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 February 2015 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 respiratory failure and heart disease in February 2015, at HMP Norwich. He was 64 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Norwich was undertaken. The prison cooperated fully with the investigation.

The man was sentenced to life imprisonment in July 2010 and was transferred to HMP Gartree in November that year. He had a history of asthma and asbestosis and, in July 2011, doctors diagnosed chronic obstructive pulmonary disease.

The man's lung condition worsened and he was admitted to hospital a number of times. In July 2014, after an initial period in hospital for emergency treatment, he was moved to a community hospital for palliative and end of life care. However, his condition stabilised and, in October 2014, he moved to the elderly care unit at Norwich. Healthcare staff at Norwich began a palliative and end of life care plan to manage him. He decided that he did not want staff to try to resuscitate him if his heart or breathing stopped. His health gradually deteriorated and, in February 2015, nurses found him unresponsive and not breathing. In line with his wishes, they did not attempt resuscitation and he died peacefully.

I am satisfied that the man received a good standard of end of life care at Norwich. The investigation notes the need for alternative arrangements to emergency procedures in the aftermath of an expected death from natural causes.

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 **June 2015**

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SUMMARY

1. In July 2010, the man was sentenced to life imprisonment for murder. He was held initially at HMP Norwich and was moved to HMP Gartree in November 2010.

2. The man had a number of health conditions, including asthma, psoriasis and vascular disease. In 2004, he had had a stroke leading to some memory loss and hearing problems. In July 2011, doctors diagnosed him with chronic obstructive pulmonary disease (COPD). Healthcare staff at Gartree managed his conditions. Despite his respiratory problems, he continued to smoke and turned down offers to help him give up.

3. The man's condition steadily deteriorated and he was admitted to hospital for treatment a number of times. In June 2014, he signed an order indicating he did not want to be resuscitated if his heart or breathing stopped.

4. In July 2014, during a hospital stay, hospital staff considered that the man could not go back to Gartree, as he appeared to be nearing the end of his life. On 27 July, he transferred to a community hospital for end of life care but his condition unexpectedly stabilised. On 13 October, he transferred to a specialist unit at HMP Norwich for palliative and end of life care.

5. Healthcare staff at Norwich began a full palliative and end of life care plan to manage the man and reviewed his medication regularly. Although a doctor did not assess him until 4 December, this did not affect his standard of care. He said he did not want to be admitted to hospital or have the hospital palliative care team review his care. He told staff that he did not want anyone to contact his family about his condition, until after his death.

6. One evening in February 2015 a nurse checked the man, who was alive at the time. About 15 minutes later, nurses found him unresponsive with no signs of life. A nurse called an emergency medical code but the nurses did not try to resuscitate him, in line with his wishes.

7. A post-mortem examination found that the man died from respiratory failure, severe emphysematous lungs and ischaemic heart disease with old myocardial infarction.

8. The clinical reviewer considered that the man received a good standard of palliative and end of life care at HMP Norwich, equivalent to that he could have expected to receive in the community. We are satisfied that he received good care at Norwich, but make one recommendation about emergency procedures after an expected death.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and inviting anyone with relevant information to contact him. No one responded.

10. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records.

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

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

13. One of the Ombudsman's family liaison officers contacted the man's son to explain the investigation. He did not have any specific issues for the investigator to consider.

14. The man's family received a copy of the draft report. They did not make any comments.

15. 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.

HMP NORWICH

16. HMP 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

17. 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.

Independent Monitoring Board

18. 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 had undergone many changes for the better and commended the staff who worked there for their care and compassion.

Previous deaths at HMP Norwich

19. 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 were terminally ill. The man was one of five prisoners to die from natural causes at the prison since the start of 2014.

KEY EVENTS

20. On 21 January 2010, the man was remanded to HMP Norwich, charged with murder. On 13 July 2010, he was sentenced to life imprisonment.

21. At an initial health assessment when he arrived at Norwich, the man said he had asthma caused by exposure to asbestos, psoriasis and vascular disease. He reported having had a stroke in 2004, after which he suffered memory loss and hearing problems. He took a number of prescribed medications and used an asthma inhaler.

22. On 22 January, a prison GP examined the man and diagnosed a chest infection. He prescribed antibiotics and reviewed his other prescribed medication. Healthcare staff at Norwich managed his various medical conditions until he transferred to HMP Gartree on 28 November.

23. At a health screen when he arrived at Gartree, a nurse noted the man's medical history and ongoing conditions. On 2 December, a prison GP advised him about the importance of trying to stop smoking. He said he smoked about 15 cigarettes a day and did not want to stop.

24. On 3 July 2011, the man reported breathing difficulties and a nurse referred him to the prison GP. The next day, when he had difficulty breathing again, healthcare sent him to hospital. The hospital admitted him to the intensive treatment unit and diagnosed chronic obstructive pulmonary disease (COPD – used to describe a range of lung diseases including bronchitis and emphysema). Hospital staff described his condition as critical.

25. The man returned to Gartree on 23 July. Because of his mobility and breathing difficulties, staff moved him to a ground floor cell. He continued to smoke, but his condition remained stable.

26. On 14 May 2012, a prison GP reviewed the man and prescribed atrovent (used to treat bronchitis, emphysema, or chronic lung disease) in addition to his usual medication and arranged a lung function test. Two weeks later, he told her he felt better since taking atrovent. However, she noted a deterioration in his lung function and again encouraged him to stop smoking.

27. On 31 July, the man was admitted to hospital with breathing difficulties and returned to the prison on 7 August. His discharge letter indicated he had a moderate exacerbation of COPD, abnormal arterial blood gases (the amounts of oxygen, carbon dioxide and acid/base level in the blood) and hyper-inflated lungs. A prison GP reviewed him the next day. The GP noted that the man looked reasonably well, but his chest had a slight wheeze and he was still smoking. The GP prescribed a gradual reduction in prednisolone (a steroid used to treat inflammatory conditions).

28. Healthcare staff monitored the man daily over the next two weeks. His condition improved and, for the next 12 months, he appeared stable. He cut down on the number of cigarettes he smoked each day. In July 2013, he

reported eye problems and his blood pressure was high, but he refused to attend a number of optician appointments. In October, the GP prescribed steroids and antibiotics for further respiratory problems and his condition improved.

29. In March 2014, healthcare staff saw the man a number of times when he complained of shortness of breath. On 13 March, he was treated in hospital for COPD and returned to the prison the same day. On 17 May, he finally agreed to have hospital treatment for his ongoing eye condition. The hospital discharged him on 13 June, after treating him for glaucoma.

30. In the early hours of 25 June, the man had breathing difficulties. He was admitted to hospital and a doctor diagnosed pneumonia. On 22 July, he signed an Order to indicate he did not want to be resuscitated if his heart or breathing stopped. He remained in hospital and prison healthcare staff maintained regular contact. The hospital wanted to discharge him, but did not consider that Gartree had suitable facilities to manage his ongoing care and alternative locations were considered.

31. On 27 July, the man transferred to a community hospital for palliative and end of life care, equivalent to a hospice. However, his condition unexpectedly stabilised to the point where he no longer required the type of care the hospital offered. Staff sought a suitable alternative location and, on 13 October, he was transferred to the unit for elderly and infirm prisoners (L Wing) at HMP Norwich.

32. When the man arrived at Norwich, a nurse recorded that he had end stage respiratory disease and had a do not resuscitate order. The nurse created a comprehensive inpatient, older person care plan to ensure all the man's personal, physical health and pain relief needs were met, including daily observations, specialist equipment, and medication reviews. The nurse noted that he was on the Gold Standards Palliative Care Framework and his condition was stable. Records show that nurses saw him every day and there are many entries about his routine physical care. He took a number of prescribed medications and on, 14 October, a prison GP reviewed all of his medication, although he did not see him. The GP authorised their continued prescription.

33. On 19 October, a nurse observed the man smoking in his cell. The nurse explained that this would worsen his condition. He was unwilling to discuss smoking with the nurse and declined any further advice about giving up smoking. On 11 November, a physiotherapist advised him about breathing techniques.

34. A prison GP reviewed the ma on 4 December, and amended his inhaler medication. He recorded the man was short of breath but able to speak in full sentences. This was the first recorded 'face to face' contact with a doctor since he arrived at Norwich, although the Head of Healthcare said that GPs had had input into his care before then.

35. On 9 December, a prison GP saw the man, who had a congested chest and cough. He diagnosed a chest infection and prescribed antibiotics. He noted that the man was a palliative patient, but did not want to go to hospital.

36. On 12 December, a mental health support worker spoke to the man and noted he was calm and polite with no mental health problems. The man told him that his breathlessness caused him anxiety but accepted that this was a natural reaction to his situation. Later that day however, he told a nurse that he believed he would die soon. He said that he wanted to die in the prison, did not want to go to hospital and did not want staff to try to resuscitate him.

37. A prison GP reviewed the man that afternoon and noted that his COPD was at an advanced stage. He advised regular oral morphine, oxygen and a continuation of his other prescribed medication to control his breathing. He repeated that he did not want to be referred to the local palliative care unit or want their input into his care. A nurse asked him for details of his next of kin and he gave his son's telephone number, but said he did not want him informed until after his death. Nurses continued to monitor him daily in accordance with his agreed care plans.

38. On 20 January 2015, a prison GP noted the man's breathing was more laboured. He prescribed oral steroids and antibiotics. The man continued to refuse any hospital referral or external palliative care intervention.

39. On 31 January, a nurse noted the man had blood in his stool. Tests later identified clostridium difficile, a bacterial infection, for which a prison GP prescribed antibiotics. Staff kept him isolated and introduced a strict hygiene and cleaning regime. On 2 February, due to his worsening condition, the Governor authorised that his cell should remain unlocked at all times to allow healthcare staff ready access.

40. On 12 February, a prison GP reviewed the man's condition, medication and care. He recorded that he was visibly short of breath and struggling to speak in full sentences. He was compliant with his medication and told the doctor he no longer had diarrhoea, vomiting or abdominal pain. The GP asked him if he wanted to be referred to the local palliative care team for support and he again said he did not want this.

41. Healthcare staff continued to monitor the man regularly, day and night. They administered his medication and attended to his personal needs. However, his health continued to deteriorate and his breathing became more laboured. Despite his failing health, he frequently said that he was comfortable.

Day of the incident

42. On the day of the man's death in February, a healthcare assistant saw the man at 11.22am. He had not eaten his breakfast and she encouraged him to drink more fluids. She washed him and changed his bed linen. She described him as hypersensitive and gave him pain relief medication.

43. A prison GP reviewed the man at 2.48pm, and noted his progressive deterioration. He had not taken oral medication for over 24 hours and had drunk very little. He said he still wanted to stay at the prison. The GP noted his wishes were clearly documented. He prescribed symptomatic relief and stopped all his usual medication. He advised the use of a syringe driver (a small pump to deliver continuous medication under the skin) to administer diamorphine if other medication did not give adequate relief. Staff began this just before 6.00pm.

44. A nurse checked the man at about 7.00pm and he was breathing at that time. At 7.15pm as part of the handover to the night duty staff, the nurse, together with colleagues, checked all the patients on the wing. When they checked him, he did not have a pulse, looked pale, was cold to touch and had no sensation.

45. In line with his wishes, the nurse did not try to resuscitate the man, but a nurse radioed a code blue medical emergency code (used to indicate a serious medical emergency, such as where a prisoner is not breathing or is unresponsive). The senior manager on duty at the prison attended. When he found that the code blue related to the man, he told the officers in the control room not to call an ambulance (which should usually be called as soon as a code blue is received). Instead, he asked the staff to call the out of hour GP service to attend and certify death.

46. The GP service would not agree to send a doctor and, at 8.45pm, an officer in the control room called an ambulance. Paramedics arrived at the prison at 8.50pm and, at 9.01pm, a paramedic confirmed the man's death.

Liaison with the man's family

47. After the man was transferred to Norwich, the prison had appointed a custodial manager as the liaison officer between the prison and his family. The man told the manager that he did not want his family to visit him or to be told of his condition until after his death.

48. On 6 February 2015, the prison received a letter from the man's son, his nominated next of kin, enquiring about his father's condition. On 11 February, a nurse discussed this with him, who agreed that that they could tell his son that he was stable but not as mobile as previously, because of his breathing problems. He said he did not want to worry his son and he did not want anyone to contact him again until after his death.

49. On 23 February at 10.15pm, the manager and a prison chaplain visited the man's son and told him that his father had died. They offered their condolences and support. The manager explained that the man had asked the prison not to contact his family before his death.

50. The manager kept in contact with the man's son and they discussed funeral arrangements. On 28 February, the man's son visited the prison, saw where

his father had lived and spoke to some of his friends. The funeral was held on 13 March. The prison contributed to the costs in line with national guidance.

Support for prisoners and staff

51. The Governor issued a notice to prisoners and staff, informing them of the man's death, and the support available. Staff reviewed the cases of all prisoners subject to suicide and self-harm prevention procedures, in case they had been affected by the news. The chaplain personally informed two close friends of the man's about his death. The chaplaincy held a service for him, the morning after he died

52. A senior manager debriefed prison and healthcare staff involved in the man's care and offered the staff support.

Post-mortem

53. A post mortem report concluded that the man died of respiratory failure, severe emphysematous lung disease and ischaemic heart disease with old myocardial infarction.

ISSUES

Clinical care

54. The clinical reviewer was satisfied that the man received a good standard of palliative and end of life care at Norwich. He was able to die comfortably and chose to remain in prison. She noted that the post-mortem report recorded that despite being confined to bed for most of the time, his skin was intact, with no evidence of pressure sores. This was a testament to his very good nursing care.

55. The man had a history of respiratory illness before he was sentenced to prison. At Gartree, his condition worsened and he was diagnosed with COPD - a life limiting respiratory condition, for which he had a number of hospital admissions. He continued to smoke and declined any help to stop, which made managing his chronic respiratory disease more difficult.

56. When the man's condition reached a level where hospital specialists recognised the need for palliative and end of life care, he was transferred to a hospital end of life ward and then to a specialist unit at Norwich. He made it clear that he wanted to stay at Norwich until he died and did not want to be resuscitated if he had a cardiac or respiratory arrest. Staff respected his wishes.

57. Although it would have been best practice for a GP to have reviewed the man shortly after he arrived at the prison, we are satisfied that this was not detrimental to his care or symptom control. Healthcare staff instigated a full palliative and end of life care plan when he arrived at Norwich. This contained all the expected elements, used standard risk assessment tools and was well documented. He had regular medication reviews and had appropriate medication to treat and relieve his symptoms. The clinical reviewer was satisfied that all aspects of his care at Norwich were equal to that expected in a community setting.

Emergency Response

58. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires Prison Governors to have a medical emergency response code protocol that instructs staff how to communicate the nature of a medical emergency using agreed emergency codes and ensures that the control room calls an ambulance automatically, as soon as a member of staff calls an emergency code.

59. When the man was found unresponsive, a nurse radioed a code blue medical emergency code, although the nurses considered that he had died and he had made it clear that he did not want anyone to attempt resuscitation. His death had been expected and nothing further could have been done for him. A manager told the investigator that the use of such an emergency medical code is the usual response when a prisoner dies on 'L' wing, in order to alert other staff. She said that under these circumstances control room staff would

not call an ambulance unless specifically directed to do so by a member of healthcare staff or a senior prison officer.

60. It is difficult to understand how the control room would be able to differentiate between such a code blue and others where an ambulance needs to be called immediately. We consider that the use of medical emergency codes in these circumstances is inappropriate and could cause confusion or delay in calling an ambulance in the case of an actual emergency. The control room should always call an ambulance as soon as an emergency code is received, without waiting to receive additional information. While a request for an ambulance can be cancelled subsequently, this would be an unnecessary burden on ambulance service resources when it is evident that a prisoner has died. The confusion about who was responsible for recognising and certifying death in these circumstances also needs to be resolved. We make the following recommendation:

The Governor and Head of Healthcare should ensure that medical emergency codes are used only when urgent medical help is required; that the control room calls an ambulance immediately in response to any emergency medical code; and that there are appropriate arrangements for managing and certifying an expected death from natural causes.

RECOMMENDATION

The Governor and Head of Healthcare should ensure that medical emergency codes are used only when urgent medical help is required; that the control room calls an ambulance immediately in response to any emergency medical code; and that there are appropriate arrangements for managing and certifying an expected death from natural causes.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor and Head of Healthcare should ensure that medical emergency codes are used only when urgent medical help is required; that the control room calls an ambulance immediately in response to any emergency medical code; and that there are appropriate arrangements for managing and certifying an expected death from natural causes.	Accepted	Consideration will be given to the appropriate method of alerting medical staff and the duty manager when a prisoner located on L wing with DNR arrangements in place is believed to have died. In all other circumstances a Code Red or Code Blue will be called to alert medical staff in order for them to attend with the correct medical bags, and enable the communication room to call an ambulance. The on-call GP service will be contacted to certify death when there is no GP on site.	30 June 2015 Governor / Head of Healthcare