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 at HMP Norwich in June 2014

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 of progressive vascular dementia in June 2014 at HMP Norwich. He was 84 years old. I offer my condolences to those who knew him.

One of my investigators carried out the investigation. A clinical reviewer reviewed the man's clinical care at Norwich. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in 1957, when he was 27. He was released on life licence in 1984, but recalled to prison in 1989. He remained in prison fro the rest of his life. In 2007, doctors diagnosed him with vascular dementia. In 2008, he transferred to a unit for older prisoners at HMP Norwich where his needs could be met more effectively. His health gradually deteriorated over time and he needed frequent nursing care. In the latter stages of his illness, healthcare staff at the prison used appropriate end of life care plans, in consultation with palliative care specialists.

The clinical reviewer found that the man received excellent care at Norwich. He noted that staff acted with professionalism, compassion and care. I agree that the man was well cared for at the prison and I add my commendation to the staff concerned.

This version of my report, published on my website, has been amended to remove the name of the man who died and those of staff and prisoners involved in my investigation.

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

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SUMMARY

1. The man was sentenced to life imprisonment for manslaughter in 1957. After being released on licence in 1984, he was recalled to custody in 1989.

2. The man had a history of cardiovascular problems. He began to show signs of confusion in 2005 and prison healthcare staff suspected he had dementia. In 2007, doctors diagnosed him with progressive vascular dementia. In September 2008, he moved to the elderly prisoners' unit at HMP Norwich, a specialist facility for older prisoners with physical and mental health needs.

3. As the man's dementia progressed, his mobility also decreased and he used a wheelchair to get about. He became doubly incontinent and prone to smearing faeces. He could not care for himself and needed hourly nursing care. He sometimes became agitated and aggressive with staff.

4. On 17 May 2014, healthcare staff sent the man to hospital after he experienced vomiting and difficulty eating and swallowing. The hospital diagnosed a chest infection. He returned to the prison on 21 May, with a terminal prognosis. The hospital advised that further hospital admissions would be of no benefit.

5. On 6 June, the man had difficulty eating and drinking. A prison GP and palliative care specialist reviewed his care. They agreed to prescribe anticipatory end of life medicine to make sure he was comfortable.

6. At 1.58pm on a day in June, the man stopped breathing. A nurse called an ambulance. As doctors had agreed that staff should not attempt to resuscitate the man, paramedics asked that a prison GP should attend and certify his death. At 2.35pm, a GP pronounced him dead.

7. The clinical reviewer found that the man had excellent nursing and medical care at Norwich. He said that terminal care was timely and thoughtful, there were excellent contingency plans and his care was equivalent to that he would have received in the community. We are satisfied that prison and healthcare staff provided good care for the man at Norwich.

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 one responded.

9. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She completed a desk top report and did not consider it necessary to interview staff at the prison.

11. We informed HM Coroner for Greater Norfolk of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. The man did not have a listed next of kin. Despite enquiries, the prison, the police and Coroner did not find any relatives.

13. The prison received a copy of the draft report; they noted one factual inaccuracy regarding the date of death, which has been corrected.

HMP NORWICH

14. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk, which holds up to 767 men. Virgincare provides health services at the prison. There is a healthcare centre with 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

15. The most recent inspection of Norwich, in August 2013, found that the prison had progressed since the last inspection. The treatment and conditions for most prisoners were satisfactory. Relations between staff and prisoners were mostly positive. The Inspectorate noted that the inpatient and older prisoner units provided good care and that there were plans to develop the palliative care provision. .

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recent annual report, for the year to February 2014, the IMB noted that the older prisoners unit at Norwich has undergone many changes for the better and commended the staff who worked there for their care and compassion. They noted that nurses were unable to administer some end of life procedures, such as syringe drivers for pain relief but reported appropriate procedures for ‘do not resuscitate’ orders.

Previous deaths at HMP Norwich

17. This man was the seventh prisoner to die from natural causes at Norwich since the start of 2012. There were no significant similarities with previous cases.

KEY EVENTS

18. On 20 July 1957, the courts convicted the man of manslaughter and rape and sentenced him to life imprisonment. He was released on life licence in 1984. He was recalled to prison in 1989 for breach of his licence conditions.

19. The man's medical history included a heart attack in 1994, an aortic aneurism (enlarged blood vessel) repair in 1997 and transient ischaemic attacks (mini strokes) from 1999. He started to show signs of dementia in 2005 with confusion, forgetfulness and a reduction in his self-care. In 2007, doctors diagnosed him with progressive vascular dementia (dementia caused by reduced blood flow to the brain).

20. In September 2008, the man moved to L Wing at Norwich, the unit for older prisoners. Shortly after he arrived at Norwich, his condition deteriorated and he became unable to care for himself. He was doubly incontinent and received 24 hour nursing care. In 2011, healthcare staff began care plans to help him with daily activities and pain relief. These included mental health plans and interventions.

21. Doctors assessed that the man did not have mental capacity to make decisions about his care. On 24 June 2013, an independent mental capacity advocate visited him to ensure that the man's wishes and feelings were being taken into account, as required by the Mental Capacity Act. The advocate was satisfied that decisions about the man's health needs and personal care were being taken in his best interests.

22. On 27 September 2013, a prison GP agreed that due to the man's deterioration in health, staff should not attempt resuscitation in the event of cardiac or respiratory arrest. Because of his lack of capacity, the doctor did not consult him and he did not have any family to consult about the decision.

23. On the evening of 17 May 2014, the man vomited four times and had difficulty eating and swallowing. A prison GP reviewed him and requested a non emergency ambulance. He went to outside hospital and remained there for treatment. Prison staff did not restrain him for the journey or during his hospital stay. The hospital diagnosed the man with a chest infection and referred him to a speech and language therapist because of his difficulty swallowing.

24. On 21 May, the man returned to the prison. The hospital discharge letter stated he was at the terminal stage of his life and a high risk of aspiration pneumonitis (blockage of the lungs or airways leading to the lungs from solids and liquid) because of his condition and frailty. The hospital said that healthcare staff should treat further episodes of aspirations in prison, as hospital admission would not improve his quality of life.

25. On 6 June, the man had difficulty eating and drinking. A prison GP reviewed him and sought advice on end of life care from a nurse at a specialist

palliative care service. The nurse advised the prison GP to keep the man comfortable and to prescribe anticipatory, end of life medication.

26. The nurse gave the GP a 24 hour palliative care helpline number if he needed further advice and asked him to complete a referral for palliative care, which he did that day.

27. On a day in June at 12.10pm, the man started struggling to breathe. The nurse from the specialist palliative care service advised prison nurses to keep the man comfortable, and to help him with mouth and personal care. At 1.58pm, he stopped breathing and appeared to have died. A nurse called a code blue to request an emergency ambulance but paramedics advised that a prison doctor should confirm the man's death, as he was subject to a *"do not attempt resuscitation"* order. At 2.35pm, a prison GP certified the man's death.

28. The prison issued notices to prisoners and staff informing them of the man's death and offering support to those affected. A manager held a debrief to offer support for the staff involved in the man's care. The prison held a memorial service in the chapel on 8 July 2014.

Cause of Death

29. The Coroner gave the cause of death as 1 (a) severe dementia, and 2 ischaemic heart disease.

ISSUES

Clinical care

30. The clinical reviewer found that the man received excellent care, with clear evidence of planning for mobility, hygiene, pressure area care, diet and nutrition, oral hygiene, distress, pain and agitation. He concluded that the standard of care was equivalent to that he might have expected to receive in the community.

31. We agree that prison and healthcare staff at Norwich appropriately supported the man through his illness. We commend healthcare staff for the hourly care they gave him and the early implementation of care plans to ensure he received appropriate care and treatment.

Location

32. On 1 July 2013, the Parole Board requested a psychiatric report to consider the possibility of the man transferring to a hospital or care home, because of his poor health. A forensic psychiatrist completed a report in October 2013. He concluded that the man had a personality disorder and vascular dementia. He said that the man was a medium risk in a prison environment, but his risks would increase if he moved to a care home, because of his impulsivity and potential access to children.

33. The forensic psychiatrist concluded that moving the man would be detrimental as Norwich was meeting his needs. He considered that moving him would cause distress and further deterioration in his mental and physical health. The man told him that he considered HMP Norwich as his home and did not want to move.

34. We are satisfied that Norwich was a suitable location with appropriate facilities to provide 24 hour and end of life care for the man.