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 August 2014 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, who died of cancer at HMP Norwich on 5 August 2014. The man was 58 years old. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care. HMP Norwich co-operated fully with the investigation.

The man had been in prison since 2007, serving an indeterminate sentence. In February 2014, a prison GP made a routine Ear Nose and Throat (ENT) referral after the man reported heartburn and pain when swallowing. The hospital did not arrange an appointment and the prison did not follow it up. By mid-May, the man had lost over two stones and a GP referred him urgently for suspected cancer. The man did not co-operate fully with tests and the ENT consultant suggested the prison should refer him urgently to a stomach specialist. The GP did so, but the word 'urgent' was crossed out on the referral letter, so the man waited another month for an appointment.

Doctors diagnosed inoperable gastro-oesophageal cancer which had spread to other organs in the man's body. On 3 August, the hospital admitted the man with dehydration and kidney failure. Hospital staff gave him intravenous fluids and inserted a syringe driver to give continuing pain relieving medication. The hospital discharged the man back to the prison the next day. He was agitated and discomforted throughout the night and dislodged the syringe driver. At 7.00am, staff found him unresponsive. Paramedics arrived and confirmed he had died.

The clinical reviewer concludes that the man's medical care was not equivalent to that he could have expected to receive in the community. I agree. The clinical reviewer considered that the GP should have referred the man to the hospital urgently when he first reported symptoms in February and problems with his later referrals also led to a delay in his diagnosis. The man's end of life care, particularly pain management, was poor and he needlessly suffered during the last days of his life. I have previously expressed concern about aspects of end of life care at Norwich and promised improvements remain to be made. Particularly given the numbers of elderly prisoners held at Norwich, this needs to be addressed urgently. I also consider that the use of restraints, when the man went to hospital in July, was not justified by fully considered risk assessments.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2015**

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SUMMARY

1. The man had been in prison since 2007. He had previously been treated for skin cancer and, during his time in prison, he received treatment for mental health problems. In February 2014, he complained that, for a few months, he had been experiencing heartburn and pain when swallowing. The GP made a routine referral to an Ear, Nose and Throat (ENT) consultant at Norfolk and Norwich University Hospital and prescribed indigestion remedies. Usually the hospital contacts the prison within a week or two to arrange an appointment. This did not happen and the prison did not chase it up. (The hospital eventually telephoned to try to book an appointment twelve weeks later.)

2. Over the next few months, the man's indigestion and heartburn symptoms continued. In mid-May, a nurse practitioner noted he had lost over two stones and the GP referred him urgently to hospital. The man attended an appointment at the end of May, but did not agree to all the necessary tests. The ENT consultant suggested that the prison should refer him urgently to the gastroenterology department. The GP made the referral, but 'urgent' was crossed out on his letter and the man did not receive an appointment until 30 June. The hospital found a large, apparently cancerous tumour in his oesophagus and took biopsies. At the end of July, prison healthcare staff told the man that the cancer was inoperable and had spread to his liver and lungs. The man decided that he did not want to be resuscitated if his heart or breathing stopped.

3. By this time, the man's condition had deteriorated significantly and doctors decided he would not be able to cope with palliative chemotherapy. His health continued to decline and he was unable to swallow any food or liquids. On 3 August, he was admitted to hospital with dehydration and kidney failure. Hospital staff gave him intravenous fluids and fitted a syringe driver so he could be given pain-relieving medication automatically. He returned to prison the next day, but could not settle and pulled out the syringe driver in his agitation. A nurse gave him some end of life pain relief and sedating medication. He had some settled periods overnight, but he became agitated and restless as the medication wore off. The man died shortly after 7.00am on the morning of 5 August 2014.

4. We consider that the prison GP should have referred the man to hospital urgently when he first reported symptoms in February. We repeat a recommendation from a previous investigation that the prison should chase up outstanding referrals with the relevant hospital department. We found that decisions to use restraints for hospital appointments were not always fully justified by risk assessments which took into account his current medical condition. The man's condition deteriorated very quickly, but healthcare staff did not manage his terminal pain and other symptoms effectively and the prison did not leave his cell door open at the end of his life, to allow nurses ready access. The clinical reviewer commented that the man had a death that no one would wish for and one that would not be expected to happen in the community. We make five recommendations.

THE INVESTIGATION PROCESS

5. 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.

6. The investigator went to Norwich on 7 August. She viewed the healthcare centre and the elderly prisoners unit (L wing) and collected relevant records. She later interviewed staff at Norwich and gave preliminary feedback about the investigation.

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

8. We informed HM Coroner for Greater Norfolk District of the investigation, who provided the results of the post-mortem examination. We have sent the Coroner a copy of this report.

9. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation and invite her to identify issues she wished the investigation to consider. His sister did not have any specific matters for the investigation to consider. She said that she would have preferred to have known about her brother's illness before he died, but understood that the prison were respecting his wishes and asked to be kept informed about the investigation.

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

11. The man's family received a copy of the draft report. They raised an issue that did not impact on the factual accuracy of this report.

12. The draft report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report. The Prison Service also said that Virgin Care, the healthcare provider at Norwich, intended to comment about the clinical review though as of the date of this report, we have not received their comments.

HMP & YOI NORWICH

13. HMP & YOI Norwich is a multi-function prison which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners. Virgin Care provides healthcare services.

HM Inspectorate of Prisons

14. In the most recent inspection of Norwich in August 2013, inspectors found that the prison had progressed since the last inspection and the prison's care and management of older prisoners was much better than in some other prisons they had inspected. 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

15. 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 had 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 Norwich

16. As Norwich has a special unit for elderly prisoners, there have been a relatively high number of deaths at the prison, mostly of prisoners who are terminally ill like the man. In another case, a GP referral had not resulted in a hospital appointment and there was no follow up by the prison. We made a recommendation that appointments be chased up with the hospital when necessary. This recommendation, made in March 2014, was accepted by Norwich, but nothing had been done to change the system by the time of this investigation. We have also made previous recommendations to Norwich about end of life care and risk assessments for hospital escorts.

ISSUES

The diagnosis of the man's terminal illness

17. On 26 November 2007, the man was charged with arson and common assault and remanded to prison. On 18 February 2008, he received an indeterminate sentence for public protection, with a minimum term to serve of nine months. A psychiatrist diagnosed that the man had a personality disorder. Between 2007 and 2013, the man moved between several prisons and a medium secure unit for patients detained under the Mental Health Act.

18. The man transferred to Norwich on 9 May 2013. He had a history of skin cancer which had been treated. After a further referral for suspected skin cancer (unrelated to his subsequent cancer) in August 2013, the man refused to attend for a biopsy, so the hospital discharged him.

19. The man reported heartburn to a nurse on 3 February 2014, and a prison GP subsequently prescribed an indigestion remedy. On 17 February, he told the doctor he had found it painful to swallow for many months. The GP made a routine referral to the Ear Nose and Throat (ENT) service at Norfolk and Norwich University Hospital. On 19 February, the hospital's outpatient co-ordinator wrote to say they would offer an appointment soon. The man's symptoms continued.

20. On 24 April, the man told the doctor that his indigestion symptoms were no better and that he also felt constipated. The GP changed a prescription for acid reflux and gave him medication for constipation. On 7 May, the doctor examined the man and noted that he had had abdominal pain for four months, but had no symptoms such as vomiting or bleeding. He referred the man to a radiologist for an abdominal ultrasound scan. There is no record of the outcome in his medical record.

21. The prison did not chase the outstanding hospital referral and, on 13 May, three months after the referral, the hospital telephoned a healthcare administrator, to offer a very short notice ENT appointment. However, the prison could not provide an escort. The hospital co-ordinator then took the man off the waiting list and advised the healthcare administrator to re-submit the referral.

22. The healthcare administrator told the investigator that the delay by the hospital was unusual. When there was a delay, the GP would normally notice at a subsequent appointment and ask the healthcare administrator to follow it up. There was no routine system to chase up appointments when there had been no response to a referral within the expected time.

23. On 15 May, a nurse noted that the man had lost 19kgs during the previous four months, and recommended an urgent hospital referral. On 19 May, the doctor referred him urgently for suspected upper gastrointestinal cancer under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks. The man attended an appointment on 27

May, but refused to have some of the tests and examinations. The consultant wrote to the doctor suggesting he urgently refer the man to the gastroenterology (digestive disorders) department. The doctor referred him on 30 May, but did not use the usual cancer referral forms and the word ‘urgent’ had been crossed out. The doctor could not explain why this was or why the letter contained incorrect information about the man’s medical history. Instead of within the expected two weeks, the man’s appointment was a month later on 30 June.

24. On 30 June, the man had a gastroscopy at Norfolk and Norwich University Hospital. Doctors found a seven-centimetre cancerous tumour on his oesophagus. They took biopsies and arranged a CT scan. That day, the man told an officer that he had been diagnosed with cancer but the hospital had arranged more tests to find out the extent of his illness.

25. On 29 July, after reviewing the biopsies, a locum GP, and a nurse explained to the man that he had inoperable cancer which had spread to his liver and lungs. They felt he took the news well but said he was not keen to have any treatment that would extend his life.

26. The next day, the man had a follow up appointment with the consultant gastroenterologist, who said he had very advanced malignant disease and needed supportive care and medication to help reduce his symptoms. The consultant did not think the man would be able to undergo palliative chemotherapy and considered he had no longer than three months to live.

27. We are satisfied that the man was fully informed of his diagnosis. However, the clinical reviewer considered that in view of the man’s history of indigestion symptoms, difficulty in swallowing, smoking, drinking and age, it would have been more appropriate for the GP to have referred him urgently to a gastroenterologist in February, rather than for a routine ENT appointment. This led to a delay of several months before the man received a full diagnosis. Although the man’s cancer was already widespread by 30 May, it is regrettable that the referral letter to gastroenterology contained inaccurate information and was not highlighted as urgent. We make the following recommendation:

The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals, including ensuring that:

- **Prisoners with symptoms suggestive of cancer are referred as two-week urgent referrals, in line with NHS guidelines.**
- **All clinical staff use the appropriate template for referrals, that they are accurate and clearly indicate the priority.**
- **Referrals are monitored and followed up as required.**

The man’s medical treatment

28. After his initial diagnosis on 30 May, The man moved to the healthcare unit, so staff could ensure he received the diet he needed. Healthcare staff

created a care plan which stipulated that the man should have a specific nutritional and falls prevention assessment, a weekly skin assessment and daily pain score assessment. There is no documented evidence that these assessments took place to underpin the care plan.

29. On 11 July, a doctor prescribed fentanyl (morphine) skin patches for pain relief. As patches of the specified strength were not in stock, the pharmacy prescribed liquid morphine until they arrived. The man told a nurse on 13 July that he had “never ending pain” which kept him awake at night and his medication was not helping. The nurse told the man that the stronger pain relief should be in the prison by the next day. There is no evidence on the prescription chart that the man received the liquid morphine in the interim.

30. The prescribed fentanyl patches arrived on 14 July and the man’s pain initially improved However, by 17 July, it became worse and, the next day, the doctor increased the strength of the fentanyl patches. The GP noted the man’s weight loss and physical deterioration.

31. On 24 July, the man told a nurse that he felt his treatment was not good enough and new medication, prescribed to relieve his pain and constipation, had not arrived. He then became verbally and physically aggressive and a custodial manager reduced him to the basic level of the prison’s privileges system. (This included removal of his television set and less association time with other prisoners.)

32. On 31 July, the day after the hospital consultant had told him that he had less than three months to live, the man told a doctor and a nurse that he did not want staff to attempt to resuscitate him if his heart or breathing stopped. He signed an order to that effect.

33. A palliative care consultant also saw the man on 31 July. The doctor noted that he was aware his disease was incurable and that his life expectancy was now considered to be around a month. The man agreed that the focus of his treatment should be on symptom control. The man was in pain and had shortness of breath on exertion, cough, itch, constipation and fatigue. The palliative care consultant asked for blood tests to see if some of the symptoms were reversible (such as a blood transfusion if anaemic). She faxed a treatment plan the next day.

34. On 1 August, a prison doctor prescribed a higher dose of fentanyl. The next day, a nurse noted that the man’s pain had increased, but they had not received the new fentanyl prescription from the pharmacy. She applied two lower strength patches instead. The man was having difficulty washing because he tired quickly and he slept on and off all day. The blood test results showed dehydration and acute renal failure. Later that day, the nurse wrote in the man’s medical record that he was too agitated for her to take a blood pressure reading and his oxygen levels were abnormally low. The nurse did not offer oxygen as she considered that the man was not settled enough to keep a mask in place.

35. At around 2.00am on 3 August, a nurse heard a noise coming from the man's cell and found the man kicking against his cell door. He had attempted to use the toilet and was on the floor as he did not have the strength to get up. The nurse called the night manager to open the cell and helped the man back into bed. The man told them he was trying to find a position which eased the pain.

36. At lunchtime, an out of hours GP, examined him and found that he could not stand, his breathing was laboured and his eyes glazed. The GP liaised with the palliative care consultant, the palliative care consultant, and they admitted him to Norfolk and Norwich University Hospital that afternoon as he was in pain, dehydrated and anaemic. His kidneys were failing. The hospital gave the man intravenous fluids and inserted a syringe driver (a battery operated pump that gives medication continuously for a period of time) to give a continuous and effective level of pain relief. The man improved slightly overnight and returned to prison at around 3.00pm on 4 August.

37. In the evening, the man became agitated again, but said he was not in pain. A doctor, reviewed him and prescribed injections of haloperidol and midazolam, both sedating drugs, to top up the syringe driver medication, if needed.

38. Around 11.00pm, the nurse saw that the man had pulled out his syringe driver but did not go into the cell at that time. At 11.30pm, the alarmed mat beside the man's bed sounded and the nurse saw him on the floor. He called for the night manager to open the cell. They helped him back to bed but he remained restless and agitated. He seemed unaware of where he was. The nurse gave the man some haloperidol and midazolam because the syringe driver was no longer in place. The nurse said he repeated the medication around four hours later to help calm his restlessness. (The prison was unable to provide a copy of the prescription charts for the administration of these drugs.)

39. Just after 7.00am, a healthcare assistant checked the man. He was on his bed. Around ten minutes later, a nurse and the healthcare assistant became concerned when they looked through the man's door hatch and saw him kneeling on the floor (the alarmed mat did not stretch along the length of the bed). A few minutes later, an officer arrived to unlock his cell. Three nurses went in and checked for a pulse or any signs of breathing, but there were none, although his body was still warm. The duty doctor, later certified the man's death.

40. The post-mortem examination found that the man died of organ failure because of widespread cancer. The primary tumour was crossing the gastro-oesophageal junction. Tumours were also present in his kidneys, lungs and liver.

41. We are concerned that there was no record of end of life care plans such as pain scores, fluid intake, nutritional needs assessment, weight monitoring, equipment needs and mouth care. There were also some delays in the man receiving his prescribed medications, which contributed to poor pain control

and increased agitation. The clinical reviewer commented that nurses did not appear to be confident about administering terminal anticipatory pain relief. After he was discharged from hospital, the man was agitated and distressed until he died. The matron, considered the hospital should not have discharged him until they were sure that medication was adequately controlling his pain and that he was comfortable.

42. The clinical reviewer concluded that healthcare staff at the prison did not properly manage the man's symptoms and that his care was not equivalent to that he could have expected in the community. We agree that the prison needs to improve the delivery of end of life care urgently. The man died in an agitated state. Staff did not properly control his pain and he often had to wait, unnecessarily, for new medication or an increase in dosages. In an investigation into a previous death at the prison, we recommended that there should be an agreed multidisciplinary pathway. In response, the prison said that all terminally ill prisoners would be placed on an end of life pathway in line with national guidelines. We are not satisfied that this has been done. We make a similar 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 including, the use of syringe drives and delivering appropriate pain relief medication promptly.

43. The clinical reviewer considered that staff attributed the man's sometimes challenging behaviour to historical behaviour patterns rather than the fact that he was terminally ill, in constant pain and probably frightened. Sometimes he was understandably angry because he had not received the pain relief medication he had been prescribed and the clinical reviewer made a recommendation about the standard of medication administration charts, which the Head of Healthcare will need to address. We are concerned that the man, a terminally ill man, was placed on the basic regime level when he expressed his frustration about not receiving his medication. The custodial manager explained that he felt he needed to send a message to the man that the poor behaviour towards staff was inappropriate. We understand that his behaviour could have been problematic, but such decisions need to be holistically considered and taken at a senior level. We make the following recommendation:

    The Governor should ensure that security and disciplinary decisions affecting the welfare of a terminally ill prisoner are referred to a senior manager to consider holistically, in line with the prisoner's care plan.

The man's location

44. The man moved to the healthcare unit on 30 June and started using a wheelchair two weeks later. On 24 July, the man told the nurse that the doctor had said he could move to L wing, the elderly care unit, because of his health needs and asked her when he could go there. The nurse explained that there were no spaces at that time and they could not move any of the

other prisoners. Four days later, the man again asked to go to L wing, as he had no energy and was finding it difficult to cope. There were still no beds available.

45. At the end of July, the man's offender supervisor, told the nurse that she considered the man was unsuitable for palliative care in a community setting because of his occasional aggression.

46. By 3 August, the man had become weaker. After he was found helpless on the floor of his cell in the early hours of the morning, the custodial manager rescinded his decision to place the man on the basic regime and moved him to L wing so that he could receive more help with his personal care needs from the healthcare assistants based there. (Staff moved another prisoner.) The nurse said that anyone who cannot care for themselves is usually moved to L wing where there are more staff, larger rooms and medical beds.

47. At lunchtime that day, the GP and the palliative care consultant admitted the man to hospital to treat his symptoms. The officer was the only escort officer. She said the hospital had not expected the man to live through the night but he returned the next day. The hospital discharge letter indicated he wanted to go back to the prison for his end of life care.

48. Staff on L wing sometimes leave prisoners' cell doors open, as many of them are bed-bound, to allow nurses easier access to meet their care needs. They did not consider this for the man. An alarmed mat was beside his bed that if he stepped on, would sound an alarm near the office.

49. We are concerned that when the man returned from hospital on 4 August, the prison did not leave his cell door open to enable nurses to go in and out of his cell easily, particularly at night. As it was locked, the nurse had to ask the prison's night manager to come to the cell each time he needed to attend to the man. This inevitably led to some delays and an inadequate level of nursing contact at the end of his life.

50. The custodial manager said that an "open door policy" is normally put in place quickly with the agreement of the duty governor and the matron. He did not know the man's cell had remained locked and, when interviewed, said, he would be very surprised if he had been locked in his cell. The matron, said the man was initially too volatile and mobile to be left unlocked, but agreed that his door should have been left open during the last few days of his life. We agree with the clinical reviewer's view that better care planning would have identified this issue in advance and steps could have been taken to address it. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that terminally ill prisoners have appropriate accommodation to meet their needs and that cell doors are left open as necessary to facilitate appropriate and humane end of life care.

Use of restraints

51. The man went to hospital on 27 May, 30 June, 23 July, 30 July and 3 August 2014. In all but the last escort, the man was handcuffed to an officer.

52. 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 maintaining their dignity. 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 and which also takes into account factors such as the prisoner's health and mobility.

53. 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 the risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and the assessment should be reviewed as circumstances changed. It found that restraining a terminally ill prisoner by handcuffs who was receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

54. The risk assessments for 27 May and 30 June included information about the man spitting at staff and a history of violence in prison. Healthcare staff noted his mobility was unaffected by his illness. We think it reasonable that Norwich decided to escort the man using a single handcuff at that time.

55. By the next appointment on 23 July, The man had been diagnosed with cancer had become much more frail and was living in the healthcare unit. He needed a wheelchair to move around outside his cell and had asked for an electric one because he found the manual chair too difficult to manage. The healthcare section of the escort risk assessment stated that the man had impaired mobility (this was not defined). The authorising manager approved the recommendation of the general assessment – for the man to be escorted by two officers and handcuffed. The escort risk assessment for the appointment on 30 July was similar to the earlier ones except the healthcare input (written on 16 July) said the man did not suffer from impaired mobility and there was no more information about his condition. The authorising manager again approved a two officer escort with handcuffs. When the man was taken to hospital as an emergency on 3 August he was appropriately escorted by one officer, with no restraints.

56. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which staff should fully consider and balance against the security risks. In the man's case his medical condition and mobility had changed quickly and the healthcare information was not up to date. Healthcare staff did not highlight that the man was terminally ill with poor mobility for his appointments in July. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of

Healthcare also needs to ensure that healthcare staff understand their responsibilities and have appropriate input into the risk assessment process. We make the following recommendation:

The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

57. On 30 June, when the man told the officer that he had cancer, she offered to contact someone in his family but he told her there was no one. He later spoke about one of his sisters, but said they had not spoken for many years and that he did not want the prison to contact anyone. Two officers visited the man on 4 July and spent some time with him talking about his life and family. The man reiterated that he did not want his family to be contacted about his illness until after his death as he did not want anyone to feel obliged to visit him. The prison respected his wishes about family contact.

58. The man's sister lived in London and, after his death, Norwich asked HMP Belmarsh to send a family liaison officer to break the news. The family liaison officer went to his sister's home and waited for 45 minutes, but no one was home. She left a note with contact details, asking them to ring an operational manager at Norwich prison. The man's sister rang the operational manager later that day. The officer telephoned his sister and kept in contact and helped with funeral arrangements.

59. The man's funeral was held in Norfolk on 26 August 2014. The prison paid for reasonable costs, in line with national policy.

Compassionate release

60. Prisoners can be released from custody on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. Other factors to be considered include adequate arrangements for the prisoner's care and treatment outside prison. Early release should bring some significant benefit to the prisoner or his family and their wishes should be taken into account.

61. The doctor completed the first part of the application process on 31 July, after the man's diagnosis of terminal cancer and the consultant's prediction that he had less than three months to live. The GP thought the man had a lot less than three months left. He said that his condition meant it would be very difficult for him to commit any violent act, and noted that he spent most of his time in bed. A probation officer should complete the second section of the application. The man deteriorated so rapidly over the next few days (which included a weekend) that there was no opportunity to progress the application any further. Nevertheless, it is unlikely that the man would have been given

early release which would have required a hospice or hospital place. He had not been in touch with his family for some years, had been homeless before going into prison and had indicated that he wanted to die in the prison.

RECOMMENDATIONS

1. The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals, including ensuring that:

    - Prisoners with symptoms suggestive of cancer are referred as two-week urgent referrals, in line with NHS guidelines.
    - All clinical staff use the appropriate template for referrals, that they are accurate and clearly indicate the priority.
    - Referrals are monitored and followed up as required.

2. 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 including, the use of syringe drives and delivering appropriate pain relief medication promptly.

3. The Governor should ensure that security and disciplinary decisions affecting the welfare of a terminally ill prisoner are referred to a senior manager to consider holistically, in line with the prisoner's care plan.

4. The Governor and Head of Healthcare should ensure that terminally ill prisoners have appropriate accommodation to meet their needs and that cell doors are left open as necessary to facilitate appropriate and humane end of life care.

5. The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

ACTION PLAN

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure there is a clear and auditable process for hospital referrals, including ensuring that: • Prisoners with symptoms suggestive of cancer are referred as two-week urgent referrals, in line with NHS guidelines. • All clinical staff use the appropriate template for referrals, that they are accurate and clearly indicate the priority. • Referrals are monitored and followed up as required.	Accepted	A standard operation procedure has been implemented to ensure there is a clear and auditable process for hospital referrals. The operation procedure, which is read and accessible by all clinical staff, ensures all cancer referrals are in line with NHS guidelines. A newly developed database for referrals is held by and monitored by administrative staff.	Completed and ongoing Head of Healthcare
2	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 including, the use of syringe drives and delivering appropriate pain relief medication promptly.	Accepted	An end of life care pathway is being developed for HMP Norwich. This is in conjunction with Priscilla Bacon Lodge, Norfolk Community Healthcare, and Palliative Case Commissioners. As part of this protocol staff will be trained in the use of syringe drives to ensure pain relieving mediation is administered promptly.	31 July 2015 Head of Healthcare
3	The Governor should ensure that security and disciplinary decisions	Accepted	Any prisoner who is terminally ill will have a full multi-disciplinary review if required	31 January 2015 The Governor

	affecting the welfare of a terminally ill prisoner are referred to a senior manager to consider holistically, in line with the prisoner's care plan.		around their behaviour. This will take into account their medical condition and the effects this may have on their behaviour. Any change to their security status or IEP status will be countersigned by the Head of Residence/Safety or in their absence the Duty Governor.	Head of Residence/Safety
4	The Governor and Head of Healthcare should ensure that terminally ill prisoners have appropriate accommodation to meet their needs and that cell doors are left open as necessary to facilitate appropriate and humane end of life care.	Accepted	The current Open Door Policy for L Wing (where terminally ill prisoners are located) will be reviewed and amended as appropriate.	31 January 2015 The Governor Head of Healthcare
5	The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.	Accepted	HMP Norwich will work alongside Virgin care, the Healthcare provider to ensure that the medical opinion about the prisoners ability to escape (in particular those suffering from a serious medical condition), is considered as part of the assessment processes for external escorts.	31 January 2015 The Governor