

**Prisons &
Probation**

Ombudsman
Independent Investigations

Investigation into the death of Mr Michael Cousins, a prisoner at HMP Norwich on 2 May 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.

Mr Michael Cousins died of lung cancer at HMP Norwich on 2 May 2015. He was 49 years old. I offer my condolences to Mr Cousins' family and friends.

The clinical reviewer was concerned about some hospital delays but noted that these were not the responsibility of prison staff, who did their best to ensure that Mr Cousins received appropriate and timely treatment. Hospital treatment is outside the remit of this investigation and the clinical reviewer has referred the matter to NHS England. I am satisfied that Mr Cousins received a very good standard of care at Norwich. Mr Cousins was not restrained when he went to hospital in the later stages of his illness. However, I am concerned that a manager authorised the use of restraints when Mr Cousins was in hospital in December, after an operation to remove a brain tumour, without a healthcare contribution to the risk assessment

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

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Nigel Newcomen CBE
Prisons and Probation Ombudsman

November 2015

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Summary

Events

1. In October 2012, Mr Michael Cousins was remanded to HMP Norwich. He received a six-year sentence in January 2013 and transferred to HMP Wayland on 10 April 2013. He had a long history of drug and alcohol misuse.
2. On 31 October 2014, Mr Cousins went to hospital with chest pains. Investigations revealed he had lung cancer. Doctors prescribed pain relief and carried out a biopsy to investigate the extent of the cancer. On 8 December, he transferred to Norwich and was looked after in the prison's healthcare centre. Scans showed that the cancer had spread to his brain and he had an operation to remove a tumour. He discharged himself from hospital on 31 December, and after that he received treatment as an outpatient, including palliative radiotherapy.
3. Mr Cousins continued to refuse to be admitted to hospital and received end of life care at the prison. He died at Norwich on 2 May.

Findings

4. The clinical reviewer noted that, although it was unlikely to have altered the outcome for Mr Cousins, there were some delays with the hospital obtaining a definitive diagnosis, which delayed treatment. The hospital was also slow to offer appointments, despite prison healthcare staff chasing these. Hospital care is outside the remit of this investigation and the clinical reviewer has referred the matter to NHS England. We are satisfied that Mr Cousin's overall care in prison was very good. There was effective liaison with Mr Cousins' family.
5. Mr Cousins was not restrained when he went to hospital in March and April. However, we are concerned that restraints were used without a healthcare contribution to the risk assessment after he had an operation to remove a brain tumour in December 2014.

Recommendation

- The Governor and Health of Healthcare 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.

The Investigation Process

6. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
7. The investigator obtained copies of relevant extracts from Mr Cousins' prison and medical records.
8. NHS England commissioned a clinical reviewer to review Mr Cousins' clinical care at the prison.
9. We informed HM Coroner for Norwich of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Cousins' mother, his next of kin, to explain the investigation. She did not identify any specific issues for the investigation to consider
11. The investigation has assessed the main issues involved in Mr Cousins' 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.
12. The prison has also submitted an action plan detailing what they have done to address the issues we raised
13. Mr Cousins' family were informed the initial report was available, but did not wish to receive a copy or make any comment.

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. The most recent inspection of HMP Norwich was in August 2013. Inspectors reported that good progress had been made since the last inspection. However, the high use of locum GPs led to inconsistencies in treatment, care and prescribing. There was a wide range of clinics and care in the inpatient unit was good. Inspectors noted that staff were being trained in palliative care due to the increasing number of older and other prisoners with palliative care needs.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2015, the IMB reported that healthcare provision had improved with a new supplier, although there were still too few GPs and too many agency staff.

Previous deaths at HMP Norwich

17. Mr Cousins was the seventh prisoner to die in Norwich since January 2014. We have previously made recommendations about the use of restraints.

Findings

The diagnosis of Mr Cousins' terminal illness and informing him of his condition

18. Mr Michael Cousins was remanded to HMP Norwich in October 2012 and sentenced to six years in prison for drug offences in January 2013. He had poor health, had received treatment for alcohol and drug addiction and was a heavy smoker. He had deep vein thrombosis and hepatitis C, for which he declined treatment. Nerve damage from intravenous drug use caused him pain in his arm. On 10 April 2013, he transferred to HMP Wayland.
19. On 31 October 2014, Mr Cousins reported that he had been having chest pains which had been getting worse over the previous few weeks. A prison GP sent him to the Norfolk and Norwich University Hospital that day. The hospital initially suspected a heart attack but a chest X-ray revealed a mass in his lungs. Mr Cousins discharged himself the same day, against medical advice and without waiting for the results of the X-ray. Nurse A reviewed Mr Cousins when he returned to the prison and booked a GP appointment.
20. On 2 November, Mr Cousins told Nurse A that the hospital had diagnosed heart problems and he was waiting for an urgent CT scan. She sent him back to hospital as an emergency. Hospital doctors diagnosed Mr Cousins with an enlarged heart and suspected cancer. He returned to prison on 4 November with an outpatient appointment for a CT scan on 6 November.
21. On 5 November, Dr A, a prison GP, examined Mr Cousins in his cell, as he was too unwell to walk to the healthcare centre. Mr Cousins said he had chest pain and was unsteady on his feet. The doctor noted the hospital test results and that he was waiting for a CT scan to investigate further. It is not recorded whether he discussed the results with Mr Cousins.
22. On 6 November, a CT scan showed that Mr Cousins had a tumour on his lung but the hospital did not give a definite diagnosis of lung cancer. The next day Officer A, Nurse A and a prison GP, B, saw Mr Cousins and told him the results of the CT scan. They explained the support available and gave him the opportunity to call his mother from the wing office. He was upset and said that he had no major symptoms but found it difficult to eat. The doctor arranged for him to receive a special diet and asked nurses to monitor him.
23. On 14 November, at a hospital appointment, a consultant confirmed the initial results and referred him for a biopsy. While waiting for the biopsy Mr Cousins became more unwell. On 6 December, he told nurses that he had a pain in the back of his head and all over his body. He was weak, felt sick and unable to eat and asked to go somewhere with 24 hour healthcare facilities. Nurse B noted his blood pressure, pulse and oxygen levels were all normal but he could not mobilise easily. She considered he was too unwell to be left unsupervised on the wing and sent him to hospital. Mr Cousins remained in hospital until 8 December, when he was discharged directly to the healthcare inpatient unit at HMP Norwich. On 15 December, hospital doctors carried out a biopsy, after which they formally diagnosed Mr Cousins with lung cancer.

24. The clinical reviewer considered there was a delay by the hospital in confirming Mr Cousins' diagnosis, which fell outside national guidelines. However, he noted that the records are clear that prison healthcare staff actively chased medical appointments, which the hospital did not arrange promptly. The delay was not caused by the prison and we are satisfied that prison healthcare staff supported and informed Mr Cousins while his lung cancer was being diagnosed. .

Mr Cousins' medical treatment

25. On 17 December, Mr Cousins complained of pain in his spine and in his head, and told nurses he thought he had a brain tumour. On 19 December, a nurse sent him to hospital after he had fallen out of bed, was in pain and dehydrated. Further investigations revealed that the cancer had spread to Mr Cousins' brain. On 23 December, surgeons removed a brain tumour. On 31 December, Mr Cousins discharged himself, against medical advice.
26. The next day, 1 January 2015, a nurse called an ambulance as Mr Cousins was unwell. Paramedics diagnosed a fever, but he refused to go to hospital. On 2 January, Dr A discussed his condition with him and Mr Cousins signed an order to say he did not want to be resuscitated if his heart or breathing stopped. The doctor referred him for physiotherapy and speech and language therapy, because he found it hard to mobilise, talk, swallow and eat.
27. Healthcare staff monitored Mr Cousins daily and a mental health nurse reviewed him each week. Prison doctors had requested a hospital oncology appointment and chased the hospital frequently, but Mr Cousins received no appointment. On 4 March, he reported worsening chest pain and headaches. A prison GP, C, changed his pain relief from tramadol to maptazinol and morphine sulphate and prescribed a steroid. The next day, the doctor spoke to an oncology nurse specialist at the hospital and arranged an appointment for 10 March.
28. On 6 March, Nurse C noted that Mr Cousins had continued to receive tramadol although the doctor had asked for his medication to be changed to maptazinol and morphine. Nor had he received the prescribed steroid. The nurse noted that this was because of 'a breakdown in communication' and the matter was reported to the accountable officer (the senior person responsible for the management of controlled drugs and related governance issues.)
29. On 10 March, Mr Cousins went to the hospital for the appointment with the specialist. Because of an administrative problem the hospital had not booked the appointment and Mr Cousins returned to the prison without seeing a specialist.
30. On 14 March, Nurse D went to see Mr Cousins after he did not collect his medication and found him unresponsive on his bed. He requested an ambulance. In hospital, doctors diagnosed a urinary tract infection and treated Mr Cousins with antibiotics. Hospital staff told him his prognosis was poor and a CT scan confirmed he had more tumours in his brain, on his liver and near his spine. A cancer specialist reviewed him in hospital, but it is not clear whether he received any cancer treatment at the time. The hospital discharged him on 18 March.

31. On 25 March, a hospital consultant reviewed Mr Cousins and recommended one dose of palliative radiotherapy to help with managing his pain. The consultant told him he had just a few weeks to live. Mr Cousins had radiotherapy on 1 April.
32. On 14 April, Dr A discussed Mr Cousins' end of life care with him and referred him to the hospital palliative care team. From 20 April, his door was left open at all times to facilitate his care and he had a wrist bell, to call staff if he needed them. Healthcare staff liaised with the hospital palliative care team about his care and pain relief.
33. From 26 April, Mr Cousins' condition began to decline significantly. Staff sat with him and encouraged him to eat and drink and take pain relief. He drifted in and out of consciousness and from late on 28 April, stopped talking. Nurses administered continuous pain relief through a syringe driver. Shortly before 11.00pm, on 1 May, he showed no signs of breathing. Nurses called an out of hours doctor who certified his death at 12.50am on 2 May.
34. Mr Cousins' palliative radiotherapy was delayed, but again this was due to the hospital and not the prison. Hospital care is outside the remit of this investigation, but the clinical reviewer has raised this with NHS England and recommended that the matter should be referred to the Medical Director of Norfolk and Norwich University Hospital for investigation as a serious incident.
35. Although there was one incident in March when poor communication meant that Mr Cousins did not receive a change in medication promptly, we are satisfied that this was resolved and dealt with appropriately. The clinical reviewer concluded that prison healthcare staff gave Mr Cousins comprehensive and high quality care and kept excellent records.

Mr Cousins' location

36. After Mr Cousins was discharged from hospital on 8 December, he transferred to HMP Norwich, which has 24-hour healthcare cover and was admitted to the prison's inpatient unit, where he remained until he died. Records show that prison staff often asked Mr Cousins where he would prefer to be and he said he would like to stay in the prison. He said he did not want to go to hospital or a hospice and discharged himself from hospital twice. We are satisfied that Mr Cousins' location was appropriate throughout his illness and took account of his preferences for end of life care.

Restraints, security and escorts

37. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated

that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

38. We are pleased to note Mr Cousins was not restrained when he attended hospital in March and April. However, when he was taken to hospital on 19 December as an emergency, he was initially restrained with an escort chain. A manager reviewed this the same day and agreed that no restraints were needed. On 26 December, just three days after Mr Cousins had had an operation to remove a brain tumour, a prison manager, A, decided that Mr Cousins should be restrained again as escort officers recorded he was more mobile. However, they also noted that Mr Cousins struggled to walk and needed support to go to the toilet. There was no healthcare input about how his condition affected his risk of escape, as the court judgment requires. We have raised this issue with Norwich before and the prison undertook to make changes. Mr Cousins remained restrained until he left hospital on 31 December. We make the following recommendation:

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.

Liaison with Mr Cousins' family

39. Staff at Wayland informed Mr Cousins' mother, who he had named as his next of kin, when he went to hospital in November 2014, and when he moved to Norwich.
40. Norwich appointed Officer B and a custodial manager, A, as the family liaison officers when Mr Cousins went to hospital on 19 December 2014. Mr Cousins did not always want to receive visits, and did not want his mother to know how ill he was. However, when he agreed, the officer arranged visits to the prison and hospital for his mother, aunt, uncle and partner.
41. Officer B agreed with Mr Cousins that he would keep in contact with his mother. On 28 April, when his condition deteriorated significantly, Mr Cousins initially said he did not want anyone to contact his family. The next day he asked to see his mother and custodial manager, A, arranged for her and his family to visit that day, and again on 1 May. As agreed with Mr Cousins' mother, custodial manager, A, phoned his uncle to let him know when he died. Custodial manager A visited Mr Cousins' mother and family the next day and offered his condolences and support.
42. Mr Cousins' funeral was on 20 May and the prison contributed to the cost in line with national policy. We are satisfied that Mr Cousins' family received appropriate support.

Compassionate release

43. Prisoners can be released from custody before their sentence has expired 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.

44. Records show that prison staff asked Mr Cousins a number of times if he wanted to apply for compassionate release. He said he did not want to leave the prison. We are satisfied that the prison appropriately considered compassionate release.