the next day. However it is important to avoid such uncertainty. We found a similar situation in another recent investigation at Norwich. Prisoners on L should have up to date care plans and the staff should be of them. Care plans should be readily available with DNAR status prominent. We make the following recommendation:

The Head of Healthcare should ensure that there are up to date care plans for all residents of the elderly prisoners unit (L wing) which include agreements about resuscitation about which all staff responsible for their care are aware.

42. We are very concerned that it took 20 minutes before any decision about resuscitation attempts was made, and that this was by the duty governor and not by the staff present in the prison. In most cases such a delay will be too late and it is a concern that resuscitation was attempted at all after that period

of time when all the staff involved were satisfied that the man was dead. The European Resuscitation Council Guidelines 2010 state that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …" We do not consider that staff should be required to attempt resuscitation when someone is clearly dead. Again, this is something that we have raised before at Norwich in another recent report. ,We make the same recommendation:

The Governor and Head of Healthcare should ensure that all staff are given guidance about the circumstances in which resuscitation is inappropriate.

43. Although it would not have helped the man, we are concerned that once the duty governor instructed that staff should follow emergency medical procedures these were not operated effectively. After they had been asked to attempt resuscitation, there was a further delay as healthcare staff did not quickly locate the correct emergency equipment.

44. The emergency ambulance records shows that the ambulance arrived at the prison main gate at 4.16am, but had to be directed to the remand centre gate on the other side of the prison to access L wing. As a result, paramedics did not get to the man until 4.26am.

45. At 4.28am, two minutes after they had arrived paramedics confirmed the man had died. He was cyanosed (blue colouring due to a lack of oxygen) with staining around the neck and lower back (due to pooling of blood after death). A GP certified the man's death at 6.10am.

46. It became apparent during the investigation that prison and healthcare staff did not clearly understand the use of emergency codes. A code blue (used when a prisoner has breathing difficulties, is unresponsive, unconscious or has chest pains) should have been used. This helps those responding to the emergency code prepare and bring the appropriate emergency equipment, as well as prompting an immediate request for an ambulance.

47. PSI 03/2013 (medical emergency response codes) took effect from 28 February 2013, and gives clear guidance on the use of emergency codes and the mandatory response. The prison issued a Medical Emergency Response Code Protocol in line with the PSI in a Governor's Notice to Colleagues on 7 February, but none of the staff the investigator interviewed were aware of the protocol or its contents. While this would not have affected the outcome for the man this is a serious concern for future incidents. We therefore make the following recommendation:

The Governor should ensure that all prison and healthcare staff (including agency nurses) are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:

- **staff efficiently communicate the nature of a medical emergency;**
- **relevant emergency equipment is brought; and**
- **that there are no delays in calling, directing or discharging ambulances**

The man's location

48. The man had lived on L wing (the elderly care unit) at Norwich since April 2010. The wing has 15 beds for elderly and infirm prisoners and caters for those who require a location without steps or stairs and has wider doors to accommodate wheelchairs. L wing is situated on a separate site from the main prison.

49. The man was due to be discharged back to Norwich from hospital on 20 September (a Friday), or over the weekend. Norfolk and Norwich University Hospital told the prison that the man required a profile bed with an airflow mattress (to prevent pressure sores), a patslide (used to safely move a patient from one bed to another) and hoist suitable for his weight. Prison healthcare staff told the hospital that the man could not be transferred back to them until this equipment was in place. An urgent order was placed for the profile bed and air flow mattress with the commissioned equipment suppliers on 20 September and a patslide was ordered on 23 September. Confirmation of an order for a hoist and commode was faxed the next day.

50. On the morning of 24 September, the hospital contacted the prison to say that the man would be discharged that day, once they had received his blood test results. A nurse had informed the hospital that the necessary equipment had not arrived and they had understood he would not be discharged until it was ready. Nevertheless, the hospital discharged the man later that day. The man was moved to a cell closer to the L wing healthcare office (with a standard bed) so the staff could keep a close eye on him. The prison later submitted a complaint to the hospital and reported their concerns to the hospital commissioners. The actions of the hospital are outside the remit of the PPO, but we are satisfied that the prison did its best to accommodate the man appropriately.

51. On 25 September, the man was referred him to the community palliative care team based at a local hospice. A multi-disciplinary meeting was scheduled for 30 September, when a possible transfer to the hospice was to be discussed, but sadly the man died before the meeting took place.

Restraints, security and bed watch

52. When prisoners have to travel outside of the prison to a hospital or hospice, a risk assessment is conducted to determine the nature and level of any security arrangements, including any restraints. We are satisfied that full account was taken of the man's health and mobility and no restraints were used when the man was admitted to hospital in September.

Liaison with the man's nominated contact

53. A custodial manager, was appointed as the prison family liaison officer on 3 September, however his log of contact did not begin until 27 September.

54. The man was estranged from his family and had nominated a friend as an emergency contact. The family liaison officer told us that he informed the Imam when the man was admitted to hospital and updated him when he was diagnosed with cancer. The Imam telephoned the man's friend twice when he was admitted to hospital, to inform him of the cancer diagnosis and to say that the man had requested a visit. However his friend was not able to visit the man before he died.

55. The duty governor contacted the family liaison officer at home at 6.25am on 29 September, to inform him that the man had died, nearly two hours after the man was declared dead by paramedics. She then telephoned the Imam to inform him. The family liaison officer arrived at Norwich at 7.00am and agreed with the duty governor and the Imam that they should break the news of the man's death, to his friend over the telephone. The family liaison officer broke the news to the man's friend at 7.25am.

56. Prison Service Instruction (PSI) 64/2011 require prisons to break the news of a death to a nominated person in person where possible and we would ideally expect this to happen. The duty governor and the family liaison officer told the investigator that they believed breaking the news over the telephone was the most sensitive way to inform the man's friend. The distance from Norwich to the man's friend's home was a factor as they did not want his friend to find out from other prisoners after they were unlocked and the journey would have taken approximately three hours. They also took into account the fact that the news would not come as a shock as his friend was aware the man had not long to live. In the circumstances, we accept that the prison used reasonable discretion

57. PSI 64/2011 states that the prison must offer to pay a contribution towards reasonable funeral expenses of up to £3,000. Reasonable costs may include funeral directors fees, the hearse, a simple coffin, cremation or burial fees (but not the cost of a burial plot) and Ministers' fees. Norwich contributed £1,300 towards funeral expenses. The total cost of the funeral was £2,600. The prison did not provide a breakdown as to the expenses their contribution covered but told the investigator that, due to budget restrictions, they were not able to offer the full contribution to funeral expenses. Instead, the prison accepted an offer from the local Islamic Centre, who contributed fifty percent of the total cost and arranged for the man to be buried in the Muslim section of the cemetery. We are not satisfied that the prison made a reasonable contribution to the cost of the funeral in line with Prison Service guidance which requires prisons to offer to pay up to £3,000. This is a responsibility the Prison Service has accepted and is a mandatory requirement of the instruction. We make the following recommendation:

The Governor should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000

Compassionate release

58. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

59. The man was given his terminal diagnosis on 16 September, but was not given a clear prognosis. A multi-disciplinary meeting had been arranged for 30 September, where a move the hospice was due to be discussed and the possibility of compassionate release. Sadly the man died before this took place.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health. When appointments are cancelled, active efforts should be made to rearrange then urgently.

2. The Head of Healthcare should ensure that there are up to date care plans for all residents of the elderly prisoners unit (L wing) which include agreements about resuscitation about which all staff responsible for their care are aware.

3. The Governor and Head of Healthcare should ensure that all staff are given guidance about the circumstances in which resuscitation is inappropriate.

4. The Governor should ensure that all prison and healthcare staff (including agency nurses) are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that:

    - staff efficiently communicate the nature of a medical emergency;
    - relevant emergency equipment is brought; and
    - that there are no delays in calling, directing or discharging ambulances

5. The Governor should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding fully justified and documented security reasons and there is no detriment to the prisoner's health. When appointments are cancelled, active efforts should be made to rearrange them urgently.	Accepted	The administration function at HMP Norwich arranges referrals for hospital appointments and monitors these as required. This is now monitored by the Head of Healthcare. Hospital appointments will not be cancelled, unless there are overriding fully justified and documented security reasons, and only where there is no detriment to the prisoner's health. The cancellation of an appointment will only take place following consultation with healthcare. A record is now kept on SystmOne recording why a prisoner's hospital appointment has been cancelled. This is also the case for re-arranged appointments, whereby an ongoing record is kept outlining actions being taken to re-arrange the appointment.	Completed and ongoing Head of Healthcare & Security	
2	The Head of Healthcare should ensure that there are up to date care plans for all residents of the elderly prisoners unit (L wing) which include agreements about resuscitation about which all staff responsible for their care are aware.	Accepted	Care plans are now compiled for each individual. A patient's mental capacity is only included if it is clinically indicated by the GP. Information relating to resuscitation status is held in the Gold Standards Framework* folder (GSFF) for all staff to access. There is a GSFF for each individual client on the older persons unit. *The GSF in End of Life Care is the leading	Completed and ongoing. Head of Healthcare	

			provider of end of life care for generalist frontline providers in the UK. http://www.goldstandardsframework.org.uk/		
3	The Governor and Head of Healthcare should ensure that all staff are given guidance about the circumstances in which resuscitation is inappropriate.	Accepted	All nursing staff are trained and aware of the resuscitation council guidelines as part of this training. Guidelines within NICE are that only a qualified GP can pronounce death therefore in the absence of a GP or a Do Not Resuscitate document all prison and nursing staff will attempt CPR. Separately, in addition to the instructions contained in PSI 64/2011, NOMS will be developing further guidance in conjunction with NHS England for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis. This will be issued to all prisons.	Completed and ongoing Head of Healthcare Equality, Rights & Decency Group	
4	The Governor should ensure that all prison and healthcare staff (including agency nurses) are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that: • staff efficiently communicate the nature of a medical	Accepted	The Governor will ensure that all prison and healthcare staff, including agency nurses are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol.	31 March 2014 Head of Healthcare and Safety	

	emergency; • relevant emergency equipment is brought; and • that there are no delays in calling, directing or discharging ambulances				
5	The Governor should ensure that, in line with Prison Service instructions, the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000	Accepted	The Governor will fund funeral expenses of up to £3,000. However, in the man's case the local Islamic Centre wished to support HMP/YOI Norwich and offered to contribute fifty percent of the total cost of the funeral. Should religious groups wish to contribute towards the cost of funeral expenses in future, HMP Norwich would accept such offers where appropriate.	Completed and ongoing. Head of Safety.	