

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Clark, a prisoner at HMP Norwich in April 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened, and identify how the organisations whose actions we oversee can improve their work in the future.

This is the investigation report into the death of Mr Kenneth Clark, who died of bronchopneumonia and heart disease in April 2015, at HMP Norwich. He was 83 years old. I offer my condolences to his family and friends.

Mr Clark had suffered from dementia and heart disease for some years and his condition had gradually deteriorated over time. I am satisfied that he received a good standard of end of life care at Norwich.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

September 2015

Contents

Summary	
The Investigation Process	
Background Information	
Key Events	
Findings.....	

Summary

Events

1. Mr Kenneth Clark was sentenced to life imprisonment in November 1968. He was released in 1983, but recalled within three months for breaching his licence conditions. He had been living in a specialist unit for elderly prisoners at HMP Norwich, since December 2004.
2. Mr Clark had suffered from dementia and heart disease since 2007. In September 2010, he had a cardiac pacemaker fitted to help regulate an abnormally slow heart rate.
3. Mr Clark's dementia gradually got worse and he required increasing support from healthcare staff. By 2011, he was doubly incontinent and was hard of hearing. He was treated for coronary heart disease, angina and heart failure. He needed daily assistance with his personal hygiene.
4. In November 2011, a prison doctor and nurse spoke to Mr Clark about resuscitation if his heart or breathing stopped. Mr Clark told them he wanted to be resuscitated. Shortly afterwards, a doctor agreed a Do Not Attempt Cardiopulmonary Resuscitation order on clinical grounds, as resuscitation would not be possible in Mr Clark's condition. This did not require Mr Clark's consent, but it is not clear that anyone informed him.
5. In 2013, Mr Clark reported difficulties in swallowing, a common feature of advanced dementia. A doctor referred him for speech and language therapy and dietary advice. The prison provided food that he could manage more easily. Mr Clark had appropriate care plans throughout his time at Norwich and healthcare staff monitored his condition and attended to his ongoing health needs. Over time, his health declined.
6. In March 2015, Mr Clark developed a chest infection and was prescribed antibiotics. Despite some initial improvement, his condition deteriorated. In April, a nurse found him unresponsive in bed. In line with the order, he did not attempt to resuscitate him. Staff called an emergency ambulance and a paramedic confirmed his death at 11.13am.

Findings

7. The clinical reviewer noted it would have been best practice to have informed Mr Clark or a representative of the decision not to resuscitate him, but he concluded that Mr Clark's care in prison was equivalent to that he could have expected to receive in the community. His care plans and medication, including pain relief were appropriate. The clinical reviewer considered that there was nothing that staff could have done to prevent Mr Clark's death. Overall, we are

satisfied that Mr Clark received good care at Norwich. As healthcare staff are reviewing their resuscitation policy to take into account recent national guidance, we make no recommendations.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.
9. The investigator obtained copies of relevant extracts from Mr Clark's prison and medical records. He interviewed one prisoner when he visited Norwich on 15 April and a member of staff by telephone on 6 May.
10. NHS England commissioned a clinical reviewer to review Mr Clark's clinical care at the prison.
11. We informed HM Coroner for the Greater Norfolk District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Clark's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked the investigator to clarify whether a 'do not resuscitate' order was in place for her father and details of his medication.
13. Mr Clark's daughter received a copy of the draft report and indicated that she was satisfied with the findings.
14. The draft report was issued for consultation with the Prison Service. There were no factual inaccuracies.

Background Information

HM Prison Norwich

14. 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

15. 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

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 had undergone many changes for the better and commended the staff who worked there for their care and compassion. They said that the procedures for 'do not resuscitate' orders were now in line with good practice but this had not been the case at the beginning of the reporting year.

Previous deaths at HMP Norwich

17. As Norwich has a special unit for elderly prisoners, there have been a relatively high number of deaths. Mr Clark was the sixth prisoner to die from natural causes at the prison since the start of 2014. There were no significant similarities with the circumstances of the other deaths.

Key Events

18. Mr Kenneth Clark was sentenced to life imprisonment in November 1968. He was released on licence in July 1983, but recalled to prison three months later, after breaching his licence conditions. He transferred to HMP Norwich on 10 December 2004, where he lived in a specialist unit for terminally ill and elderly prisoners.
19. In 2007, a specialist in old age psychiatry diagnosed Mr Clark with dementia, probably Alzheimer's disease.
20. Mr Clark had a cardiac pacemaker fitted in September 2010 following a diagnosis of bradycardia (an abnormally slow heart rate). In 2011, Mr Clark was treated for coronary heart disease, angina and heart failure. Doctors reviewed his ongoing heart problems and checked his pacemaker in April 2013 and 8 April 2014.
21. Mr Clark's dementia deteriorated, as is typical of the disease, and healthcare staff provided increasing amounts of nursing care. By 2011, he was doubly incontinent and needed daily assistance with personal hygiene. Nurses implemented an older person's care plan to cover his personal and physical health needs. Nurses saw him daily.
22. On 29 November 2011, prison GP and a nurse spoke to Mr Clark about resuscitation if his heart or breathing stopped. Mr Clark said he wanted staff to try to resuscitate him. Although Mr Clark had dementia, there is no record that the clinicians considered his mental capacity.
23. On 5 December, a nurse completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order, which a prison GP reviewed and endorsed. The order, made on clinical grounds, noted that resuscitation was considered futile because of 'heart failure, dementia and permanent atrial fibrillation (irregular heart beat)'. The decision not to resuscitate was put in place indefinitely. As it was made on clinical grounds, it did not require Mr Clark's consent. There is no record that anyone informed Mr Clark or a representative.
24. Mr Clark remained relatively stable throughout 2012. In early 2013, he reported symptoms of dysphagia (difficulty swallowing), a common feature of advanced dementia. Between January and May, a specialist examined him and carried out tests. Investigations did not reveal any abnormality and the doctor referred him for speech and language therapy and dietary advice. The prison gave him a soft diet and Mr Clark's weight increased by 4kg.
25. Mr Clark remained on an older person care plan throughout his time at Norwich. Healthcare staff monitored his condition, health and physical needs each day. His condition fluctuated and he was confused at times. He still had trouble swallowing food and the prison continued to provide a suitable diet.
26. On 30 March 2015 at 5.51pm, a nurse examined Mr Clark when he reported symptoms of a chest infection. Mr Clark had a high temperature and low blood pressure. She gave Mr Clark paracetamol and oxygen. He made an

appointment with the prison GP for the next day but at 6.45pm, he called the out of hours GP service for a prescription of antibiotics. An out of hours GP agreed that Mr Clark should have liquid amoxicillin (an antibiotic) and a nurse gave him his first dose at 7.15pm.

27. On 31 March, prison GP prescribed the continued use of amoxicillin. Mr Clark's condition showed little signs of improvement. Healthcare staff continued to monitor him regularly, gave him medication, and administered oxygen when required.
28. On 1 April, another prison GP saw Mr Clark, who had breathing difficulties, although he appeared to be comfortable. The GP told staff that Mr Clark should maintain his fluid levels and continue his liquid diet. Later that evening, a nurse noted that Mr Clark had eaten little and struggled to take his medication.
29. A nurse monitored Mr Clark throughout the night and noted no major changes. Mr Clark remained poorly.
30. On 2 April at 1.55pm, a prison GP reviewed Mr Clark. He looked brighter and not in any obvious pain. The GP considered changing all of Mr Clark's medication to a liquid form but decided to leave Mr Clark on his current medication and review him again a week later.
31. At 6.58am, a nurse, who was working the night shift, checked Mr Clark in bed in his cell. Mr Clark had slept well and appeared to be recovering from his chest infection.
32. The day duty nurse began work at 7.00am. The night nurse handed over to him and together they checked all the prisoners, including Mr Clark, who they considered were weak and physically unwell.
33. Shortly after 8.30am, a nurse began dispensing medication. Mr Clark took most of his medication but refused his angina medication. At 9.00am, a healthcare assistant offered Mr Clark breakfast. He took a few sips of juice but did not eat anything.
34. Mr Clark's cell door was left unlocked at all times to allow staff ready access to care for him. Shortly after 9.00am, he became very agitated, restless and began calling out. Healthcare staff reassured and calmed him.
35. At 10.55am, a nurse went back to check Mr Clark and found him completely unresponsive to touch, voice or pain. His eyes and mouth were wide open and he was hardly breathing. He looked pale and had no wrist pulse. He had a very weak carotid (neck) pulse, which was barely noticeable.
36. The nurse called to other staff to assist. The healthcare assistant asked the control room to call an ambulance and notified the senior manager on duty. Another healthcare assistant brought the emergency equipment bag.

37. The nurse knew that Mr Clark was subject to a no not resuscitate order so did not try to resuscitate him. However, he gave Mr Clark oxygen, as he wanted to make him more comfortable.
38. A nurse from the healthcare unit on the floor above arrived at 10.58am and the Healthcare Manager arrived two minutes later. They stayed with Mr Clark while a nurse arranged documentation for the ambulance crew.
39. Paramedics arrived at 11.10am and three minutes later, at 11.13am, a paramedic confirmed Mr Clark's death.

Contact with the family.

40. After Mr Clark's death, a senior manager assumed the initial responsibility for family liaison. Mr Clark's daughter lived a long way from Norwich and the senior manager did not consider it practical for staff from Norwich to travel to her home to inform her of her father's death.
41. In such circumstances, prisons are usually expected to ask someone from a prison close to the prisoner's family to visit them and inform them of a death. However, Mr Clark died on Good Friday and the senior manager knew that there would be limited staff on duty in the prison and this would be difficult. He therefore asked the local police to inform Mr Clark's daughter.
42. A police officer visited Mr Clark's daughter at 5.15pm and told her that her father had died. At 5.45pm, the senior manager telephoned her and offered his condolences. He outlined the circumstances of her father's death and the support available. He explained that a family liaison officer would contact her again on 7 April, after the Bank Holiday weekend, but that she could contact him at any time before then, if she had any concerns.
43. On 7 April, the prison a custodial manager, who acted as the prison's family liaison officer, contacted Mr Clark's daughter. He offered support and help with the funeral arrangements.
44. The family liaison officer kept in contact with Mr Clark's daughter. Mr Clark's funeral was held on 28 April and the prison contributed towards the cost in line with national guidance.

Support for prisoners and staff

45. The senior manager debriefed the staff who were present when Mr Clark died, to ensure they had the opportunity to discuss any issues arising and to offer support.
46. The prison posted notices informing staff and prisoners of Mr Clark's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by the news.
47. Staff in the elderly prisoners' unit personally informed the other prisoners there that Mr Clark had died. Two prison chaplains attended to support them. The chaplaincy held a memorial service for Mr Clark.

Post-mortem report

48. A post-mortem examination concluded that Mr Clark had died of bronchopneumonia with pulmonary atelectasis (collapsed lung) and coronary heart disease.

Findings

Clinical care

49. The clinical reviewer considered that Mr Clark received a good standard of care at Norwich. A specialist in old age psychiatry had diagnosed dementia, probably Alzheimer's disease, in 2007, although there was evidence of memory concerns much earlier. A slow progressive decline with increasing confusion and disability was typical for such a diagnosis.
50. Mr Clark had developed ischaemic heart disease by 2010, including bradycardia, angina and heart failure. The clinical reviewer was satisfied that the medication and treatment provided were appropriate.
51. Healthcare staff at Norwich implemented appropriate care plans that contained all the expected elements, used standard risk assessment tools and were well documented. Mr Clark had regular medication reviews and had appropriate medication to treat and relieve his symptoms. The clinical reviewer considered that all aspects of Mr Clark's care at Norwich were equivalent to that he could have expected to receive in the community. We are satisfied that Mr Clark was appropriately cared for at Norwich.

Resuscitation

52. On 29 November 2011, two clinicians discussed resuscitation with Mr Clark. Though he suffered from dementia, there was no indication that they had considered his mental capacity and no one else was consulted. Mr Clark said he wanted to be resuscitated if he had a respiratory or cardiac arrest.
53. On 5 December 2011, two different clinicians completed a Do Not Resuscitate order on clinical grounds, as there was no realistic prospect of success. This did not require Mr Clark's consent. The clinical reviewer was satisfied that the decision was clinically appropriate but considered that he, or a member of his family, should have been told.
54. Since the decision in Mr Clark's case, in October 2014, the British Medical Association, Resuscitation Council and the Royal College of Nursing have revised the advice and recommendations about resuscitation with an emphasis on involving people in decisions. When it is decided that resuscitation has no realistic chance of success the person or their representative should be told at an early stage.
55. The clinical reviewer considered that Norwich should review its policy on resuscitation to reflect current guidance and has made a recommendation in his review that the Healthcare Manager will need to address. The Healthcare Manager has told us they are currently reviewing the policy, in the light of the new guidance. As this is covered in the clinical review, and action is currently being taken, we make no recommendation.

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