

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in June 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 from a bleed on his brain, at HMP Norwich, in June 2014. I offer my condolences to his family and friends.

One of my investigators carried out the investigation and a clinical reviewer was, appointed, to review the man's clinical care at Norwich. The prison cooperated fully with the investigation.

On 10 April, the man was, remanded to HMP Norwich. Before being, sent to prison, he had suffered several fits and, at the beginning of March 2014, a scan showed that he had some damage to the front of his brain. In prison, the man's community GP records were not requested until a month after he arrived and no efforts were made to obtain the results of the brain scan. The man reported having an outstanding neurology appointment for 12 May, but no arrangements were made for him to attend or rebook it until he pursued the matter himself. Sadly, the new appointment was not until two months after his death.

During the two months he was at Norwich, healthcare staff assessed the man several times after suspected fits or feelings of dizziness. It is unclear whether the prison doctor treating the man was fully aware of this or adequately reviewed his medical record before assessing him. He recognised that the man was suffering from life-threatening fits and prescribed anticonvulsant medication, but I am concerned that he did not implement a care plan or recommend safeguards such as locating the man in a double cell and informing wing staff to be vigilant about his safety.

An officer found the man unresponsive in his single cell on the morning of 17 June and it was evident that he had been dead for some hours. The officer had unlocked the man's cell 90 minutes earlier but does not seem to have checked the man's welfare at the time. The investigation identified a number of concerns about the standard of care given to a clearly vulnerable man and I consider that Norwich needs to adopt clear multidisciplinary care plans to manage men susceptible to fits or seizures.

The 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

The investigation process

HMP Norwich

Key events

Issues

Recommendations

SUMMARY

1. On 10 April, the man was remanded to HMP Norwich. He told the nurse at a first health screen that he had a history of fits and that a scan in March 2014 had shown damage to his brain. He told her and a prison GP that he was due to attend a follow-up neurology appointment on 12 May but staff made no arrangements to take him to the appointment or re-book it.
2. At the end of April, nurses assessed the man three times after wing officers were concerned that he had symptoms of fits. Two weeks later, the prison GP assessed him, but it is not clear whether the GP consulted the man's recent medical record before he saw him. The man told him that he had missed his neurology appointment the day before. The GP noted that administrative staff should obtain a further neurology appointment for the man, but this did not happen.
3. Nurses assessed the man twice on 19 May after he reported feeling dizzy. On 22 May, he reminded the GP that he had missed his hospital appointment and said he had had a seizure a few days before. The doctor prescribed anticonvulsant medication and contacted the hospital neurology department. A few days later, the prison received an appointment for August.
4. On 17 June, an officer unlocked the man's cell shortly after 8.00am for him to attend a vocational training course. At the time, the officer believed he had heard the man make a noise in response. He later noticed that the man had not gone to his course and, at 9.36am, he went back to the cell to find out why. The man was unresponsive and the officer radioed a code blue emergency. Officers and healthcare staff quickly attended and attempted to resuscitate the man but noted he was stiff and looked blue. At 9.45am, a prison doctor pronounced the man dead.
5. The investigation found that the man's clinical care was not equivalent to that he could have expected to receive in the community. Healthcare staff did not request his community GP records until a month after he arrived in prison and did not obtain the results of a recent CT scan. They wrongly assumed, that, for security reasons, he could not attend his scheduled neurology appointment as he was aware of the date. However, they did not arrange another one until the man reminded them again.
6. We are concerned that the prison doctor did not have the man's full medical history. Although he knew the seizures were potentially life threatening and prescribed appropriate medication, he did not take further steps to protect the man, including considering admitting him as an inpatient, alerting wing staff or recommending a shared cell. The officer who unlocked the man's cell on the morning of 17 June did not adequately check his wellbeing. Officers and healthcare staff attempted to resuscitate him although it was apparent this would be futile. Support for staff after the man's death was not in line with national guidelines. We make eight recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Norwich, informing them of the investigation and inviting anyone with information to contact her. No one responded.
8. The investigator obtained the man's prison and healthcare records. She interviewed seven members of staff and two prisoners. After the interviews, the investigator informed the Governor of the initial findings of the investigation. She also contacted the man's community GP and the neurology department at Norwich and Norfolk University Hospital for clinical information about the man.
9. NHS England commissioned a clinical reviewer to review the clinical care the man received at Norwich. The clinical reviewer participated in some of the interviews.
10. Dr A, a prison GP, believed there were inaccuracies in the transcript of his original interview with the investigator and in the clinical review. The investigator and an Assistant Ombudsman subsequently re-interviewed him and passed the information to the clinical reviewer.
11. We informed HM Coroner for Norwich of the investigation and have sent her a copy of this report.
12. One of our family liaison officers (FLO) contacted the man's family. They identified no specific issues for the investigation to cover but wanted to know more about the circumstances of his death. The man's family received a copy of the draft report. They did not make any comments.

HMP NORWICH

13. HMP & YOI Norwich is a multi-function prison which mostly 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.

Her Majesty's Inspectorate of Prisons

14. In the most recent inspection of Norwich in August 2013, inspectors reported that since a critical inspection in 2012, the prison had improved in some important areas. In relation to healthcare, the report concluded:

“ ... clinical governance arrangements were robust, but there was uncertainty around future provision and no clear strategy. There was a wide range of primary care clinics, although not yet a long-term conditions clinic. The nurse practitioner service was very good, but a high use of locum GPs led to inconsistencies in treatment, care and prescribing.”

15. Inspectors also noted that staff-prisoner relationships were courteous but lacked depth and quality. The personal officer scheme was ineffective.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The IMB annual report for the year to February 2014, commended many aspects of the service Norwich had provided during an unsettling year with many changes to staff and policy. The IMB noted that communication had improved between GPs, nursing staff and officers.

Previous deaths at HMP Norwich

17. Since the beginning of 2012, there have been 14 deaths at Norwich. Nine of these, including that of the man, were due to natural causes. The relatively high number of deaths is partly because Norwich has a special unit for elderly prisoners, including a number of terminally ill prisoners.
18. In an investigation into a self-inflicted death in July 2013, we recommended that guidance should be given to staff about when resuscitation is appropriate. We repeat the recommendation in this report.

KEY EVENTS

19. The man had several fits towards the end of 2013 while living in the community. In December, his GP referred him to the neurology department of the local hospital. On 7 March 2014, he had a CT head scan which showed bi-frontal encephalomalacia (softening of the brain tissue). On 10 March, he had an electroencephalogram (EEG – a record of the electrical impulses caused by the brain) which showed normal results. The neurologist told The man he had some frontal lobe damage, possibly due to a past head trauma, and arranged a further appointment for 12 May.
20. On 10 April, police arrested the man and charged him with drug offences, dating from 2012. The man later appeared at Norfolk Magistrates' Court and was committed to Luton Crown Court for trial on 14 July. He was remanded in custody and arrived at HMP Norwich shortly after 4.00pm. The man had been in prison several times before, most recently in 2012.
21. During an initial health screen, the man told Nurse A that he had been having fits or seizures preceded by altered vision and shaking. He said that he had had two fits in the previous month. He mentioned the outcome of his recent brain scan and said that his fits were not epileptic. The man told the nurse that he had an outstanding neurology appointment at Norfolk and Norwich University Hospital on 12 May.
22. The man said that he had problems with alcohol misuse. Nurse A noted the man was shaking, sweating, fidgety and had a mild headache and assessed his withdrawal symptoms as mild. The man said his community GP had previously prescribed him sertraline (an antidepressant), but he had not taken it for a while. He said he was feeling depressed and anxious and Nurse A referred him to the primary mental health team.
23. Dr B assessed the man and prescribed vitamin B and librium for alcohol withdrawal symptoms. Nurse B also assessed the man for drug and alcohol problems and he told her he felt unwell and depressed. Prison staff assessed the man as suitable for sharing, but he was allocated a single cell on the induction landing, A6.
24. The next day, 11 April, Nurse C assessed the man's mental health. He said he had not taken antidepressants for 15 months and would discuss this further with the GP the next week. The man had a history of self-harm but said he had no current thoughts of self-harm or suicide. Over the next few days, the substance misuse team monitored the man's withdrawal from alcohol and discharged him from their care on 15 April.
25. Dr A assessed the man later on 15 April. The doctor told the investigator that the man had told him he had an "undiagnosed seizure disorder" which he thought it was epilepsy. The doctor did not note this in his medical record and although this was contrary to what the man had told Nurse A, there is no record that the doctor questioned it.
26. The man told Dr A that he had an outstanding hospital neurology appointment, but hoped he might be released from prison before this. Dr A told the investigator that as the man knew the date of his appointment, for

security reasons, he would not have been allowed to attend on that date if he was still in prison. He decided not to reschedule the appointment, which would have probably delayed it, but to keep it open in the hope that the man could attend if he were released. The doctor told the man to make an appointment with him in four weeks, if he was still in prison, to review the situation. Dr A prescribed the man sertraline.

27. Shortly before midday on 26 April, officers asked a nurse to assess the man. Nurse B noted that the man was standing, looked pale, said he felt vacant and was unsure what was happening. He told the nurse he had experienced similar symptoms before he came to prison. He said he had not eaten that day but had exercised a lot. The nurse checked the man's blood pressure and pulse, which were normal. She advised him to eat and drink regularly and to tell staff if he felt unwell again.
28. Later that day, just before 5.00pm, officers again asked a nurse to assess the man. He told Nurse D that he felt strange and his head hurt. He went to get some pain relief and other prisoners told the nurse that they believed the man had had a fit. The nurse noted he was pale, sweating and shaking but was lucid. He said that he had not eaten all day. As Nurse B had done, Nurse D advised him to eat regularly and to tell staff if he felt unwell. The nurse checked the man's blood glucose level, which was satisfactory.
29. On 27 April, staff radioed an emergency code blue because the man was unwell. (A code blue is meant for circumstances such as when a prisoner is not responding, unconscious or has breathing difficulties and emergency assistance is needed.) Nurse E responded. She observed that the man was standing but looked anxious. An officer told her that the man had been shaking before she arrived on the wing but he had not been having a seizure. The nurse took him back to his cell and noted his blood pressure and pulse were normal. (It is not clear why officers used an emergency code when it was not an emergency life-threatening situation and it appears to have been used to get a nurse to attend quickly.)
30. The man said he had been feeling anxious since he had stopped drinking alcohol and had recently cut down on tobacco. Nurse E thought he had suffered an anxiety attack rather than a seizure, but noted that it could be related to the front lobe damage in his brain. The nurse booked an appointment with Dr C for the man to discuss his anxiety management and noted he had an appointment with the GP on 29 April about his referral to a neurologist. There is no further reference to this GP appointment in his medical record.
31. On 1 May, Dr C assessed the man. They discussed his alcohol misuse and withdrawal symptoms since being in prison. The doctor prescribed medication to help the man sleep.
32. The man did not attend his outstanding neurology appointment at Norwich and Norfolk University Hospital on 12 May. Both Nurse A and Dr A said that this was because the man knew the date of his appointment and would therefore be an escape risk.

33. On 13 May, the man moved to a single cell on B wing, a general residential wing. That morning, the man told Dr A that he had been due to see the neurologist the day before and said that he had collapsed a few times. The doctor assessed that he had no body weakness or neurological deficit. (A neurologic deficit is a functional abnormality of a body area due to a decrease in the function of the brain, spinal cord, muscles, or nerves.) Dr A recorded in SystmOne (the prison medical record) that he planned for a healthcare administrator responsible for arranging hospital appointments, to get a neurology appointment for the man. The healthcare administrator said he never received such a request and there is no record in SystmOne of staff contacting the hospital. Dr A prescribed the man more sleeping tablets.
34. On the morning of 19 May, officers asked Nurse A to attend the prison's vocational training centre, where the man was doing a painting and decorating course. The man had felt dizzy while sanding a wall. Nurse A took his observations, including his blood pressure, which were satisfactory. The nurse considered that the dizziness related to the work he was doing and advised the man to go back to his wing, drink fluids and report any further dizziness to staff. Despite the advice, the man continued to work.
35. After lunch, the man went to see Nurse A and told him that he had had another dizzy spell, but now felt well. The nurse took the man's blood pressure and pulse, which were normal and told the man he should not return to his course that afternoon. Nurse A reviewed Dr A's notes from 13 May and booked an appointment with the doctor for a further assessment. He advised the man to report any further dizziness to staff.
36. On 20 May, the healthcare administrator requested the man's community GP records, which arrived the next day. These noted that the doctor had arranged for a CT scan and EEG in February but the results were not in the records. There was also a note that the man's fits were most likely due to alcohol and/or drug misuse or withdrawal
37. On 22 May, Dr A assessed the man who said that he suffered alcohol withdrawal seizures and again reminded the doctor he had missed his neurology appointment on 12 May. He told the doctor that his last seizure had been a few days before but no one else had witnessed it. The doctor telephoned the neurologist's secretary at the hospital who said they would send another appointment to the prison. Dr A told the investigator that he had stressed that the man needed an urgent appointment. It does not appear that Dr A knew that nurses had assessed the man in the previous month.
38. Dr A ordered a number of blood tests and an electrocardiogram (ECG – a test which records the electrical impulses of the heart). He was concerned that the man might not see the neurologist quickly and that the seizures would continue as he was not on medication. He therefore reviewed the man's community GP records and prescribed him sodium valproate twice daily (an anticonvulsant). The doctor told the investigator that he was concerned that the man might have a fatal seizure. On 27 May, the neurologist sent the man an appointment for 11 August.

39. The man's test results were recorded on 3 June. On 10 June, Dr A told the man that the ECG showed no abnormality and the blood tests showed a raised cholesterol level. He prescribed statins to help lower his cholesterol.
40. On 16 June, the man collected his evening meal and went back to his cell with it at 5.45pm. Prisoner A, who lived in the cell next door to the man, told the investigator that the man came into his cell at 5.50pm and they chatted. Prisoner A said the man did not seem any different to normal.
41. Officer A locked the man in his cell about 6.10pm. He was lying on his bed watching television and told the officer he was okay. Prisoner A said he usually heard the man snoring at night, but when he woke up at 3.30am, he did not hear him. He had thought this was unusual.
42. At about 8.00am on 17 June, three officers began unlocking the prisoners on B wing. The man's cell was the second Officer B unlocked. The officer looked through the observation panel and thought that the man was asleep in bed. He said that he opened the door and told the man that he should go to his course. At the time, the officer said he thought that he had heard the man make a noise in response, but on reflection, said this might have been in another cell. The officer said the man was lying on his front with the sheets drawn up to the top of his shoulders.
43. Officer B unlocked the other cells and booked out the prisoners who were leaving the wing for work or training. He then locked the cell doors of prisoners who had stayed in their cell (including the man's) and counted the prisoners left on the landing. These numbers were then collated centrally to ensure the 'roll count' for the prison was correct. The numbers were incorrect three times. Each time, officers had to recount the prisoners on their wing and submit them. For the last count, they locked up all the prisoners on the wing to ensure the figures were correct.
44. Once the number of prisoners was correct, Officer B went back to the man's cell to check why he had not gone to his course. He realised that the man was still in the same position as when he had first unlocked his cell, shortly after 8.00am and that he looked blue. The officer radioed a code blue emergency at 9.36am and the control room immediately called an ambulance.
45. Officer B tried to turn the man over but could not do so because of his weight. He estimated that it took Officer C and Officer D about 20 seconds to join him in the cell. Together, they lifted the man onto the floor on his back. Officer B said the man was stiff and his arms and legs remained in the same position as when he had been on the bed. He also noticed some blood where the man's mouth had been on the mattress. Officer C began chest compressions to try to resuscitate the man and Officer B took over shortly afterwards.
46. Officer A and Officer E also responded to the code blue immediately. Officer A estimated it took him around 40 seconds to get to the man's cell. He then took over the chest compressions. He told the investigator that the man looked blue and seemed slightly stiff.

47. The first nurse on the scene was working on B wing that day and was responsible for responding to any emergencies. She heard the code blue on her radio and immediately went to the man's cell as she was nearer to the cell than the landing office where the emergency equipment was kept. When she arrived, she assessed the man. He did not respond to stimuli, had no pulse, was blue and slightly rigid.
48. The first nurse on the scene requested an ambulance, the doctor and a back-up nurse which officers communicated over the radio. She told the investigator that she was aware that prison staff would have called an ambulance automatically in response to the code blue call but asked for one as a safeguard. She offered to take over the chest compressions but the officers said they would continue. The nurse said an officer brought the emergency equipment soon after she arrived and, as she was getting a defibrillator out of the bag, second nurse on the scene arrived to assist. The nurses set up the oxygen, ambu bag (a mask used to aid resuscitation) and defibrillator. The cell log indicates that this had all happened within two minutes of the man being discovered. Officer A continued with chest compressions.
49. At 9.43am, Dr A arrived at the cell. The doctor examined the man and noted that he was lifeless, blue all over, stiff, and with dilated pupils. The doctor pronounced the man dead at 9.45am. He told the investigator that it looked as if the man had died some hours before.
50. The Governor and the prison's family liaison officer left the prison at 10.40am to inform the man's parents of their son's death. They remained in contact over the next few days and the prison offered a contribution to the funeral, in line with national policy. The operational manager debriefed the officers involved in the emergency response but did not include the healthcare staff.
51. A post-mortem report concluded that the cause of death was a subarachnoid haemorrhage (a bleed between the brain and the membrane covering the brain).

ISSUES

Clinical care

Obtaining community records

52. When a prisoner arrives at Norwich, they are asked to sign a disclosure consent form which healthcare administrative staff use to request the prisoner's community health records. The man signed a form in reception but staff did not request the man's community GP records until 20 May, over a month later. They received a reply the next day, which noted that the man's GP had arranged a CT scan in February but the records did not contain the results of the scan. The prison made no effort to obtain the results of the CT scan from the hospital or the GP, which detailed the frontal lobe damage to the man's brain.
53. Prison Service Instruction (PSI) 74/2011, Early Days in Custody, requires efforts to be made to retrieve any information required from the prisoner's GP or other relevant service the prisoner has recently been in contact with. We are concerned about the original delay in requesting the man's community records and then the subsequent failure to obtain the CT results, which would have provided important information about the man's condition to help decisions about ongoing treatment. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff request all relevant community medical records promptly when a prisoner first arrives at the prison.

Hospital appointments

54. When the man arrived at Norwich on 10 April, he told Nurse A that he had an outstanding neurology appointment on 12 May. He also told Dr A about this appointment five days later. Both Nurse A and Dr A believed that if a prisoner knew the date of a hospital appointment in advance, they could not attend due to the risk of escape. It is apparent that this was routine at Norwich. The doctor did not ask administration staff to rearrange the appointment since the man thought he might be released before then. In fact, he was not released and he did not attend his appointment.
55. The Prison Service's National Security Framework, which governs prisons' security arrangements, does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that prisons often do this without sufficient reason. The national guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when making such a decision. Prisoners can still attend hospital appointments even when they are aware of the date and time, unless there is clear intelligence that the prisoner is a high risk of escape or likely to have external assistance to aid an escape. There is no evidence that this was the case with the man. If the prison had security concerns, they should have considered strengthening the escort arrangements. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners attend hospital appointments unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.

56. On 13 May, when the man told Dr A that he had missed his hospital appointment the day before, Dr A noted that he would contact the healthcare administrator, to arrange another appointment. Dr A said he remembered telephoning the healthcare administrator but the healthcare administrator said he did not receive this request. The Head of Healthcare, said such requests are usually made either verbally or by the 'tasks' tab on SystmOne, which provides an auditable trail.
57. Dr A said he had telephoned the outpatient neurology department's secretary on 22 May, and indicated that he was concerned about the man's seizures and they told him that an appointment would be sent to the prison. On 27 May, the hospital sent the man an appointment for 11 August. (This was not documented in the man's record until after he died.)
58. Dr A said that he does not normally learn the date of hospital appointments until after a prisoner had attended and this causes difficulties. He said that managers had told him this was because a doctor might inadvertently tell a prisoner the date of the appointment if they knew it. We do not think this a sensible or proportionate approach and consider that SystmOne should be used to request **and** record appointments, unless there are specific and recorded security concerns. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff use SystmOne to request and record hospital appointments.

Treatment and ongoing care

59. We interviewed Dr A twice during this investigation. The clinical reviewer, was present at the first interview but not the second (although we invited him to attend). Some of the information from the second interview gives a different account from the first and that contained in the clinical review (which the clinical reviewer completed before the second interview). We therefore set out the clinical reviewer's findings first.
60. The clinical reviewer concluded that Dr A did not read the man's medical records before assessing him, either on 15 April or 13 May. Therefore, he was unaware of the information from Nurse A's initial health screen that the man had frontal lobe damage. At the original interview, Dr A said that he did not have time to read records in advance because of the workload caused by the shortage of staff and that he only dealt with, "things that come into my consulting room" and that those were the "only matters that [he] took responsibility for". The clinical reviewer wrote:

"Dr A correctly identified that the man might be having seizures and that such a condition was serious and indeed, in his own words, life threatening. He took steps to accelerate the neurology appointment and made a wise decision to prescribe an anticonvulsant medication, prophylactically, to afford the patient some measure of protection,

whilst he was waiting to see the neurologist. Dr A deserves credit for these efforts. The man had not been witnessed experiencing full grand mal seizures, providing unequivocal evidence of epilepsy. It could be argued that whilst taking such measures, without having attempted to read his patient's clinical records was certainly not "good" care; those parts of his actions would probably not have been very different, even if he had read them.

"Paradoxically, whilst Dr A was in ignorance in respect of the scan results, in fact, the man's neurologist was already in possession of this information. Had Dr A appreciated that the man had obvious cerebral pathology, and was also displaying odd absence symptoms of increasing frequency and severity, he might have pressed for a most urgent appointment or sent him to hospital directly. However, as he remained in ignorance of both the scan results and the recent apparently deteriorating clinical history, he may not have done so"

61. When we interviewed him again, Dr A wanted to clarify that he had read the man's medical record before he first assessed him on 15 April, but he did not have the community GP records or the results of the man's recent CT scan. He did not remind the healthcare administrators to request this information.
62. Dr A told the investigator that the man said he had an "undiagnosed seizure disorder" which the man thought was epilepsy. He did not note this in the medical record and this contradicts what the man told the nurse at his initial health screen when he said he had frontal lobe damage and his fits were not epileptic in nature. This information was correct.
63. Dr A originally said that he had not been aware that officers had asked nurses to assess the man before his GP appointments in May. At his second interview, Dr A said that he had known about this but when he assessed the man on 13 May, he did not consider that he had any neurological impairment deficit and did believe he needed to see a neurologist urgently. He therefore concluded that he should wait for a routine appointment.
64. It is difficult to draw firm conclusions from the differing evidence provided by Dr A at the two interviews. The clinical reviewer acknowledged that Dr A took an appropriate prescribing decision and chased up the neurology appointment, and it is unlikely that those actions would have been different even if he had read the records in full. Nevertheless, we consider that all healthcare staff reviewing prisoners should have a clear and up to date account of their recent medical history from their records. We make the following recommendation:

The Head of Healthcare should ensure that all clinicians adequately review prisoners' clinical records before assessing them and that all important information about serious health issues and diagnoses and appointments are summarised and highlighted in the SystmOne record.

65. The clinical reviewer was concerned that Dr A did not consider whether the man should have been admitted to the prison's healthcare centre as an inpatient. Although intervention might not have affected the outcome for the

man, he considered that greater vigilance might have helped earlier detection of his crisis.

66. Nurse A said doctors put information on SystemOne but did not always communicate directly with nursing staff. He believed this was a well-known and ongoing problem in the prison. The clinical reviewer concluded that there was no systematic or structured multidisciplinary communication and considered that Dr A should have discussed his plan for the man with the nursing team and shared information with them (and they with him) when he began to prescribe anticonvulsant medication. A plan of review should have been created, detailing the need for regular (possibly daily) health checks until the man had his appointment with the neurologist.
67. The clinical reviewer also considered that, with the man's permission, healthcare staff should have briefed prison staff responsible for his daily management, about his risk of seizure and collapse and an appropriate multidisciplinary care plan developed for his management on the wing. This should have covered multidisciplinary reviews, contingencies and risks, wellbeing checks, consideration of his location, either as an inpatient or in a shared cell, and a communication strategy to alert wing officers to the risks. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **Healthcare staff are trained in epilepsy, risk and seizure management and that there is effective communication within the healthcare team about the management of such patients.**
- **Vital information about a prisoner's health is shared between healthcare and prison staff and multidisciplinary plans are developed to help safeguard prisoners subject to fits and seizures.**

Unlocking cells

68. It does not appear that Officer B adequately checked the man's welfare when he unlocked his cell around 8.00am on 17 June. Wing staff gave the investigator inconsistent accounts of whether they were expected to get a response from a prisoner when unlocking cells.
69. For their own safety, officers are supposed to make contact with a prisoner through the observation hatch before opening a locked cell door. When unlocking a cell they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:
- “Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”
70. As Officer B did not get a clear response from the man when he unlocked his cell at 8.00am, we cannot know whether earlier intervention would have helped save him. However, the indications are that he was dead at the time. The man remained in the same position from the time Officer B first saw him

at 8.00am to when he discovered him over 90 minutes later and it appears he had been dead for some time. Nevertheless, in other cases, a welfare check when a cell is unlocked can help ensure that prisoners who are unwell receive appropriate and prompt medical treatment. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Attempting resuscitation

71. The officers, nurse and doctor who responded to the code blue said that there were no signs of life and the man was stiff when they found him. All staff thought they had to start and continue chest compressions until a doctor or paramedic arrived to confirm death.
72. The European Resuscitation Council Guidelines 2010 state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Resuscitation Council (UK) and the Royal College of Nursing (RCN) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be based on a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies.
73. We accept that the staff acted in what they considered to be the man’s best interests and do not criticise them for their actions. However, attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We consider that it was inappropriate to attempt to resuscitate the man. After the death of a prisoner at HMP Norwich in July 2013, we recommended that staff be given guidance about the circumstances in which resuscitation is inappropriate. We repeat this recommendation:

The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.

Debriefing and staff support

74. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires a ‘hot’ debrief to be held immediately after all deaths in custody, to be led by a senior member of staff and with a member of the prison’s care team present. The purpose of the debrief, as set out in PSI 08/2010 on post-incident care, is to ensure the immediate needs of the staff involved have been met. A critical incident debrief must also be held within five to ten days of the death. Its purpose is to provide further ongoing support and access to support networks. The PSI also instructs Governors that staff may need support any time after a death in custody and on more than one occasion.
75. Staff’s views of how well they had been supported after the man’s death varied and not all believed this was the case. Officer B said he had not

received the counselling he expected and Officer A said he was not invited to the debrief and felt disappointed by the lack of support. The first nurse on the scene and the other healthcare staff involved were not invited to the debrief, although they said that their managers had been supportive. There was no critical incident debrief. We make the following recommendation:

The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff request all relevant community medical records promptly when a prisoner first arrives at the prison.
2. The Governor should ensure that prisoners attend hospital appointments unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.
3. The Head of Healthcare should ensure that healthcare staff use SystmOne to request and record all hospital appointments.
4. The Head of Healthcare should ensure that all clinicians adequately review prisoners' clinical records before assessing them and that all important information about serious health issues and diagnoses and appointments are summarised and highlighted in the SystmOne record.
5. The Governor and Head of Healthcare should ensure that:
 - Healthcare staff are trained in epilepsy, risk and seizure management and that there is effective communication within the healthcare team about the management of such patients.
 - Vital information about a prisoner's health is shared between healthcare and prison staff and multidisciplinary plans are developed to help safeguard prisoners subject to fits and seizures.
6. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
7. The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.
8. The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.

ACTION PLAN: Mr The man – HMP Norwich

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that healthcare staff request all relevant community medical records promptly when a prisoner first arrives at the prison.	Accepted	<p>Community medical records are called for upon request by the clinician from the point of the prisoner's initial appointment with the General Practitioner within 48 hours.</p> <p>A Standard Operating Procedure (SOP) will be implemented to outline this procedure.</p>	<p>March 2015</p> <p>Head of Healthcare</p>
2	The Governor should ensure that prisoners attend hospital appointments unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.	Accepted	<p>The administration function within the healthcare provider at HMP Norwich arranges referrals for hospital appointments and monitors these as required. This is monitored by the Head of Healthcare.</p> <p>Hospital appointments will not be cancelled unless there are overriding, fully justified and documented security reasons where there is no detriment to the prisoner's health.</p> <p>If a prisoner is made aware of his hospital appointment, and there is a perceived risk, then an alternative will be sought at the earliest opportunity. This will only take place after consultation with healthcare in the first instance.</p> <p>A record is kept (on SystemOne) of the reason why a prisoner's hospital appointment has been cancelled. This is also the case for re-arranged appointments, whereby an ongoing record is kept outlining actions</p>	<p>Complete</p> <p>Head of Healthcare & Safer Custody</p>

			being taken to re-arrange the appointment.	
3	The Head of Healthcare should ensure that healthcare staff use SystemOne to request and record all hospital appointments.	Accepted	Healthcare staff formulate hospital referrals through SystemOne. Hospital appointments will continue to be logged on SystemOne once the patient has attended the appointment. The administrative team keep a log of the appointments and this is accessible to all healthcare staff.	Complete Head of Healthcare
4	The Head of Healthcare should ensure that all clinicians adequately review prisoners' clinical records before assessing them and that all important information about serious health issues and diagnoses and appointments are summarised and highlighted in the SystemOne record.	Accepted	Clinicians working at HMP Norwich now review patients' records prior to any consultations and the overview of their past medical history is documented at the beginning of any consultation.	Complete Head of Healthcare
5	The Head of Healthcare should ensure that: <ul style="list-style-type: none"> Healthcare staff are trained in epilepsy, risk and seizure management and that there is effective communication within the healthcare team about the management of such patients. Vital information about a prisoner's health is shared between healthcare and prison 	Accepted	Healthcare staff currently undertake E-Learning in epilepsy and seizure management. Face to face training for the management of epilepsy and seizures is also being resourced. Vital information regarding a prisoner's health in relation to seizures will be shared appropriately with prison staff.	April 2015 Head of Healthcare

	staff and multidisciplinary plans are developed to help safeguard prisoners subject to fits and seizures.			
6	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.	Accepted	Staff will be reminded that, for their own safety, they must make contact with a prisoner through the observation hatch before opening a locked cell and that when unlocking the cell they should take active steps to check on the prisoner's wellbeing.	April 2015 Head of Safer Custody
7	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is inappropriate.	Accepted	In October 2014, the British Medical Association, RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR). NOMS Equality, Rights and Decency Group is due to meet with NHS England colleagues in early 2015 to discuss the guidance, after which a note will be issued to prison staff. The healthcare provider, Virgin Care Limited, adhere to current guidance regarding resuscitation. However, healthcare will review existing policies to ensure parity with the new guidance once it is rolled out to prison staff.	Early 2015 NOMS Equality, Rights and Decency Group/ Governor Head of Healthcare
8	The Governor should ensure that staff are appropriately supported after the death of a prisoner, in line with national instructions.	Accepted	Action will be taken to ensure that local contingency plans reflect the need to hold a hot de-brief immediately after all deaths in custody. This will be led by a senior manager with a member of the Care Team present. This de-brief will ensure that the immediate needs of staff are met. If an individual raises concerns which the Care Team member cannot address, the individual will be	April 2015 Head of Safer Custody

			referred to an Employee Support Officer. In all cases the Care Team member will ensure that the member of staff concerned is aware of the support mechanisms available and how to access them.	
--	--	--	---	--