

**Investigation into the death of a man
at HMP & YOI Norwich in April 2012**

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

July 2013

This is the report into the death of a man, a life-sentenced prisoner at HMP Norwich. He had a number of medical conditions and died in April, after contracting a chest infection. He was 92 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by two of my investigators. A clinical reviewer conducted a review of the man's clinical care. I apologise for the delay in issuing this report.

The man transferred to HMP Norwich in April 2005, when he was 86 years old. He was admitted to the Older Prisoners' Unit, where he received treatment for a number of chronic medical conditions. In April 2012, the man, who was already in poor health, developed a chest infection. A healthcare assistant found him lifeless in his cell on a day in April. He had signed a "do not resuscitate order", so staff did not attempt resuscitation.

The investigation found that the quality of medical care given to the man towards the end of his life was unsatisfactory. In particular, the management of his medication and medical records was poor and healthcare staff did not assess his capacity to sign a do not resuscitate order. Previously this office has been complimentary about the high quality of end of life care in the Older Prisoners' Unit at Norwich. However, this quality of care was not evident in this man's case, nor in another more recent case we have investigated at the prison. Norwich needs to address this apparent decline.

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.

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SUMMARY

1. The man was 92 years old. He was a life-sentenced prisoner, who had been in prison since 1979. He had transferred to the Older Prisoners' Unit at HMP Norwich in April 2005, when he was 86 years old and had been receiving treatment for a number of chronic medical conditions.
2. On 5 April 2012, the man was diagnosed with a chest infection. Due to his age and general health, this was considered to be serious and he was monitored closely. His condition deteriorated and, on 11 April, staff placed him on the Liverpool Care Pathway (LCP), an end of life care plan used in the last days and hours of life. This was stopped on 20 April, when his health temporarily improved but re-started when his condition worsened on 23 April.
3. At 12.40pm on an afternoon in April, a healthcare assistant went to check the man and discovered that he was not breathing and had no pulse. Additional healthcare staff attended, but they did not attempt resuscitation as the man had completed a "do not resuscitate" order indicating that in such circumstances he did not wish attempts to be made to revive him. Nevertheless, paramedics were called and a prison GP confirmed his death at 12.30pm. The cause of death was given as chest infection, chronic renal disease, diabetes mellitus and atrial fibrillation (fast and irregular heartbeat).
4. The man was elderly with a number of severe health conditions, managed by prison healthcare staff and secondary care services at local hospitals. The clinical reviewer found a number of shortcomings in the man's care, particularly in the latter stages of his life. We are concerned that Norwich did not provide a satisfactory standard of care. End of life care was not well planned, medical record keeping was poor and healthcare staff did not fully complete the man's do not attempt resuscitation order or assess his capacity to agree it. We have made recommendations on these points.

THE INVESTIGATION PROCESS

5. The Ombudsman's office was notified of the man's death on 24 April 2012. Notices were issued informing staff and prisoners of the investigation and asking them to contact the investigator with any relevant information. No responses were received.
6. Another investigator obtained copies of the man's medical record and relevant prison records when he visited Norwich on 26 April. The medical record supplied was incomplete.
7. NHS Norfolk and Waveney commissioned a clinical reviewer to carry out a review of the clinical care the man received at Norwich. The investigator visited Norwich on 30 July, with the clinical reviewer to conduct interviews with healthcare staff. The doctor responsible for the man's care towards the end of his life did not make himself available for interview and failed to respond to a list of questions submitted to him.
8. The investigator informed HM Coroner for Norfolk of the investigation. A copy of the report has been sent to the Coroner.
9. One of the Ombudsman's family liaison officers contacted the man's nominated next of kin, a family friend, to outline the purpose of the investigation and to ask if there were any issues she wished to be considered. The man's friend said that she had no concerns about his treatment and was grateful for the care he had received.
10. The man's friend received a copy of the draft version of the report as part of the consultation period. Having considered the investigation findings, his friend agreed with the findings of the investigation. The man's son also received a copy of the draft report. No further representations were made in response to the findings.
11. We are sorry for the delay in issuing this report which was caused by a backlog of work in the office and staffing changes during the investigation.

HMP & YOI NORWICH

12. 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 NHS Norfolk and Waveney and provided by Serco Health 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)

13. 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 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 ...”

14. 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.
15. 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

16. 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 is 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 ..."

17. 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. Previous investigations found the care provided in the Older Prisoners' Unit was of a high standard, but this was not evident in this or in another more recent case we have investigated at Norwich.

KEY EVENTS

18. The man was convicted of serious sexual offences in 1979. He was sentenced to life imprisonment, with a minimum time to serve of eight years before he could be considered for release. This expired in January 1987, but successive Parole Board reviews found that his risk had not reduced sufficiently to allow release. At later reviews, he indicated that he no longer wished to be released from prison and that he would prefer to stay at Norwich.
19. In 1996, the man transferred to HMP Wayland to take part in further sex offender treatment programmes. Later that year, at the age of 86, he transferred to HMP Norwich as his health had deteriorated and he needed access to 24 hour healthcare. He lived on L wing, the Older Prisoners' Unit.
20. The man received treatment for a number of longstanding chronic medical conditions including:
 - Ischemic heart disease (reduced blood supply to the heart)
 - Atrial Fibrillation (irregular heart beat)
 - Hypertension (high blood pressure)
 - Emphysema (long-term lung disease)
 - Previous Myocardial infarction (heart attack)
 - Early prostate cancer
 - Diabetes (a disease caused by high blood sugar)
 - Alzheimer's disease (a form of dementia)

He attended frequent hospital appointments to manage these conditions.

21. Records indicate that in 2010 and 2011, the man became increasingly confused and forgetful. During a sentence plan interview in May 2011, he told staff that he had no recollection of his offending behaviour and did not wish to be released from custody. In December 2011, he signed a 'do not resuscitate' form, but there is no indication in his medical record that staff had assessed whether he had the mental capacity to agree to this.
22. On 5 April 2012, a nurse assessed the man after he reported feeling unwell. The nurse checked his blood pressure, pulse and blood glucose levels as he was diabetic. She thought that he might have a chest infection, and referred him to the doctor. Later that day, a locum prison GP confirmed that he had a chest infection and prescribed him a seven-day course of penicillin.
23. At 1.49am on 8 April, the man got out of bed and sat in a chair unaided. He told a nurse that he felt unwell. The nurse examined him and helped him back to bed. She then called the emergency doctor, who advised her to continue monitoring him and call again if his condition deteriorated.
24. Later that morning, the nurse recorded that the man had a disturbed night's sleep, only sleeping for short periods and that he appeared disorientated about the time, where and who he was. He stayed in bed for the remainder of the day, apart from a brief spell when he went to the day room and became

breathless. He remained in bed throughout 9 April, and nurses checked on him frequently throughout the day and night.

25. On 10 and 11 April, the man remained confined to his bed. A locum prison GP visited him in his cell on both days. As he was having difficulty swallowing his medication, the doctor changed it to a liquid. In view of his continuing deterioration, the doctor also instructed that his cell door should remain open to allow nurses continuous access. (The Unit operates an 'open door' policy, which allows for cell doors to be left unlocked on the instruction of a GP who considers that a patient requires 24 hour medical care and observations.)
26. In addition to the 'open door' policy, the healthcare team put in place the Liverpool Care Pathway (LCP) on 11 April. The LCP is an end of life care plan, used in the last hours and days of life. (The records detailing the man's care under the pathway were not provided by the prison, despite requests by the investigator and clinical reviewer.)
27. The Safer Custody Manager at Norwich contacted the man's nominated next of kin, a family friend, to inform her of his deteriorating health. Arrangements were made for her to see him in the healthcare unit and she visited him on 16 April.
28. A locum prison GP reviewed the man daily. On 16 April, the doctor noted that he had reached the end of his course of antibiotics and he decided not to prescribe a further course. That evening, a nurse noted that the man's other prescriptions for warfarin and insulin had been removed from his prescription folder and recorded that this should be followed up with the locum prison GP. The doctor reviewed the man's medication on 18 April. He recorded that both medications could be stopped as they were now 'non-essential' and others might need to be given in liquid form after a further assessment.
29. Over the next two days, the man's condition seemed to improve. He still found it difficult to swallow medication, but was able to take soluble tablets. On 20 April, a multi-disciplinary review decided that the LCP should be stopped and restarted if his condition deteriorated. On 23 April, nurses asked for the man's blood pressure and heart medication to be restarted. He was prescribed medication in tablet form, despite earlier concerns about his ability to swallow. The GP assessed him later that day and staff decided to restart the LCP as his general condition had deteriorated.
30. At 2.47am on a morning in April, a nurse tried to give the man some water, but he refused. Nurses monitored him frequently throughout the morning as his condition remained poor. At 11.35am, a healthcare assistant went into the man's cell to check on him and noticed that his colour had changed. He checked his pulse, but he could not feel one and the man was cold to the touch. He immediately left the cell and told a senior healthcare officer that he thought that he had died. The senior healthcare officer and a nurse both went to the cell and checked the man. They confirmed that he had no pulse and was not breathing.

31. The man had previously completed an advance directive, which indicated that he did not wish to be resuscitated in the event of a cardio or respiratory arrest. Nurses were aware of his wishes and therefore did not attempt resuscitation. They called for a paramedic, who arrived at the unit at 11.55am, followed by a locum prison GP at 12.30pm, however it is not clear at what time he was asked to attend. He discussed the man's medical history with the paramedic and confirmed his death.

Events after the man's death

32. The duty governor held a debrief with all the staff involved. She said that support had been offered to the other patients in the Older Prisoners' Unit.
33. At the debrief, the staff were concerned that it had taken about 55 minutes for the GP to attend. The duty governor recorded that this had been raised as an issue with the healthcare manager for future learning.
34. The prison's nominated family liaison officer telephoned the man's friend to notify her of his death, which she had expected. She had maintained contact with the man's friend and they had agreed that she would contact her by telephone if he died suddenly. She explained the procedures to be followed and offered financial and practical assistance with funeral arrangements. The man's friend asked for his property to be donated to charity, which the family liaison officer organised on her behalf.
35. A post-mortem concluded that the man died as a result of 1a) chest infection 1b) chronic renal disease 1c) diabetes mellitus 2) atrial fibrillation.

ISSUES

Medical care

36. The clinical reviewer commented on a number of matters relating to the man's clinical care. She pointed out that he was an insulin-dependent diabetic who had annual reviews for this condition with secondary care services but it was unclear whether he had access to primary care diabetic nursing while in the Older Prisoners' Unit.
37. The clinical reviewer was also concerned that, although the man had been assessed by a dietician in 2010, he had been discharged from their care. Despite various diagnoses and consistent weight loss during the last 12-18 months of his life, there were no further referrals to this service. There was no evidence that staff recorded his food and fluid intake, or provided a soft diet when he experienced difficulty swallowing and some of his medication had to be provided in liquid form. (There is a possibility that this information was in the Liverpool Care Pathway documents but these documents were not provided by the prison.).
38. The management of the man's medication, in particular warfarin, was not robust. The clinical reviewer identified the following errors:
- No testing strips.
 - No current prescription.
 - Nurses not administering the medication as they had not been trained.
39. The clinical reviewer made a number of recommendations about deficiencies in primary care services in the prison. We repeat those which are particularly relevant to the man's death:

The Head of Healthcare should ensure that, if a patient has difficulty swallowing, healthcare staff carry out an assessment and record all actions in the medical notes, including changes to diet or medication.

The Head of Healthcare should develop a clinical pathway for warfarin users and train staff in its use.

End of life care

40. 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. Among the benefits of an end of life pathway is that it helps patients to make choices about how they are cared for and where they wish to die. Although the Liverpool Care Pathway was used this is for the very end of life and the clinical reviewer found that there was no overarching integrated end of life care pathway at HMP Norwich to clarify the various responsibilities of healthcare and prison staff and local health services before that stage. The clinical reviewer considered that a formalised pathway

would ensure a multi-disciplinary approach to providing a comfortable and dignified death for prisoners while continuing to meet security requirements. This should include discussions with prisoners about their preferences as the end of life approaches and involve their families and friends where appropriate.

41. The clinical reviewer was also concerned that links between staff at Norwich and a local specialist palliative care team had deteriorated and this was reflected in the care the man received in the latter stages of his life. Although he had been unable to take appropriate amounts of fluids or foods in the last few weeks of his life, the clinical reviewer found nothing in the man's medical record to indicate that he had been considered for artificial fluids, such as through an intravenous catheter or by a tube into the stomach.
42. Staff put in place the Liverpool Care Pathway, for the final stages of life, on 11 April, yet they recorded no rationale in the man's clinical record for starting this. The clinical reviewer considers that, at this point, they should have completed a review of his medication and considered stopping all non-essential items. The Liverpool Care Pathway was stopped on 20 April and re-started three days later. Again, no reason was given for these actions in the clinical record. The clinical reviewer considers that healthcare staff would benefit from training in the proper use of the Liverpool Care Pathway.
43. At 2.47am on a morning in April, the nurse on night duty made an entry in the man's medical notes. There were no other entries until 12.40pm, when a GP recorded an entry after his death, so we do not know how frequently staff checked him during this period, if at all. The clinical reviewer suggests that contacts might have been recorded in the Liverpool Care Pathway documents, which is kept beside the patient's bedside and not integrated into the main medical notes. These documents were not made available to the investigator or reviewer. Therefore, the clinical reviewer has only been able to assess those episodes of care recorded in the man's medical notes. We endorse the clinical reviewer's findings about the inadequacy of end of life care planning and make the following recommendation:

The Head of Healthcare should develop an agreed multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care.

The man's 'do not resuscitate' order

44. The 'do not resuscitate' (DNR) form in December 2011 was incomplete and incorrect. The man had seen a dementia specialist in November 2011, as prison staff had concerns about his memory and confused state. In spite of this, healthcare staff appear not to have assessed his mental capacity to complete such a form. There is no reference to this in his medical record and the form does not appear to have been linked to the record.
45. The clinical reviewer said that, as a DNR form existed, it is not clear why paramedics were called when the man was found. At interview, the clinical

lead for the Older Prisoners' Unit recognised that there was a need for staff training in relation to DNR orders, and said this had recently been addressed. However, we make the following recommendation:

The Head of Healthcare should ensure that staff are familiar with the “do not resuscitate” policy. The mental capacity of the patient should be considered and the form should be kept with the medical record.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that if a patient has difficulty swallowing, healthcare staff carry out an assessment and record all actions in the medical notes, including changes to diet or medication.

The recommendation was accepted and the prison made the following comment:

Any prisoner with a difficulty in swallowing will be seen by a doctor and a care plan will dictate and monitor his care. Medical notes will be updated and staff will be reminded of this necessity.

2. The Head of Healthcare should develop a clinical pathway for warfarin users and train staff in its use.

The recommendation was accepted and the prison made the following comment:

A newly appointed nurse who has experience in clinical matters around the use of Warfarin will ensure that her staff are trained in its use. The Compliance Manager who is responsible for training will arrange training dates relevant to the use of Warfarin.

3. The Head of Healthcare should develop an agreed multidisciplinary end of life care pathway and ensure that relevant staff are trained to provide appropriate care.

The recommendation was accepted and the prison made the following comment:

There is an agreed end of life care pathway in place. In view of the lead nurse in this area resigning the newly appointed lead nurse will address this training.

4. The Head of Healthcare should ensure that staff are familiar with the “do not resuscitate” policy. The mental capacity of the patient should be considered and the form should be kept with the medical record.

The recommendation was accepted and the prison made the following comment:

All healthcare staff working in the Elderly Care area of the prison will be instructed (as part of the end of life pathway) in the use of the ‘do not resuscitate’ policy, the doctor responsible for this area will be informed and a reminder to enter data pertinent to this into clinical notes will be addressed. The mental capacity of all prisoner/patients who might be subject to this policy will also be assessed by a Mental Health professional.