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 on 8 May 2013 while in the custody of 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 who died on 8 May 2013 at Norfolk and Norwich University Hospital, while in the custody of HMP Norwich. He was 49 years old. I offer my condolences to the man's family and friends.

A doctor conducted a review of the man's clinical care. HMP Norwich cooperated fully with the investigation.

When the man arrived at HMP Norwich in April 2011 he had no serious medical or mental health problems. His security category was reduced in August 2012, making him suitable for open prison conditions and shortly after he moved to Norwich's resettlement unit outside the prison walls. In April 2013, while on resettlement leave at his home, he felt unwell and saw a doctor. Two days later, he collapsed and was taken to hospital. He was diagnosed with a possible urinary infection and he went back to the prison that night. A prison manager decided he should return to the closed prison the next day as prison staff were not satisfied that he complied with his licence conditions to keep in touch with the prison, when he was temporarily released. The man's health deteriorated over the next week and on 2 May he was admitted to hospital for investigations.

A scan revealed possible lymphoma. A biopsy was performed under general anaesthetic which found that the man had an aggressive form of non-Hodgkin's lymphoma (a blood cancer). After the operation, he did not regain consciousness and could not breathe unaided. He was taken to the intensive care unit where he suffered multi-organ failure. On 8 May, following a discussion with the man's relatives, his life support was turned off.

The clinical reviewer concludes that the man's clinical care in prison was as good as he could have expected to receive in the community and I am satisfied that the prison could not have done anything to diagnose his condition earlier or prevent his death. I am concerned that the use of restraints when the man went to hospital was not based on fully considered risk assessments and it is difficult to see how the decision to return him to closed conditions was justified. Family liaison should have started at an earlier stage and the prison left too much of the initial communication with his family to the hospital.

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

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SUMMARY

1. The man arrived at HMP Norwich on 30 April 2011. He told staff he had three medical problems for which he had been prescribed medication: depression, acid reflux and high blood pressure (hypertension). He spent his entire sentence at HMP Norwich. From 11 September 2012 until 22 April 2013 he was in Britannia House, a separate building outside the prison walls which houses category D prisoners in open prison conditions.

2. During his time in prison, the man had no serious health problems until April 2013. On 19 April, while on home leave, he saw his GP and had some blood tests. On 21 April, while still on home leave he collapsed and was taken to hospital. He was subsequently discharged and returned to Britannia House later that evening.

3. On 22 April, the man was moved to the Local Discharge Unit (LDU) in HMP Norwich as it was considered he had not abided by the conditions of his licence for temporary release. A nurse examined him on 24 April and a doctor reviewed him on 25 April. His health deteriorated over the next few days and he was admitted to Norfolk and Norwich University Hospital on 2 May.

4. A full body CT scan on 4 May showed lymphadenopathy (swollen lymph nodes) in his neck, chest and abdomen, with liver lesions, pleural effusions (fluid in the lungs) and ascites (fluid in the abdomen). The likely diagnosis was stage 4 lymphoma (a type of blood cancer).

5. A biopsy of tissues from a gland in the man's neck was carried out on 6 May.

6. At the end of the operation, the man's condition deteriorated and he could not breathe unaided and he was moved to the hospital's intensive care unit (ITU). The biopsy confirmed stage 4 high grade non-Hodgkin's lymphoma. The man's condition deteriorated over the next two days. After discussion with his relatives on 8 May, staff stopped all active treatment and he died at 6.35pm on 8 May.

7. We make four recommendations about family liaison, the use of restraints, the recording of medical information and decisions about returning prisoners to closed conditions.

THE INVESTIGATION PROCESS

8. Notices were issued at HMP Norwich announcing the investigation to staff and prisoners, asking anyone with relevant information to contact the investigator. No one came forward.

9. The investigator visited Norwich on 16 May and collected copies of relevant prison records relating to the man. He saw where the man had lived and spoke to the Head of Residential and Safety and a custodial manager. A doctor reviewed the clinical care the man received at Norwich. On 11 July, the investigator and the clinical reviewer interviewed several members of staff at Norwich.

10. A copy of this report has been sent to the Coroner.

11. One of our family liaison officers contacted the man's wife, explained the purpose of the investigation and invited her to identify any relevant issues she would like the investigation to cover. On 31 July, the man's wife wrote with details of the events she could recall during her husband's final home leave from 17 April 2013 until his death three weeks later.

12. As a result of feedback from NOMS to the draft report, we have amended paragraphs 26 and 28.

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 adult and young adult men under 21. At the time of the man's death, the prison's health services were 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.

Previous deaths at HMP Norwich

14. Since 2010 there have been 16 deaths at HMP Norwich, 11 of which were due to natural causes. We have previously made recommendations about family contact with seriously ill prisoners, and the use of restraints.

Her Majesty's Inspectorate of Prisons

15. The Inspectorate carried out a full follow-up inspection of HMP Norwich in January 2012. In their report, inspectors noted that:

> "Britannia House offered a positive opportunity for the 42 prisoners there to develop employment skills and experience before release. They usually had at least six months still to serve when they entered the category D facility. Around 40 prisoners at a time worked outside the prison and were subject to ROTL (release on temporary licence), most from Britannia House, although prisoners on the LDU (local discharge unit) could also have accessed such provision, subject to risk assessment."

Independent Monitoring Board (IMB)

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure prisoners are treated fairly and decently. The most recent annual report for the year ending 28 February 2013 noted that healthcare provision had improved in the previous year, although concerns remained about the lack of permanent GPs and communication between healthcare staff and prison officers. The IMB welcomed instructions for escorts to assess the need for gravely ill prisoners to wear handcuffs or restraints while in hospital, but were not certain the instructions were being followed.

KEY EVENTS

17. On 30 April 2011, the man was remanded into custody by Ipswich Magistrates' Court. He was taken to HMP Norwich to await trial. When he arrived, he saw a nurse who completed his first reception screen and assessed his mental health. The man said he was taking four drugs, lansoprazole (for indigestion), losartan and amlodipine (for hypertension) and citalopram (an antidepressant). He declined a hepatitis B vaccination. He had recently had an operation on his nose and the nurse referred him to a doctor.

18. The doctor saw the man on 2 May and re-prescribed his medications, apart from lansoprazole. On 3 May, another doctor noted a history of hypertension (high blood pressure) and reactive depression. The doctor examined his nose and requested his community GP records which were obtained. A doctor prescribed lansoprazole the next day.

19. The man did not attend for a routine blood test on 24 June 2011. On 18 July, he saw a nurse to re-order his medication, and she completed a questionnaire to measure his level of depression. However, there is no record that his medication was reviewed as she had requested.

20. On 24 February 2012, the man was sentenced to four and a half years imprisonment.

21. On 23 May, the man had a full health review by a healthcare assistant. His weight was noted as 96.6kg, cholesterol as 4 mmol/l (normal) pulse as 74 bpm (normal), and blood pressure 144/82 (normal). He had a diabetes risk score of three (normal, low risk). His prescriptions were repeated in June, July and August, with no change in his medication.

22. On 30 August, the man was recategorised from category C to category D and, on 11 September, he transferred to Britannia House, a resettlement unit on a separate site outside the prison which houses category D prisoners. Prisoners in Britannia House either register with a GP in Norwich or continue with their own GP. There are therefore no prison healthcare records for him at this time.

23. On 25 October, a ROTL (release on temporary licence) board recommended that the man could be given ROTL for work placements and have regular family resettlement releases to his home (home leave). He subsequently had two work placements.

24. The man was allowed home leave from 17 to 21 April 2013 to help re-establish his family ties. This was not his first such release. He signed the form to say that he understood the ROR conditions. These included his liability to arrest if he did not return before 6.00pm on 21 April and that he should inform the local police if he was taken ill during the release.

25. On Friday 19 April, the man saw his local GP in Dunmow, Essex, and had some blood tests.

26. On Sunday 21 April, the man collapsed at his home and was taken by ambulance to a local hospital. At 11.45am, a paramedic informed HMP Norwich that the man had been taken ill on home leave and had been due to return by 6.00pm. The paramedic said that the man appeared to have a urinary infection. At 12.45pm the man's wife telephoned Norwich to say that she had informed Essex police as his licence conditions required, and would get updates that afternoon. At 4.30pm, according to the LDU log, the prison telephoned the hospital and was told the man was waiting to see a doctor and to call back in an hour. The prison called again at 5.30pm and the man had been discharged at 5.10pm and that his condition did not prevent him from travelling.

27. At 6.30pm, a custodial manager at Norwich recorded that the man had not contacted them even though they had left messages for him to do so. At 7.40pm, the man called Norwich and said he had only just been released from hospital and had a doctor's appointment the next day, after which he would return to Britannia House. However, he was told to return to the prison by 11.00pm that day. He arrived at the prison at 10.55pm.

28. The Head of Residential and Safety interviewed the man on 22 April and decided to return him to closed conditions. She noted that neither she nor the custodial manager had been able to confirm the man's account of what had happened. (In their response to the draft report, NOMS gave further information about the interview. They informed us that the custodial manager had contacted three surgeries named by the man, but that none had an appointment booked. The hospital confirmed that they had not made a follow-up appointment. The man said that there was no mobile signal in the part of the country he was in. He confirmed that he was aware that his ROTL paperwork should have been signed by a medical professional. However, the paperwork was blank.) The staff thought he had lied about the reasons why he had returned late when he was told his licence could not be extended. The Head of Residential and Safety referred the man for a categorisation review. He returned to the local discharge unit on 22 April, and thus came back under the care of the prison's healthcare team.

29. On 23 April, a nurse recorded that the man's wife telephoned the prison to say that he had been unwell over the weekend and had been admitted to hospital after collapsing in the doctor's surgery. The man's wife said her husband had lost weight over the past three months and had been complaining of pain when urinating and in his lower back. His GP's details were entered on his medical record.

30. On 24 April, the nurse saw the man on the wing. She noted that the man had had symptoms of pain on passing urine for the past six weeks, had seen a GP and blood tests had been done. They carried out a dipstick check of his urine which showed the presence of blood and protein and a urine sample was sent for further investigation. Another nurse later noted that the man had felt

unwell for six weeks, lost weight, felt tired all the time, had body ache and pain on passing urine. His GP had called and said that he probably had a blood infection. The nurse thought he looked unwell, his skin was dry and she thought there was a yellow tinge to it. She examined his abdomen and found it to be tender. He weighed 93kg. The nurse contacted his GP and asked them to fax the blood results and booked an appointment for him to see doctor the next day.

31. On 25 April the man saw another nurse and asked if his blood tests had returned. She noted that he felt unwell and was concerned about his health. The man then saw a doctor who noted that he had been unwell with generalised aches and pain and was feeling thirsty. The doctor recorded that the man's GP blood test results were generally good but his estimated glomerular filtration rate (eGFR tests renal function) was 60 (low) with a normal creatinine level. His haemoglobin (which carries oxygen in blood) level was 12.9 (normal).

32. The man told the doctor he had had a blackout and was taken to hospital where he was told his blood pressure was low and his ECG (heart tracing) was normal. The doctor examined him and noted he was not in any obvious chronic pain. His blood pressure was 100/60 and 95/50. The doctor agreed to reduce the dosage of his blood pressure medication and have his blood pressure monitored over the next few weeks and, if it remained variable, to consider a 24 hour blood pressure check. Because of the indicator of reduced renal function a urine test for ACR (albumin creatinine ratio, to quantify the level of protein in the urine). The man was to avoid non steroidal anti-inflammatory drugs, (such as ibuprofen) and he gave him vitamin D supplements.

33. When interviewed, the doctor said that the man started by complaining that he had been brought back to the closed prison. The doctor realised that the man was very unwell and discussed the possibility of admission to hospital with him. The man declined saying that he had been to a hospital at the weekend. The doctor told the man he would see him again on 30 April when he next held a clinic in the unit.

34. On 29 April at 1.25am, a nurse was called to see the man as he was complaining of abdominal pain. He told her he had not slept for the past three days because of the pain, which was all over his body. He said he had vomited twice. The nurse measured his blood pressure, pulse and temperature which were all normal she gave him paracetamol and told him to see healthcare staff in the morning. At 10.45am, the man saw a nurse who noted that he was unsteady on his feet and thought he needed to see a doctor. At 11.52am, the man had blood taken. At 2.06pm, a nurse saw the man and noted that he looked unwell, had bags under his eyes and a tender abdomen. She arranged for the man to see the GP the next day with the blood test results.

35. At 3.23pm on 30 April, a doctor saw the man but the results of the blood tests were not yet available from the hospital. The doctor noted that the man had

lost 4kg in 6 days, had SATs (the oxygen concentration in the blood) of 93% and his abdomen was generally soft with some tenderness in the upper abdomen. The doctor noted in his records 'Malaise/lethargy + infection of lower respiratory tract + weight loss + dehydration". He gave painkillers, protein supplements, antibiotics (co-amoxiclav) and sleeping tablets (zopiclone). He told him to seek help if he got worse and planned to review the man two days later.

36. A nurse saw the man at 4.00pm on 2 May, after the chaplain had seen him and was concerned that he was barely able to stand. The man said he was in a great deal of pain especially in the lower back, was urinating every two to three hours and had not opened his bowels for seven days. He said he could not eat as he vomited afterwards, but could drink water.

37. The doctor reviewed the man at 5.00pm, and noted that he was drinking but not eating but was coughing less. He looked exhausted and unwell. The doctor commented that the blood tests showed a normal white cell count but that the level of protein in his blood was raised and referred the man to the Norfolk and Norwich University Hospital.

38. A senior officer authorised a risk assessment on the emergency escort log recommending that single cuffs and an escort chain should be used unless medical issues suggested otherwise. Although the man was category D, he had recently been removed from open conditions. He did not have impaired mobility and medical information stated his medical condition did not restrict his ability to escape unaided. There was no requirement for restraints to be removed for treatment or consultation.

39. Two officers escorted the man to hospital by taxi, arriving at 6.35pm. The doctor who assessed him made a provisional diagnosis of possible intra-abdominal neoplasm (cancer) or obstruction with sepsis (severe infection) from another cause. Several tests were ordered and intravenous (IV) fluids were started. At 11.40pm the escort officers were told it was unlikely that the man would be leaving hospital that night. His risk assessment was not reviewed at that stage and he remained restrained by an escort chain.

40. The man's wife has told us that he had telephoned her on 27 April and told her that he was feeling very uncomfortable. She had not expected to hear from him for a few days because he did not have any money on his prison telephone account. (Previously while he was in Britannia House, he was able to use a mobile phone). On 2 May, The man's wife received a telephone call from someone describing themselves as a friend of the man's, who told her that he was in hospital. However, the prison refused to confirm this when she telephoned to check this.

41. At 5.30am on 3 May, the man was reviewed by a senior doctor who noted that he had a great deal of pain on the left side of his abdomen and diagnosed possible diverticulitis (a common digestive disease) or cancer. The doctor ordered a CT scan (X-rays that show 'slices' of specific areas of the body) of the abdomen and pelvis. Restraints were removed for the scans and

reapplied afterwards. The man still could not pass urine and a scan at 4.30pm revealed that there was over 950ml of urine in his bladder. A urinary catheter was put in place and the urine drained.

42. The man's condition deteriorated overnight. At 8.45am on 4 May, a doctor asked for another chest X-ray. At 5.38pm it was noted that a full thorax, abdomen and pelvis CT scan showed 'lymphadenopathy (swollen lymph nodes) in the neck, chest and abdomen with liver lesions, pleural effusions (fluid in the lungs) and ascites (free fluid in the abdomen). The likely diagnosis was stage 4 lymphoma (cancer of the blood). At 6.20pm, the man was referred to the haematology team. There was still no security review and he remained restrained by an escort chain.

43. The next day, 5 May, the senior doctor from the haematology team asked for a lymph node biopsy to confirm the diagnosis, which was scheduled for the next day. At 7.10pm, the man called his wife using the escort officers' prison mobile phone. He was moved to a surgical ward to await the operation and was noted to be in a cheerful mood with no issues. The duty governor gave permission to remove the escort chain during surgery.

44. On 6 May, at 9.05am, the man was given an anaesthetic and taken to theatre. The biopsy went well, but at the end of the procedure he became increasingly hypoxic (lack of oxygen) in spite of the fact that his breathing was being done for him by a machine which was giving him maximum oxygen. The anaesthetist called his senior and a haematologist for advice. At 10.40am, a doctor told the escort officers that they were having difficulty resuscitating the man and asked for details of his next of kin. Hospital staff called the man's wife and left a message for her.

45. Just after 12.00pm, the man was transferred to the intensive care unit. He was still unconscious. At 12.10pm, a nurse told the escort officers that he was breathing, but only with the aid of a machine. He did not regain consciousness. Restraints were not re-applied.

46. At 2.18pm (according to the hospital records), the man's sister and mother were contacted in the USA. Hospital staff explained his illness and said that he was in a critical condition. The man's family wanted to return to the UK to see him and they were told that treatment would continue for the time being. At 3.15pm, the man's wife and mother-in-law arrived and were told by a doctor that he had lymphoid cancer at grade 4 and that he was unlikely to survive. The doctor said she was planning to operate to relieve some fluid in his chest.

47. At 10.30pm, the man's daughters and his ex-wife visited him for over two hours. His condition was explained to them. An entry in his hospital records at 11.39pm noted that a chest drain had worked and a chest X-ray showed good resolution in the lungs after the drain. The next day, it was noted that he probably had a very aggressive form of lymphoma and multi-organ failure from sepsis (blood poisoning). He was given antibiotics but the prognosis remained bleak.

48. The man's family were updated that afternoon. Biopsy results indicated he had a high grade lymphoma. It was noted that his kidney function was deteriorating and he was short of fluid.

49. At 8.30am on 8 May, the prison appointed a family liaison officer. The man was reviewed at 9.30am and it was noted that that he had multi-organ failure. At 11.45am the full biopsy result became available and stated the appearances were strongly suggestive of a high grade non-Hodgkin's lymphoma (a cancer which affects lymphocyte cells in the lymphatic system).

50. At 1.35pm, hospital staff told the man's family of the diagnosis. As his condition had declined despite treatment, they agreed that active treatment should be withdrawn and he should be kept comfortable. The family liaison officer introduced herself to the man's family at 2.15pm, explained her role. At 4.20pm, the man's life support machine was switched off and at 6.35pm a nurse reported that the man had died. The man's death was certified by a hospital doctor at 7.20pm.

51. The duty governor held a hot debrief at the hospital with the two escorting officers. They were offered the services of the staff care and welfare teams.

52. Notices informing staff and prisoners of the man's death were issued at HMP Norwich and the Chaplaincy team, IMB and Samaritans were made available to offer support.

53. No post-mortem was carried out. The cause of death was certified as:

- 1a Multi-organ failure
- 1b Sepsis (infection)
- 1c Lower respiratory tract infection
- 2 Non-Hodgkin's Lymphoma

54. HMP Norwich offered to pay towards the man's funeral and crematorium fees in line with national guidance. The funeral took place on 21 May.

ISSUES

Clinical Care

55. The clinical reviewer conducted a review of the care provided to the man while he was at Norwich. He found that the level of care provided was equivalent, if not better, to that the man could have expected in the community.

56. The clinical reviewer noted that the man went to his own GP on 19 April 2013 with a series of non-specific symptoms. He does not think that these should have alerted a doctor a specific diagnosis. The blood tests taken at this stage did not point to a specific problem. After he returned to Norwich, the man saw healthcare staff frequently. He initially declined to be admitted to hospital. Following the receipt of abnormal blood results on 2 May, the doctor sent the man to hospital. The clinical reviewer notes that the man was given appropriate pain relief while he was at Norwich.

57. The clinical reviewer notes that the cause of the man's illness was not identifiable through blood tests, only by scans and biopsies. Because of this, it was only on 4 May that there was a definite diagnosis. The clinical reviewer does not believe that the man's death was foreseeable of preventable.

58. All the prison medical records at Norwich are recorded electronically using SystmOne. The clinical reviewer notes that the records, especially in comparison with others he has seen, are good. He notes that blood test results from the hospital were not sent electronically to SystmOne as they are in other prisons and the fax from the man's GP with his blood test results from 19 April was not scanned on his medical record. (Although the doctor referred to the results on 25 April and noted them.) This did not affect the outcome in the man's case we but refer the Head of Healthcare to the clinical review.

59. The man's records did not contain a summary of his past medical history. Since the time of his arrival, Norwich has instigated a procedure to ensure that a summary of the prisoner's records is obtained from the prisoner's GP and then scanned into the medical record. There is a follow up system in place to ensure that summaries are chased if necessary.

Return to closed conditions

60. After the man returned to Norwich, he was interviewed by the Head of Residence on 22 April. She did not believe his account and returned him to the LDU.

61. This decision did not affect the man's health and in fact might have given him easier access to healthcare staff. However, it appears that, the man did as required under the terms of his licence when taken ill. He was then given an extension, and returned as he was asked to do, although he had expected to be allowed to attend an appointment with his community GP the next morning. The prison was initially informed of the man's illness by a paramedic and his

wife had contacted the police as his licence required. While the man did not return to the prison immediately from the hospital it is undoubtedly the case that he was unwell and we understand that he first needed to return home. It is not clear to us why the managers did not accept the man's account, which could have been verified. (In response to the draft version of this report, NOMS set out the checks that they made. These are listed in paragraph 27 of this report.) We make the following recommendation:

The Governor should ensure that decisions to return prisoners to closed conditions are reasonable and based on the evidence available.

Family liaison

62. Prison Rule 22(1) states:

> 'Notification of illness or death
>
> '22. - (1) If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed.'

63. The man was taken to hospital on 2 May. While it might not have appeared that he was seriously ill, he was then kept in overnight and a series of tests were performed. As early as 3 May, a doctor gave a possible diagnosis of cancer. At this stage, the prison should have spoken to the man's family, but it was not until 7 May that any prison staff besides the escort team had contact with his family. Although hospital staff clearly have a role to play in keeping families informed of medical issues, the prison has a responsibility to keep families informed. This did not happen on this occasion.

64. Chapter 11 of Prison Service Instruction 64/2011 which covers the management of prisoners who are terminally ill or seriously ill states that:

> *"Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.'* [the use of italics means that this is a mandatory action for governors]

65. Although a family liaison officer was appointed before the man died, it was clear that he was seriously – and probably terminally – ill several days earlier. The prison should have informed the man's wife, at the latest, when it became clear that he would be in hospital for some time and definitely when he was given a probable diagnosis of cancer. We make the following recommendation:

The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated

member of staff is appointed to support and keep families informed about their condition.

Use of restraints

66. 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 decency. 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, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

67. 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. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. The judgement required that risks during stays in hospital needed to be assessed separately and should be reviewed regularly during a hospital stay or when circumstances change.

68. Security Group at Prison Service Headquarters issued guidance in January 2008 in response to the judgement. The guidance included advice specifically about seriously and terminally ill prisoners. It said that "separate risk assessments need to be conducted in relation to the level of restraint used for a) transportation to and from the hospital, and, b) for the prisoner's time at hospital. Any subsequent revision of the original risk assessment MUST have any medical opinion/input clearly annotated."

69. When the man was taken to hospital on 2 May, he was restrained using single handcuffs and an escort chain. At that point, it was not clear how ill the man was, but it is surprising that restraints were judged necessary for a category D prisoner. After his admission to hospital, the use of restraints should have been reviewed but this was not done, despite the man's failing health and serious condition. We make the following recommendation:

The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all incoming faxed medical documents are scanned into the medical records within 24 hours of receipt.

2. The Governor should ensure that decisions to return prisoners to closed conditions are evidence-based where possible.

3. The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.

4. The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.

ACTION PLAN:– HMP Norwich

No	Recommendation	**Accepted/Not accepted**	**Response**	**Target date for completion**	**Progress (to be updated after 6 months)**
1	The Head of Healthcare should ensure that all incoming faxed medical documents are scanned into the medical records within 24 hours of receipt.	Accepted	SystmOne is a 'closed system' it does not link in with the community modules such as GP practices. It will only link in to other prisons. Any prisoner who has medical records open to them in another prison will have records immediately available to healthcare onsite when they arrive, however a prisoner arriving from the community is reliant upon information being requested. Due to the transient population the amount of scanning received at HMP Norwich means that there is a backlog, however the prison is in the process of recruiting a member of staff to specifically deal with scanning to ensure that all medical information received after 9am Monday morning and up to midday on a Friday afternoon is scanned on to SystmOne within 24 hours of receipt. The person is expected to be in post subject to clearances by 1st December 2013. In the meantime the Day Care Administrator is responsible for scanning all medical information received. Pathology results ordinarily come through Monday to Friday. If a prisoner requires urgent	1st December 2013	

			medical care at the weekend then it will be given on the basis of clinical need. This would be exactly the same as being in the community. The Practioner would decide if the prisoner could be treated on site or needed to be referred for urgent care.		
2.	The Governor should ensure that decisions to return prisoners to closed conditions are evidence-based where possible.	Accepted	All prisoners who are returned from open conditions to closed conditions are done so on a thorough risk assessment which is evidence based. This decision is made by the Duty Governor at the time and is an individual risk assessment on the reasons for their return. These decisions will be documented on the prisoner's Prison Nomis case notes and the prisoner will be provided with a written account as to their return to closed conditions.	31st October 2013	
3.	The Governor should ensure that the next of kin of seriously ill prisoners are informed as soon as possible and that a nominated member of staff is appointed to support and keep families informed about their condition.	Accepted	The decision regarding initial contact with families is made during the risk assessment process for all escorts. For those escorts that remain in hospital this risk assessment is reviewed daily by a visiting manager who liaises with the hospital staff and the prisoner concerned. The medical condition is discussed and discussions take place with medical staff with regards to contacting the Next of Kin and the need to appoint a Family Liaison Officer (FLO). The escorting staff will notify the duty governor of any changes/deterioration in the prisoner's health and they will establish consent from the prisoner for contact with the next of kin. In all cases where prisoners are assessed as seriously ill, the establishment will make contact with the next of kin and a FLO will be	Completed	

			appointed to support the family. In the man's case the establishment was not notified of the seriousness of his illness until 4th May, and it is accepted that the Next of Kin should have been notified at this point to support the family. The above process is now in place to mitigate such circumstances arising again.		
4.	The Governor should ensure that risk assessments for escorts fully take into account the medical condition of the prisoner and are based on the actual risk the prisoner represents at the time.	Accepted	Security staff completing initial risk assessment documents now ensure the correct information is contained. This is checked again by the discharging Custodial Manager. Healthcare offer a full input to the risk assessment and get a daily update from the hospital which is fed back to the morning operational meeting, where the escort check manager is present. Any information imparted is then included in the daily review of the risk assessment and takes account of any change/deterioration in health. This is documented in the escort log and continued reviews are contained within the manager's checklist within the escort log.	Completed	