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 September 2014 while a prisoner 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 in September 2014, while in the custody of HMP Norwich. He was 94 years old. I offer my condolences 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 12 months in prison on 12 June 2014 for offences committed many years previously. He was sent to HMP Norwich the same day, where he lived in a special unit for older prisoners. Healthcare staff saw him daily. Nurses identified him as at risk of falling due to his age and fragile physical condition and had a care plan to manage him. His bed had cot sides which staff raised to help prevent him falling out.

On 15 September, a nurse found the man on his cell floor, although the cot sides on his bed were up. He had hurt his head and chest. He went to hospital for treatment. The hospital discharged him back to the prison in the early hours of the next morning. On 17 September, he complained of pain in his right side. A nurse suspected he had a possible pneumothorax or a chest infection and he was taken to hospital again. He never recovered and died in hospital just over a week later.

While it is unfortunate that the man suffered a fall in the prison, I consider that staff took appropriate steps to safeguard him. Sadly, his death illustrates the difficulties prisons face when dealing with an increasingly elderly prisoner population, of whom he was among the oldest. I am pleased to note that since his death, the older prisoners' unit now has electric height adjustable beds which should help reduce the risk of vulnerable prisoners falling from bed and injuring themselves. The clinical reviewer considered that his death could not have been prevented and I am satisfied that he received a good standard of care at Norwich.

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 **April 2015**

CONTENTS

SUMMARY

1. The man was sentenced to 12 months in prison on 12 June 2014 for historic sexual offences. He was sent to HMP Norwich the same day, where he lived in a special unit for older prisoners.

2. The man was a frail, elderly prisoner who needed daily care from healthcare staff. He used a wheelchair and was unable to stand without help from a Zimmer frame. Nurses drew up a care plan to ensure his personal and medical needs were met. He was assessed as a high risk of falling and had a bed with raised cot sides.

3. On 6 July, hospital doctors diagnosed the man with aspiration pneumonia (an inflammation of the lungs and bronchial tubes caused by inhaling secretions or contents from the throat or stomach). He was treated in hospital until 24 July and discharged back to the prison.

4. On 15 September, the man fell out of bed and cut his head and banged his chest, although the cot sides of his bed were raised. He was taken to hospital and had an X-ray which identified no concerns. The hospital discharged him in the early hours of 16 September. On 17 September, a nurse noted that he was in obvious pain and distress. He diagnosed a possible pneumothorax (collapsed lung) or a chest infection and sent him back to hospital. His condition deteriorated and the hospital stopped active treatment. He died in hospital and his family were with him at the time.

5. We agree with the clinical reviewer that the standard of healthcare the man received at HMP Norwich was equivalent to that he could have expected to receive in the community.

6. We are satisfied that the prison took appropriate steps to reduce the risk of the man falling out of bed. We are pleased to note that the prison has recently replaced the beds in the older prisoners unit which should help reduce the risk in future.

THE INVESTIGATION PROCESS

7. 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.

8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She informed the Governor of the preliminary findings of the investigation.

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

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

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation. His son-in-law said his family were surprised at how quickly his condition had deteriorated and asked how the prison had managed his healthcare needs.

12. The draft report was shared with the Prison Service. There were no factual inaccuracies.

13. The man's family received a copy of the draft report. They pointed out some factual inaccuracies. This report has been amended accordingly. The family also raised an issue that does not impact on the factual accuracy of this report and has been addressed through separate correspondence.

HMP 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.

Previous deaths at Norwich

17. 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 three prisoners 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. The man was found guilty of historic sexual offences on 12 June 2014 and sentenced to 12 months in prison. He was taken to HMP Norwich the same day. He was 94 years old.

19. At an initial health screen, a nurse noted that he was very frail. His mobility was poor and he used a wheelchair and could not stand without help. He took a number of prescribed medications and used an asthma inhaler. He was allocated to L Wing, a specialist unit for older prisoners.

20. On 14 June, nurses implemented an older person's care plan to ensure the man's personal and physical health needs were met. This included a falls risk assessment which showed he had a high risk of falling. His bed had cot sides and staff kept these raised to reduce his risk of falling out. Records show nurses saw him every day and there are many entries relating to his routine physical care. Nurses also assessed him to prevent hypothermia.

21. On 20 June, a prison GP prescribed the man amoxicillin (an antibiotic) for a chesty cough. On 24 June, the doctor changed this to augmentin (another antibiotic) and mucolytic (used to dissolve or breakdown mucus in the respiratory tract) because his condition had not improved.

22. On 26 June, a GP asked the man whether he wanted staff to attempt to resuscitate him if he had a cardiac or respiratory arrest. He said he did not want to be resuscitated and signed an order to that effect.

23. On 3 July, the man fell from his wheelchair after trying to do up his shoes. A nurse noted he had not injured himself and advised him to ask staff for help in future. The same day, the doctor reviewed his medication and changed it from tablet to liquid form because he was having difficulty swallowing.

24. The man's cough continued to cause concern. On 6 July, a nurse noted he had discoloured phlegm and laboured breathing. The nurse noted he was pale and incoherent and his respiratory rate was 23, which was above the normal range. His oxygen saturation level was 70 per cent, which was low, but increased to 91 per cent after the nurse gave him oxygen. The staff arranged for him to go to hospital by ambulance. One officer accompanied him. No restraints were used on this or other occasions.

25. Hospital doctors diagnosed the man with aspiration pneumonia (an inflammation of the lungs and bronchial tubes as a result of inhaling secretions or contents from the throat or stomach). They treated him with antibiotics and referred him to a speech and language therapist, because

of his difficulty swallowing. A scan of his brain showed chronic small vessel ischaemia (where the blood flow through small arteries and vessels is restricted because of a blockage or constriction). This is common in people of his age and can cause some memory loss and confusion. Nurses inserted a catheter to ease urinary problems he was experiencing.

26. On 24 July, the man returned to prison. Nurses implemented a catheter management care plan and left his cell door open permanently to allow regular checks and clinical observations.

27. Nurses monitored the man every day. They regularly recorded his respiratory level and oxygen saturation level which remained within acceptable ranges. Records show that he began calling out to staff for no clear reason and appeared slightly confused. Nurses checked and calmed him each time.

28. At 2.48pm on 15 September, a nurse found the man lying on his cell floor. He had fallen out of bed, although the cot sides were up. He had a deep cut on the right side of his face (where he had hit the bedside cabinet) and complained of pain in his right rib cage area. The nurse noted his breathing and oxygen saturation levels were normal. However, he was disorientated and his pupils did not respond to light. He was taken to hospital by ambulance.

29. At hospital, the man had a chest X-ray which identified no concerns. He went back to the prison at 1.10am on 16 September. He asked if he could sit in his wheelchair through the night, because he was frightened of falling from his bed again. A nurse reassured him that they would keep the cot sides on his bed raised at all times and they would check him regularly. Records show staff checked him at least 16 times that day.

30. At 2.43pm on 17 September, a nurse noted that the man had reduced movement on his right side and was in obvious distress. The nurse diagnosed a possible pneumothorax (collapsed lung) or a chest infection. He sought further advice from the healthcare manager who agreed that the man should go to hospital.

31. At 4.12pm, the man was taken to hospital by ambulance. Hospital staff drained his chest and treated him with intravenous antibiotics and fluids. On 22 September, hospital staff told the prison that they had removed his chest drain and stopped his active treatment. His chest symptoms had remained the same and hospital doctors considered that further treatment would not be of any benefit. He continued to receive palliative care in hospital. He died in hospital and his family were with him at the time.

Liaison with the man's family

32. The prison informed the man's family each time he went to hospital and they were able to visit him there. On 8 July, the prison appointed an officer as their family liaison officer. The officer spoke to the man's family frequently and offered advice and support. When he returned to prison from hospital his family were able to visit him on L Wing.

33. After the man died, the officer remained in contact with his family to offer advice and support. The funeral was on 29 October and the prison contributed to funeral costs in line with national guidance

Support for staff and prisoners

34. A Governor's notice informed prisoners and staff that the man had died. A senior manager debriefed the staff on L Wing on 26 September and offered appropriate support. Staff supported other prisoners on L Wing.

Cause of death

35. The Coroner told us that the cause of death was respiratory failure and pneumonia. The man also had small rib fractures, possibly due to his fall.

ISSUES

Clinical care

36. The clinical reviewer noted that, although healthcare staff at Norwich took all reasonable steps to care for him, the man fell from bed and struck his head and chest. Staff appropriately sent him to hospital, although the hospital discharged him a few hours later. He subsequently developed a traumatic pneumothorax which developed slowly over a period of hours. Once his symptoms developed, a prison nurse made a rapid diagnosis with good clinical accuracy, and he was taken back to hospital.

37. Hospital staff treated the man's condition appropriately. However, because of his age and other health problems his condition deteriorated. Hospital staff decided that there was no benefit from further active treatment and he died a few days later.

38. We agree with the clinical reviewer that the man was very well cared for in prison and that his care was equivalent to that he could have expected to receive in the community.

The man's fall from bed on 15 September

39. When the man arrived at Norwich, staff completed a falls risk assessment, which identified he was at risk of falls and needed the help of two carers to get out of bed. At the time of his death the beds in the unit had height adjustable cot sides. These are designed to reduce the risk of people falling out of bed and are used in the community. Staff raised the cot sides on his bed because of his vulnerability and risk of falling. The clinical reviewer considered that he might have attempted to get out of bed in a state of confusion, which resulted in his fall. We are satisfied that staff took appropriate steps to reduce the risk of him falling out of bed and checked him frequently.

40. The interim Head of Healthcare told us that the beds in the unit were replaced with electric height adjustable beds on 15 November. Prisoners who are assessed as a high risk of falling are now placed in beds at floor level. If necessary, they now also have safety "crash" mats to place alongside the beds to cushion any falls. We are satisfied that the prison has taken appropriate action to reduce the risk of prisoners falling out of bed and injuring themselves.