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 October 2013, while in the custody of 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 bronchopneumonia on 19 October 2013, while in the custody of HMP Norwich. He was 65 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. DA clinical reviewer reviewed the clinical care the man received at Norwich. The prison cooperated fully with the investigation.

The man had been in prison since 1985. In November 2004, as a result of poor health, he was moved to a unit for older prisoners at HMP Norwich. The man had a number of medical conditions including chronic obstructive pulmonary disease (COPD) and his health continued to deteriorate gradually after he moved. By January 2013, the man needed 24 hour nursing care. In May 2013, the Parole Board asked for a plan to identify how he would be managed if he were released. An assessment was delayed because of difficulties in getting social services departments to accept responsibility for funding his care. The man's health continued to deteriorate and he was admitted to hospital in October 2013. Although a local authority eventually accepted responsibility, he died before they were able to carry out an assessment.

While we identify some scope for improvement in family liaison, the clinical reviewer considers, and I agree, that the man received very good care in HMP Norwich which often exceeded that he could have expected in the community.

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 **May 2014**

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SUMMARY

1. The man was sentenced to life imprisonment for an offence of arson in September 1985. In December 2003, he moved to North Sea Camp, an open prison. The man was in poor health and, as a result, was transferred to HMP Norwich in November 2004 where he lived on a wing for older prisoners and those with long term chronic conditions.

2. The man had a number of chronic conditions, including chronic obstructive pulmonary disease (COPD – a term used to describe a range of lung diseases). The man was a heavy smoker and continued to smoke despite advice. By September 2012, he required 24 hour nursing care. From January 2013, the man's cell door was left open so staff could provide care and for ease of access in an emergency.

3. In May 2013, the Parole Board reviewed the man's case and requested a pre-release assessment, and management and release plan for the man by the end of July. The prison frequently contacted social services but, it was not until October that West Yorkshire Adult Services accepted responsibility for assessing the man's care needs. The assessment was not completed before the man's death.

4. The man became increasingly ill and developed a respiratory tract infection. He was admitted to the Norwich and Norfolk University Hospital on 15 October and diagnosed with pneumonia. The man's condition continued to deteriorate and he died on 19 October.

5. The clinical reviewer considers that the man received very good care at Norwich and his death could not have been prevented. We agree that the man was well cared for. The man's family was not told he was in hospital until three days after his admission and the prison informed his next of kin of his death by telephone rather than in person as Prison Service Instructions require. We make one recommendation about this.

THE INVESTIGATION PROCESS

6. The investigator issued notices informing staff and prisoners at HMP Norwich of the investigation and asking anyone with any relevant information to contact her. No one responded.

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

8. The investigator obtained and reviewed copies of the man's prison and prison medical records. She wrote to the Governor giving feedback about the initial findings of the investigation.

9. The investigator informed HM Coroner for Greater Norfolk District of the investigation who provided the results of the post-mortem examination. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's grandson, his nominated next of kin, to explain the purpose of the investigation. The man's grandson did not have any specific issues he wanted the investigation to cover.

11. The man's family received a copy of the draft report. They shared their concerns regarding the issues raised in the report but did not make any comments that have led to any factual changes.

12. The prison considered our draft report and its recommendation and has accepted it. No factual inaccuracies were raised. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included here, after the recommendations section.

HMP NORWICH

13. HMP & YOI Norwich is a multi-functional prison, predominantly serving the courts of Norfolk and Suffolk. The prison holds up to 767 men. There is a healthcare centre which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Norwich was in August 2013. The Inspectorate found there was uncertainty around future healthcare provision and no clear strategy. While the nurse practitioner service was very good, the high use of locum GPs led to inconsistencies in treatment, care and prescribing. The Inspectorate noted that the inpatient and older prisoner units provided good care and there were plans to develop the palliative care arrangements.

Independent Monitoring Board

15. 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 annual report, for the year ending February 2013, the IMB had major concerns about healthcare provision, although it was noted that management had improved. In some areas the IMB regarded the service as inadequate to meet the complex needs of prisoners. The IMB was concerned about the lack of permanent GPs and that many other temporary healthcare staff impacted on continuity of care. The IMB was positive about the care provided by permanent healthcare staff.

16. The IMB noted that improvements had been made to the unit for elderly prisoners which was now a much friendlier and more homely place than previously. Although the cells remained outdated, the prisoners there had a better quality of life for their final years.

Previous deaths at HMP Norwich

17. The man was the sixth prisoner to die from natural causes at Norwich since the start of 2012. There are no similarities with this investigation.

KEY EVENTS

18. In June 1985, not long after release from a previous sentence, the man was remanded to prison for an offence of arson. He was sentenced to life imprisonment in September 1985. In December 2003, the man moved to HMP North Sea Camp, an open prison.

19. Records show that the man had a number of chronic conditions including diverticulitis, chronic retention of urine, osteoarthritis, Meniere's disease (which causes vertigo and tinnitus) and COPD. In December 2004, because of poor health he transferred to the wing for elderly prisoners at HMP Norwich. Healthcare staff saw the man almost every day.

20. The man's health gradually deteriorated and, by September 2012, he was using a wheelchair and had developed further health conditions including ischaemic heart disease, spinal problems, hiatus hernia, umbilical hernia and essential tremors (uncontrolled shaking, most commonly in the arms and hands). He had a supra-pubic catheter fitted (a catheter which enters through the abdominal wall into the bladder). He had frequent urinary tract infections and required 24 hour nursing care. The man was a heavy smoker and, although healthcare staff frequently encouraged him to stop, he continued to smoke.

21. By the end of 2012, the man's condition had deteriorated considerably. From 9 January 2013, his cell door was left open at all times to allow healthcare staff easy access to care for him. A nurse reviewed his care plans and developed a management plan to cover all aspects of the care he required, including treatment of a pressure sore. The records show that treatment of the man's pressure sore was frequent and of a high standard.

22. On 29 January, a prison GP diagnosed the man with acute pulmonary oedema (fluid leaking around the lung) and pneumonia. The man went to the Norfolk and Norwich University Hospital the same day. He returned to prison that evening. The hospital had prescribed antibiotics, anti-inflammatory medication and an inhaler to ease his symptoms. A prison GP, reviewed the man on 4 February and noted that he had a recurrent chest infection but continued to smoke. He diagnosed COPD exacerbation on 5 February and prescribed further antibiotics and steroids.

23. In February 2013, the man's offender manager, and his offender supervisor submitted reports to the Parole Board supporting his release to an appropriate nursing home.

24. On 10 March, the man appeared drowsy and was leaning to one side in his wheelchair. He was taken to the Norfolk and Norwich University Hospital where he was treated for a urinary tract infection. He returned to the prison 10 days later. An X-ray taken in hospital showed fluid in his right lung, but it was not considered to be pneumonia. The man had developed further pressure sores in hospital and healthcare staff updated his care plans to include treatment for these.

25. On 3 April, the man seemed disorientated and was wheezing. One of the prison GPs diagnosed COPD exacerbation and prescribed an antibiotic and a short course of steroids.

26. On 30 May, the GP discussed the man's preferences about resuscitation in the event of a cardiac or respiratory arrest. The man indicated that he would want resuscitation to be attempted. Records show that this decision would be reviewed every six months or earlier if the man requested.

27. In May, the Parole Board requested a pre-release assessment and a management and release plan for the man by the end of July. Throughout June and July, the man's offender manager and offender supervisor frequently contacted social services departments in Norfolk, Leeds and Wakefield (the man's preferred locations) in an effort to establish who was responsible for funding the man's assessment and placement. An agreement could not be reached and the Parole Board were updated about this on 23 August.

28. Between June and September 2013, healthcare staff frequently saw the man, and reviewed and updated his care plans. The GP examined the man on 5 September and diagnosed that he had acute bronchitis. He prescribed antibiotics. On 17 September, the man complained of pain in his left lower chest and loin area. The doctor noted that he had no cough or difficulty in breathing at rest.

29. On 28 September, the man vomited and was nursed in bed. On 13 October the man was again noted to be vomiting and also constipated. A prison GP examined him on 14 October and diagnosed a lower respiratory tract infection. The next day 15 October, a GP saw the man and noted that his speech was slurred and arranged for him to be admitted to Norfolk and Norwich University Hospital. No restraints were used.

30. On 17 October, hospital staff informed the prison that the man had pneumonia and that he would be in hospital for at least the next week. The man's condition continued to deteriorate in hospital and he died in the morning of 19 October.

31. In October, West Yorkshire social services accepted responsibility for funding the man's care in the community should he be released. He was not assessed before he died.

Contact with the man's family

32. A custodial manager was appointed as the prison family liaison officer on 18 October. She then contacted the man's grandson, his nominated next of kin, to let him know that his grandfather was in hospital. The manager gave him the man's contact details at the hospital and her own and explained she would be his point of contact. She visited the man that afternoon and told him that

she had been in touch with his grandson. The man and his grandson spoke to each other later that day.

33. Because of the distance from Norwich, the family liaison officer contacted HMP Leeds after the man died to see if a member of staff could break the news to the man's grandson. HMP Leeds did not have a family liaison officer available so the family liaison officer then telephoned the man's grandson to break the news. He was shocked and upset. She called back later that morning and discussed plans for him to visit the prison and to see the man's body. She spoke to the man's grandson again on 21 October and he visited the prison with his brother on 22 October.

34. A memorial service was held at the prison 22 October. The prison paid for the man's funeral, which took place on 8 November.

Staff and prisoner support

35. A Governor's notice informed staff and prisoners of the man's death and directed those who needed it to appropriate support.

Post-mortem Report

36. A post-mortem confirmed that the man had died from bronchopneumonia; chronic obstructive pulmonary disease and severe coronary artery atherosclerosis (hardening of the arteries).

ISSUES

Clinical care

37. The clinical reviewer concluded that the care the man received at HMP Norwich was at least equivalent to that which he could have expected in the community. He made several recommendations about general healthcare issues not directly related to his death, which the Head of Healthcare will need to take forward.

38. The clinical reviewer was satisfied that the man's death was not preventable and noted that he continued to smoke heavily, against frequent advice. He considered that the man's care was often better than he would have received in the community as he had daily access to nurses, doctors and support staff. The man's care plans were updated frequently as his needs changed. The man received a high level of care and attention with regard to his pressure sores, which ensured that they healed well.

Release arrangements

39. Prisoners can be considered for release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months). The man did not have a clear diagnosis, so an application for compassionate release was not pursued.

40. The Parole Board reviewed the possibility of the man's release but first needed to be satisfied that there was an appropriate release plan including suitable accommodation and care arrangements in place. The man's offending history, persistent smoking and debilitating medical condition meant that he was hard to place. We are satisfied that the man's offender manager and offender supervisor made good efforts to try to resolve this but an assessment was delayed by social services while responsibility for funding was identified. The actions of social services departments are outside the Ombudsman's remit, but we consider that the prison took what steps it could to address the issue.

Liaison with the man's family

41. PSI 64/2011 Safer Custody requires: "Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill". Prison Rule 22 also requires governors to notify families when a prisoner is seriously ill.

42. The man was admitted to hospital on 15 October as he was very ill. On 17 October the prison learnt that he had developed pneumonia, but his grandson, his nominated next of kin, was not told until 18 October.

43. The man's grandson lived in Leeds. In line with Prison Service guidance, when the man died on 19 October, the family liaison officer contacted staff at HMP Leeds to request help to break the news but the prison said they were unable to assist. The family liaison officer then contacted the man's grandson by telephone and informed him that he had died. Prison Service Instruction (PSI) 64/2011 makes it clear that wherever possible a member of prison staff should break the news of a death to the next of kin in person, and failing this the police should be asked to deliver the news. We would have expected the prison family liaison officer to have tried to enlist help from another prison in the Leeds area or the police, before deciding to inform his grandson by telephone. We make the following recommendation:

The Governor should ensure, that the families of seriously ill prisoners are informed of their admission to hospital promptly and, where possible, the news of their death is delivered in person.

RECOMMENDATION

The Governor should ensure, that the families of seriously ill prisoners are informed of their admission to hospital promptly and, where possible, the news of their death is delivered in person.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure, that the families of seriously ill prisoners are informed of their admission to hospital promptly and, where possible, the news of their death is delivered in person.	Accepted	The decision regarding initial contact with families will be made during the risk assessment process for all escorts. For those escorts where the prisoner remains in hospital the risk assessment will be reviewed daily by a visiting manager who will liaise with the hospital staff and the prisoner concerned. The prisoner's medical condition will be discussed with medical staff, along with a discussion about contacting the next of kin and the need to appoint a family liaison officer (FLO). The escorting staff will notify the duty governor of any changes/deterioration in the prisoner's health and they will establish consent from the prisoner for contact with the next of kin. In all cases where prisoners are assessed as seriously ill, the establishment will make contact with the next of kin and a FLO will be appointed to support the family. Wherever possible news of a prisoner's death will now be delivered to the next of kin in person. Where this is not possible the FLO will try to enlist help from another prison.	April 2014 All Custodial and Duty Managers/ Heads of Healthcare/ Safety/ Equalities	