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 July 2013 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 at HMP Norwich in July 2013. He was 83 years old and died from coronary artery thrombosis. I offer my condolences to the man' family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in prison. HMP Norwich cooperated fully with the investigation.

The man was suffering from dementia, diabetes and heart disease when he was remanded and subsequently sentenced to prison in 2009. In April 2013, he moved to a unit for older prisoners with serious long term medical conditions and disabilities at Norwich prison. On the morning of 23 July, the man was found unresponsive in his cell. Nurses noted that rigor mortis had set in and believed he was dead but a prison manager instructed them to attempt resuscitation. When paramedics arrived they immediately confirmed that the man had died.

The clinical reviewer concludes that, overall, the man's medical needs were met, but his diabetes care was not equivalent to that he could have expected to receive in the community. The investigation also found a need to ensure that hospital referrals are followed up, that all men in the elderly prisoners unit have care plans and that staff have guidance about the circumstances when it is not necessary to attempt resuscitation.

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

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SUMMARY

1. The man was remanded to HMP Wormwood Scrubs in 2009, charged with serious offences. At the time he had dementia, diabetes and heart disease. In October 2009, the man was sentenced to eight years imprisonment and transferred to HMP Bure in January 2010.

2. The man was given medication to control his conditions and managed well for the first few years in prison. He was able to live fairly independently and got about with the aid of a walking frame. The man's dementia deteriorated and, in April 2013, he moved to a specialist unit at HMP Norwich for older prisoners with long term medical conditions.

3. At Norwich, the man was referred to the nurse, GP and community nurse for older people and had an age sensitive health assessment on 26 April. The man settled well and received day to day support from nurses and officers. In May, the prison GP referred him for an echocardiography appointment at the hospital but this appointment was never made or followed up.

4. There is very little evidence in the medical notes that regular checks were made of the man diabetes and no evidence that he attended any clinics to manage his diabetes.

5. On 6 June, a mini-mental state examination indicated that the man's dementia was deteriorating. The man never completed a 'preferred priorities of care form' (which encourages patients to discuss their preferences and priorities for care at the end of their life) and his wishes about resuscitation in the event of a cardiac or respiratory arrest were not discussed with him. There was an undated note in his medical records stating that he did not have the mental capacity to make an informed decision and should be referred to the Independent Mental Capacity Advocates. No referral was made before his death.

6. On 23 July, the man was found unresponsive in his cell when it was unlocked. Nurses who attended assessed that he had been dead for some time as rigor mortis was present but a prison manager asked nurses to attempt resuscitation as she believed they were not qualified to declare death. When a paramedic arrived, he told the nurses to stop and confirmed that at 8.50am. The post mortem showed that the man died from coronary artery thrombosis (heart attack), which would have been exacerbated by his diabetes.

7. Overall, the man medical needs were met, but the clinical reviewer did not consider that the man's diabetes care matched that he could have expected to receive in the community. We make recommendations about diabetes management, hospital referrals, care plans and resuscitation guidance.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and inviting anyone with relevant information to contact her. No responses were received.

9. The investigator went to the prison on 29 July, visited the unit where the man had lived and spoke to the manager of the unit. She obtained copies of relevant aspects of the man's prison and prison medical records. On 5 and 6 September 2013, the investigator interviewed staff and a prisoner at Norwich and gave initial feedback to the Governor.

10. NHS England commissioned a clinical review of the man's clinical care at the prison.

11. HM Coroner for Greater Norfolk District was informed of the investigation and provided the results of the post-mortem examination. The Coroner has been sent this report.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation and invite them to identify issues they wished the investigation to consider. They had no specific concerns about the man's treatment.

13. The man's family received a copy of the draft report. They did not raise any issues that impact on the factual accuracy of this report.

14. The National Offender Management Services also received a copy of the draft report. They accepted the recommendations and their action plan is attached to this final report at page 17.

HMP & YOI NORWICH

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

HM Inspectorate of Prisons

16. The most recent inspection of HMP Norwich was in August 2013, the report of which has not yet been published. At the previous inspection in February 2012, HM Inspectorate of Prisons (HMIP) commented that prisoners were dissatisfied with some aspects of healthcare, particularly the appointments system. The inspectorate noted that health services had improved since their last inspection. In relation to the older prisoner unit, the inspectorate said that the unit offered good standards of care but in dated and often very poor environments.

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In their latest published annual report for the year ending February 2013, the IMB noted that they had major concerns about healthcare provision, although the management of healthcare had improved. In some areas the IMB regarded the service as inadequate to meet the complex needs of prisoners. The IMB was concerned about the lack of permanent GPs and that there were many other temporary healthcare staff which caused a lack of continuity of care. They were positive about the permanent healthcare staff who it believed provided an excellent service in difficult and challenging circumstances. 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.

Previous deaths at Norwich

18. The man was the ninth prisoner to die from natural causes at Norwich since the start of 2011. In two other cases we have identified the management of DNAR notices as an issue; we do so again in this report.

KEY EVENTS

19. The man was remanded into custody on 13 July 2009 and went to HMP Wormwood Scrubs, where he lived in the prison's healthcare unit. On 5 October 2009, the man was sentenced to eight years in prison. A pre-sentence report identified the man's medical conditions as diabetes, a chronic foot infection, dementia and poor vision. He was also diagnosed with vascular dementia (caused by decreased blood flow, leading to areas of the brain being damaged). His mobility was poor and he used a walking frame to move around.

20. The man transferred to HMP Bure, in Norfolk, on 5 January 2010. Because of his health and poor mobility he was given a single cell on the ground floor. He had help collecting his meals and nurses went to the wing every day to give him his medication.

21. The man's offender supervisor noted in March 2010 that the man had settled well at Bure. He mixed with other people on the wing and received support from them and staff with day to day tasks. His family kept in touch and visited him. The offender supervisor commented that the man did not normally remember who she was, when they met. In 2011, staff at Bure noted that the man was struggling with day to day tasks and needed to be reminded to do most things. However, he was still managing to live on a standard prison wing.

22. By 2012, the offender supervisor noted that the man could be very confused at times and his memory seemed to be deteriorating. He continued to attend the over 65's gym club and enjoyed walking with the aid of a frame.

23. Towards the end of 2012 the man's behaviour changed. On one occasion, he punched another prisoner about a game of pool and became argumentative about playing in a tournament. (He did not understand when he had lost a game and was no longer in the match.) Staff were also concerned about his safety because the man had been boiling his kettle with the lid off. After discussions between wing and healthcare staff, a care plan was put in place. A consultant psychiatrist for older people's services in Norfolk and Suffolk saw the man on 12 February 2013 to assess his dementia.

24. On 23 April 2013, the man transferred to the elderly prisoners unit (L wing) at HMP Norwich because of his dementia and increasing care needs. His medical history was noted as dementia, type 2 diabetes and peripheral vascular disease. His medication was listed as simvastatin (cholesterol lowering medication), metformin (diabetic medication), donepezil (for the treatment of dementia), gliclazide (diabetic medication) and ferrous sulphate (iron supplement).

25. The man had complex medical needs and was referred to the nurse, GP and community nurse for older people. On 26 April, a nurse carried out an age sensitive health assessment for the man. She recorded that he did not have speech or vision problems but his hearing was deteriorating. (However, there

are several references in some documents to indicate that the man had problems with his vision and was blind in one eye). The assessment showed the man could move around with the use of an aid, could get in and out of bed and a chair but could not manage any stairs. The man could use the toilet, but needed assistance in the shower. Although he knew his own age, he was not able to give his date of birth, the time, month or year and he did not know where he was. It was noted that he was a moderate smoker.

26. Over the following weeks the man settled well on the unit and nurses observed him eating and drinking well. He continued to be confused at times. The man was checked regularly throughout the night and observed to be generally sleeping well. Nurses continued to administer his medications.

27. On 7 May, the man saw a prison GP, because he had a swollen left leg. The GP noted there was no calf swelling or ulcers and that the man was already on frusemide to reduce water retention. He noted that the man had a raised pro-BNP in his blood (pro-BNP is measured to determine levels of heart failure). The doctor requested an echocardiography appointment at the Norfolk and Norwich University Hospital. However, an appointment was never received and this was not followed up.

28. A mental health nurse completed a mini mental state examination on 6 June as part of her assessment of the man's dementia. The man could not manage several elements of the test and it was clear that his dementia was worsening.

29. Patients nearing the end of their lives are encouraged to complete a document called 'Preferred Priorities for Care' (PPC). This is a tool to encourage people to talk and write down their preferences and priorities for care at the end of their life. It allows patients to refuse specific medical treatments in advance; including resuscitation and it also allows people to change their view. An unnamed person wrote an undated note on the Preferred Priorities for Care document that the man "does not have the mental capacity to make an informed decision in relation to the PPC". It was noted that a referral to the Independent Mental Capacity Advocate service should be made. The main purpose of the advocacy service is to provide support so that someone can participate in relevant decisions about their care. No referral was made and no further decisions were made about resuscitation.

30. A care plan written for the man on 12 June covered his hygiene, mobility, sleep, eating, pain relief and pressure care needs. On 17 June, the man went to the Norfolk and Norwich University Hospital to have hearing aids fitted. He was escorted by one officer and no restraints were used because of his age and mobility. The man became confused about why he was there and then refused to wear the hearing aids after trying them on. He returned to the prison without them.

31. A nurse saw the man on 30 June and noted there was some mild deterioration in his dementia but that he was happy on the unit. The man's family visited him on a regularly and saw him on 23 May and 27 June. A further visit was booked for 25 July.

32. On 5 July the older persons lead nurse completed a supportive care register front sheet for the man. She listed his medical history and recurrent leg ulcers. The nurse noted that the man did not have the mental capacity to fill in the Preferred Priorities for Care.

33. On 8 July an Officer wrote that she thought the man's mental state was deteriorating. He had complained at lunch about not having had a drink although the officer knew he had had several drinks during the morning and over lunch.

34. On 20 July the nurse checked the man and recorded his pulse as 70 and his blood pressure 120/60mmHg (both within normal limits). The man was eating well, continuing to walk with his frame and wash and dress himself.

35. On the night of 22 July an Officer was responsible for patrolling the unit as well as the healthcare inpatient unit. A healthcare assistant was working that night, based primarily on the elderly prisoners' unit and said she remembered talking to the man at around 9.30pm and suggested that he should get ready for bed. She said he seemed to be his usual self. A healthcare assistant checked the man four more times during her shift. At around 10.30pm, she spoke to him to see if he had settled for the night. At about 12.30am and 2.30am, she noted that the man was lying on his bed and appeared asleep. The healthcare assistant's last check was around 4.00am when she saw The man getting back onto the bed and then lying down as though to go back to sleep. She did not speak to him at that time.

36. An officer did an early morning check of all the prisoners just before 5.30am and shone a torch through the door panel to help him see. He said he could not remember exactly what position the man was in when he did the roll check, but he told us that he always makes sure he sees chest movement or some other physical movement from every prisoner on the unit, because of their age and general health. The officer said he was therefore certain that the man was alive at that time.

37. Another officer was the first officer on duty on Tuesday 23 July and went onto the unit at around 8.10am. At about 8.30am, the officer started to unlock each cell and got to the man's cell shortly afterwards. When he unlocked the door he called out to the man but got no response. He could see that the man was not in bed and noticed that the toilet door was shut. A healthcare assistant who was in a nearby cell, joined the officer. The officer opened the toilet door and they saw the man on the floor, sitting, but slumped forward, between the toilet and the wall. The officer said the man was blue, not breathing and they could not find a pulse. The officer radioed a code blue (an emergency request for medical assistance) and shouted for help from the nurses on the wing. The prison control room noted this call at 8.31am and an ambulance was requested immediately. Another officer was on the landing upstairs and went straight down to the unit. When she got there the officer was outside the cell and said he needed help with the man. They could not get a response and so tried to move the man to enable them to assess his condition better. The

officer said the man's limbs were very stiff and it was difficult to do anything. They worried about causing the man more harm and decided to wait for the nurses. A few moments later, two nurses arrived and took over his care.

38. A nurse checked his carotid pulse (in the neck) and used a stethoscope but could not find any signs of life. She also looked for any chest movements but could find nothing. She described the man as wedged between the toilet and the wall, having slipped off the toilet seat. The nurse said rigor mortis had definitely set in and she did not think any resuscitation should be attempted. She said the man's body was cold and stiff and his knees were set and she thought the man had been dead for some time. The nurses put a sheet over the man. As they were doing someone checked whether there was DNAR (do not attempt resuscitation) order in place for the man. When it was found there was not, there was some discussion about whether resuscitation should be attempted.

39. The operational manager responsible for the unit, said that because the nurses were not qualified to certify death, resuscitation must be attempted. The staff therefore pulled the man out of the toilet area and laid him flat on the floor of the main cell. The two nurses began cardiopulmonary resuscitation (a mixture of rescue breaths and chest compressions to circulate oxygen around the body). However, they were not able to move the man's head and so could not get a proper airway. A nurse said that although they tried to resuscitate the man while waiting for the paramedics to arrive she knew it would not be successful.

40. According to the wing incident log, a paramedic arrived at the cell at 8.48am. The paramedic told the nurses to stop the resuscitation attempt within a minute or so of entering the cell and pronounced the man dead at 8.50am.

After the man's death

41. The operational manager chaired a hot debrief about the incident at 10.00am. At the debrief, one of the nurses said she was concerned about the decision to carry out resuscitation and said she felt very unhappy about having to attempt this when the man was so clearly dead.

42. The news of the man's death was broken to the other prisoners on the unit by one of the managers. A Listener (a prisoner trained by the Samaritans to offer emotional support to fellow prisoners) came to the unit to talk to the prisoners about what had happened.

43. A custodial manager was appointed as the family liaison officer. The man's next of kin lived in Romford, a journey of about two to two and a half hours by car from the prison. Because of the distance the prison tried to get someone from a nearer prison to inform his family in person but was unable to do so. After taking advice from Prison Service headquarters, the operational manager who had spoken to the man's family before, telephoned his daughter-in-law at 10.30am and told her of his death. The operational manager offered to visit the man's family that afternoon but they said they wanted some time to take

the news in. The family liaison officer telephone again later in the day and introduced herself as the family liaison officer. She repeated the offer of a visit but the man's family declined.

44. In line with national guidelines the prison offered financial help towards the cost of the funeral.

Post-mortem

45. The post-mortem found that the cause of death was coronary artery thrombosis with type 2 diabetes as a contributory factor.

ISSUES

Clinical Care

46. The clinical reviewer notes that the man suffered from type 2 diabetes, peripheral vascular disease, dementia, reduced mobility, reduced vision and hearing and an ulcerated right foot. She notes that most of the man clinical needs were met. He was appropriately referred for assessment for his dementia and was seen on a number of occasions by a nurse with experience of older clients, which the reviewer says is good practice. However, the clinical reviewer finds that effective care and management of the man's diabetes was lacking. The clinical reviewer says that as a result, the man's care was not equivalent to that he could have expected in the community.

47. The clinical reviewer makes a number of recommendations, not all of which are repeated in this report, which the head of healthcare will need to consider.

Diabetes Care and Management

48. There is no evidence in the clinical record that the man was provided with specialist care in relation to his diabetes while at Norwich. There are no HbA1c monitoring results (a way of helping to find the average blood glucose over a period of time and thereby how well diabetes is being managed) and blood sugar testing does not appear to have been done regularly. The prison was unable to provide us with all of the man's hospital letters and it is therefore difficult to know whether the man was under the care of an endocrinologist (who deal with the treatment of diseases related to hormones) or a hospital diabetic specialist. There is no evidence in the records of the man attending any diabetic outpatient appointments or diabetic clinics at the prison. The National Institute for Health and Clinical Excellence (NICE) provides guidelines for the management of diabetes and other life long conditions which should be followed by healthcare professionals. We note that there is a newly appointed nurse for long term conditions nurse in the healthcare team at Norwich which we hope will improve the situation. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners with diabetes (and other life long conditions) are monitored and managed in line with NICE guidelines.

Hospital appointments

49. On 7 May, the doctor referred the man to a cardiologist because he had a raised pro-BNP which the doctor wanted followed up. The referral was faxed to the Norfolk and Norwich University Hospital on 13 May. We were told that it is usual for the hospital then to ring the prison and book a suitable appointment date. This did not happen and therefore no appointment was booked. Although the man saw the GP again on 21 May and 14 June the referral was not followed up. As The man was 83 years old and very unwell it is not possible to say that this medical investigation would have made any difference to the outcome for him, but it is important that hospital referrals are

arranged as planned and followed up when this does not happen. We make the following recommendation:

The Head of Healthcare should ensure that referrals for hospital appointments are arranged and chased up as necessary.

DNAR and Mental Capacity

50. A Do Not Attempt Resuscitation (DNAR) order means that in the event of cardiac or respiratory arrest, resuscitation will not be attempted. All other appropriate treatment and care will continue to be provided.

51. When a prisoner is admitted to the elderly prisoners' unit at Norwich, 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 the matter of resuscitation. No one completed a care plan for the man. Someone had written on one of the forms that the man did not have the mental capacity to make an informed decision because of his dementia and that he should be referred to the Independent Mental Capacity Advocate service. We have not been able to find out who wrote this comment or when it was made. There was no referral to the advocacy service.

52. As no formal decision about resuscitation had been agreed there was some lack of clarity about whether there was a duty to attempt resuscitation when the man was found collapsed and not breathing. Had one been agreed the position would have been clear. We found some confusion amongst the healthcare staff we spoke to about how Do Not Attempt Resuscitation (DNAR) Orders are initiated. Serco provide the healthcare at Norwich and their policy states that the GP has responsibility for coordinating a consultation between the multidisciplinary team and patient. As there is a weekly GP review of all patients on the unit it is difficult to understand why, given the man's poor health, that a DNAR had not been considered with him, and if appropriate, a mental capacity assessment requested. Had the expected care plan been completed when the man arrived at Norwich we consider this uncertainty would have been avoided. We make the following recommendation:

The Head of Healthcare should ensure that care plans are completed for all residents of the elderly prisoners unit (L wing) which cover mental capacity and agreements about resuscitation.

Emergency Response

53. Staff called a code blue within moments of finding the man and an ambulance was called immediately in line with Prison Service instructions for responding to emergency medical codes.

54. The nurses who responded to the code blue said that there were no signs of life and described the man as stiff and cold. It appears that against their better judgement they were required to begin resuscitation, even when they were sure there was no hope of success. It was apparent from interviews with staff

that attempting to resuscitate the man when he was clearly dead was traumatic for them.

55. We consider the attempted resuscitation of the man was inappropriate in the circumstances. It is not necessary for resuscitation to be attempted unless death had been declared. 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 healthcare staff should be required to attempt resuscitation when someone is clearly dead and make the following recommendation:

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

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with diabetes (and other life long conditions) are monitored and managed in line with NICE guidelines.

2. The Head of Healthcare should ensure that referrals for hospital appointments are arranged and chased up as necessary.

3. The Head of Healthcare should ensure that care plans are completed for all residents of the elderly prisoners unit (L wing) which cover mental capacity and agreements about resuscitation.

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

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with diabetes (and other life long conditions) are monitored and managed in line with NICE guidelines.	Accepted	Long term Condition Nurses are now in place and are currently undertaking the appropriate training to ensure that prisoners with life long conditions are managed and monitored according to NICE Guidelines.	March 2014 Head of Healthcare	
2	The Head of Healthcare should ensure that referrals for hospital appointments are arranged and chased up as necessary.	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.	Completed and ongoing Head of Healthcare	
3	The Head of Healthcare should ensure that care plans are completed for all residents of the elderly prisoners unit (L wing) which cover mental capacity and agreements about resuscitation.	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 provider of end of life care for generalist frontline providers in the UK. http://www.goldstandardsframework.org.uk/	Completed and ongoing Head of Healthcare	
4	The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is	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	Completed and ongoing Head of Healthcare	

	inappropriate.		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.		