

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jan Gillett a prisoner at HMP Norwich on 14 December 2016

**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 Jan Gillett died on 14 December 2016 of heart failure caused by hypertensive disease while a prisoner at HMP Norwich. Mr Gillett was 71 years old. I offer my condolences to Mr Gillett's family and friends.

The management of Mr Gillett's care was challenging, as he was obese and had multiple health conditions. Nevertheless, I am concerned that healthcare staff at Norwich did not recognise that Mr Gillett might have sepsis and did not respond appropriately to this life threatening infection. I am also concerned that healthcare staff at Dovegate and Norwich did not follow NHS best practice in the prevention, treatment or documentation of pressure sores.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2017

Contents

Summary 1
The Investigation Process 3
Background Information 4
Key Events 6
Findings..... 9

Summary

Events

1. On 15 December 2008, Mr Jan Gillett was sentenced to 12 years in prison for sexual offences and was sent to HMP Norwich. On 5 August 2009, Mr Gillett was transferred to HMP Dovegate.
2. Mr Gillett had a number of complex physical health conditions including heart failure, respiratory and kidney disease. Doctors prescribed him appropriate medication. He was obese and used a wheelchair. Healthcare staff assigned him a buddy (a prisoner who assists another prisoner in their daily life). He received treatment and healthcare staff monitored him.
3. On 13 May 2015, Mr Gillett was sent to hospital because of high potassium levels in his kidneys. While there, hospital staff noted Mr Gillett had a pressure sore on his leg. Tissue Viability nurses (TV nurses) reviewed Mr Gillett over time, and gave advice on pressure sore treatment. Nurses in Dovegate monitored his sores inconsistently.
4. On 22 November 2016, Mr Gillett transferred from Dovegate to Norwich so that he could be nearer to a local care home to which he was to be released on 14 December.
5. A nurse examined Mr Gillett the next day, washed him and examined his pressure sores.
6. On 30 November, Mr Gillett had a fall in his cell. A nurse booked a GP appointment and requested day staff to take a urine sample and leg swab to rule out infection. On 1 December, a prison GP saw him in his cell. He was hyperventilating and had an enlarged abdomen. The GP requested another urine sample and leg swab. Neither of the samples and swabs were taken.
7. On 9 December, a nurse found Mr Gillett unwell in his cell and asked for a GP to attend. The GP did not attend but reviewed Mr Gillett's records and told healthcare staff to continue to monitor him. Later that day a nurse saw that he was grey in colour and struggling to breathe and requested an ambulance. Paramedics said he might have sepsis (a life threatening widespread infection) and admitted him to hospital.
8. Hospital staff treated Mr Gillett for cellulitis (bacterial infection) of his legs and sepsis. He died on 14 December, from heart failure caused by hypertensive disease (high blood pressure) while a patient at hospital.

Findings

9. Mr Gillett was a very large man with multiple health conditions which meant his care was challenging. However, the clinical reviewer said that the care Mr Gillett received at Dovegate and Norwich was not equivalent to that he could have expected to receive in the community.
10. Mr Gillett went into a septic state of shock on 9 December, which was aggravated by an open pressure sore. Sepsis is a life threatening infection and

death can occur due to heart failure. Healthcare staff at Norwich did not recognise that Mr Gillett may have sepsis and therefore did not respond appropriately to the symptoms he showed.

11. We are concerned that healthcare staff at Dovegate did not follow NHS best practice for preventing and treating pressure sores. Healthcare staff at Norwich also did not regularly measure and document Mr Gillett's pressure sores.

Recommendations

- The Head of Healthcare at Norwich must ensure that healthcare staff are adequately trained in the recognition of sepsis including the escalation process as per NICE guidelines.
- The Head of Healthcare at Dovegate and Norwich should ensure that healthcare staff follow NHS best practice for preventing and treating pressure sores.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded
13. The investigator obtained copies of relevant extracts from Mr Gillett's prison and medical records.
14. The investigator interviewed a member of staff from Dovegate by telephone on 10 February 2017.
15. NHS England commissioned a clinical reviewer to review Mr Gillett's clinical care at the prison. The clinical reviewer interviewed the Head of Healthcare at HMP Dovegate on 6 January 2017, and the deputy Head of Healthcare on 27 February. She jointly interviewed with the investigator three members of the healthcare team on 9 January.
16. We informed HM Coroner for Norfolk of the investigation who gave us the results of the post mortem examination. We have sent the coroner a copy of this report.
17. The investigator wrote to Mr Gillett's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond to our letter.
18. The initial report was shared with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Norwich

19. HMP Norwich is a multi-function prison, which predominantly serves the courts of Norfolk and Suffolk. The prison holds up to 769 men. Virgin Care provides healthcare services. There is a healthcare centre, which provides 24-hour nursing cover and a dedicated unit for older prisoners.

HMP Dovegate

20. HMP Dovegate is privately run by Serco. The main prison holds around 933 remanded and sentenced adult men. There is also a therapeutic community, separate to the main prison, which holds up to 200 men. Care UK, who took over from Serco Health in October 2014, provides healthcare services. There is an inpatient unit for 12 prisoners and 24-hour nursing cover. Two GPs provide cover Monday to Friday and Saturday mornings. There is an out of hours GP service at other times.

HM Inspectorate of Prisons

21. The most recent inspection of Norwich was in December 2016. Inspectors reported that the prison had continued forward momentum since their last inspection. The prison had a strong and stable leadership team. Relations between staff and prisoners were good. Healthcare services were reasonably good overall. The healthcare centre was in need of refurbishment, however support from both prison and healthcare staff was impressive.
22. The most recent inspection of Dovegate was in January 2015. Inspectors reported that the prison had struggled to maintain outcomes for a more challenging population and to respond adequately to the destabilising impact of new psychoactive substances. Care UK took over health services in October 2014. The experienced nurse manager and her deputy provided effective leadership and stability. Prisoners with lifelong conditions and complex needs were identified effectively and relevant clinics, including a weekly GP led session, were provided.

Independent Monitoring Board

23. 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 2016, the IMB at Norwich reported that there was strong and effective management by the healthcare centre manager and arrangements were in hand to recruit more GPs and non-agency nurses. Care provided on the elderly prisoner unit was done so with care and sensitivity and palliative care was considered to be of a high standard.
24. In its latest annual report, for the year to September 2016, the IMB at Dovegate reported that staff shortages throughout the year had been a constant problem. A new healthcare manager who had come from a variety of roles from the

operational side of the prison had been welcome, resulting in a greater sense that the prison and healthcare were working together.

Previous deaths at HMP Norwich

25. Mr Gillett was the sixth person to die from natural causes at the prison in the last year. There are no significant similarities with these deaths.

Key Events

26. On 15 December 2008, Mr Jan Gillett was sentenced to 12 years in prison for sexual offences and went to HMP Norwich. On 5 August 2009, he was transferred to HMP Dovegate.
27. Mr Gillett had a number of complex physical health conditions including hypertension, heart disease, respiratory and kidney disease. Prison doctors prescribed appropriate medication. He was obese and used a wheelchair. Healthcare staff assigned him a buddy (a prisoner who assists another prisoner in their daily life).
28. On 2 December 2014, a nurse examined Mr Gillett and noticed a small red lump on the back of his leg. The skin was intact and she advised monitoring this as often as possible.
29. On 13 May 2015, Mr Gillett went to hospital, as he had high potassium levels in his kidneys. Hospital staff gave him fluids for rehydration and adjusted his medication. Mr Gillett was found to have a grade three pressure sore on his leg (pressure sores are graded from one to four, four being the worst). He returned to prison, where nurses dressed his sore.
30. During August and September, different nurses examined Mr Gillett and described the pressure sores inconsistently in his records, so it is not clear what the condition of them was. On 30 December, a nurse contacted the community Tissue Viability (TV) Service, who suggested a pressure relieving mattress. On 8 January 2016, Mr Gillett was admitted to the prison inpatient unit and a pressure relieving mattress was provided. Mr Gillett saw the TV nurse at hospital on 8 March. The nurse documented a grade three pressure sore and created a care plan for the prison healthcare staff.
31. Mr Gillett attended hospital on 3 October, for shortness of breath. A cardiologist saw him and diagnosed asthma. He returned to Dovegate two days later with steroids for asthma and blood pressure tablets. He returned to hospital on 18 November with a suspected blood clot on his leg, which hospital staff did not find, and he returned to Dovegate the same day. He continued to suffer from grade 3 pressure sores.
32. On 22 November, Mr Gillett transferred to HMP Norwich. Mr Gillett was due for release on 14 December, and staff at Dovegate had found a local care home for him in the community which was the reason for the transfer.
33. On arrival at Norwich, a nurse completed an initial medical assessment. Dovegate provided details of a care plan for Mr Gillett's pressure sores. A prison GP also saw Mr Gillett, and noted gross swelling and oedema (a build up of fluid in the body which causes swelling) of both feet with some leaking fluid. He prescribed his medications which included furosemide and ramipril for heart failure and blood pressure. Mr Gillett went to the elderly prisoners' unit. On 23 November, a nurse examined Mr Gillett. He noted pressure sores on his left buttock and on the rear of his left thigh which he dressed. He completed a nurse assessment which included falls and older persons risk assessment.

34. Later that day a social worker and a care home manager visited Mr Gillett, to discuss his move to a care home in the community. Nurses dressed his sores and reviewed him.
35. On 30 November, Mr Gillett had a fall in his cell. A nurse booked a GP appointment for him and requested day staff to take a urine sample and leg swab to rule out infection. There is no evidence this was completed. A nurse completed a falls assessment. The following week Mr Gillett fell twice more.
36. On 1 December, a prison GP saw Mr Gillett in his cell. He was hyperventilating and had an obese, enlarged abdomen. She requested another urine sample and leg swab. Again there is no evidence this was completed. She told healthcare staff to continue to monitor Mr Gillett closely and report any concerns.
37. On 9 December at 9.02am, a nurse saw Mr Gillett lying half off his bed. With the help of other staff he attempted to get Mr Gillett to stand up and to move him onto his chair. Mr Gillett could not support his own weight and kept sliding down. He tried to take his blood pressure, but he kept pulling his arm away.
38. The nurse continued to monitor Mr Gillett and tasked a doctor through the electronic medical record system to attend. Staff had moved Mr Gillett onto the bed and he was unable to communicate. He again asked a doctor to attend 2 hours and 5 minutes later again by telephone and through the electronic medical record system.
39. A prison GP spoke to the nurse on the telephone. The GP told the nurse that Mr Gillett's observations remained within the normal limits and his behaviour was not in keeping with sepsis. He told the nurse to continue monitoring him and that if his results became abnormal then he would review. The nurse then tried to change Mr Gillett's dressings but was unable to do so as Mr Gillett remained uncooperative.
40. At 7.40pm a nurse saw Mr Gillett slumped on his bed. He was grey in colour and struggling to breathe. She noted that his blood oxygen level was low (80%), his pulse was high (101), his temperature high (37.7), and blood pressure within the normal range (111/82). He was not very responsive and she requested an ambulance. She gave Mr Gillett oxygen and monitored him before the ambulance arrived 45 minutes later. Paramedics examined Mr Gillett and suspected sepsis. They took him to hospital, and a doctor admitted him. Two prison officers escorted him and he was not restrained.
41. Healthcare staff stayed in regular contact with the hospital where they treated Mr Gillett for cellulitis (bacterial infection) of his legs, and for sepsis. His health deteriorated and he died at 1.50am.

Contact with Mr Gillett's family

42. On 10 December, senior prison manager spoke to Mr Gillett's brother, his nominated next of kin, and arranged for him to visit Mr Gillett in hospital. She later appointed a prison officer as the family liaison officer.

43. On 14 December, a member of the hospital staff informed Mr Gillett's brother that he had died. At 10.20am, the officer met Mr Gillett's brother and niece at the prison. She offered them her condolences.
44. The officer kept in contact with the family regarding funeral arrangements, the return of his property and to offer support. Mr Gillett's funeral was held on 11 January 2017. The prison contributed towards the cost in line with national policy.

Support for prisoners and staff

45. After Mr Gillett's death, senior prison manager debriefed the escort staff at the hospital to ensure they had the opportunity to discuss any issues arising and to offer support. The staff knew that the care team were available should they require it.
46. The prison posted notices informing staff and prisoners of Mr Gillett's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Gillett's death.

Post-mortem report

47. A post mortem examination found that the cause of Mr Gillett's death was from heart failure caused by hypertensive disease (high blood pressure).

Findings

Clinical care

48. Mr Gillett was grossly obese with multiple health conditions. The management of his care was challenging and he was at very high risk of developing pressure sores. He received appropriate care and medication in relation to his pre existing conditions including hypertension and heart disease.
49. However the clinical reviewer did not consider that the care Mr Gillett received, either at Dovegate or Norwich, was equivalent to that he could have expected to receive in the community. She said that on 9 December, it appeared that he went into a septic state of shock which may have been exacerbated by the presence of an open pressure sore. This added additional stress on his already failing heart caused by his existing conditions.

Recognition of Sepsis

50. On 9 December, Mr Gillett was admitted to hospital with suspected sepsis. The clinical reviewer considered that he had symptoms of potential sepsis at least 12 hours earlier (when he displayed six significant indicators including an increasing temperature and altered behaviour) and that a doctor should have assessed him face to face.
51. A prison GP told the investigator that he did not attend to examine Mr Gillett on 9 December because he did not think he had sepsis. His observations were within normal limits and his behaviour was not unusual. He told a nurse to continue to monitor him. He said that, even in hindsight, he would not have done anything differently, however in future he would have a lower threshold where he would consider a likelihood of sepsis.
52. Healthcare staff at Norwich did not recognise that Mr Gillett might have sepsis and, as a result, did not respond appropriately to this life threatening infection. We make the following recommendation:

The Head of Healthcare at Norwich must ensure that healthcare staff are adequately trained in the recognition of sepsis including the escalation process as per NICE guidelines.

Management of Pressure Sores

53. In December 2014, Mr Gillett reported skin problems on the back of his left leg but there was no further reference to this until May 2015 when staff at the hospital reported that Mr Gillett had a grade 3 pressure sore. Overall pressure sore management was poor and there is no evidence that appropriate pressure ulcer care planning was used. The pressure sore on Mr Gillett's left buttock was twice recorded as being on the right side.
54. Mr Gillett had access to a pressure relieving mattress in Dovegate when he moved to the inpatient unit on 8 January 2016. The records suggest he had previously been sleeping in his chair as his bed was not big enough for his size.

55. There is no evidence from December 2014, to November 2016, of appropriate and consistent pressure sore measurement as per national quality guidance (NICE 2015). The level of care at Dovegate was not what we would have expected in the community. Healthcare staff were not active in reducing the size of and managing Mr Gillett's sores.
56. Mr Gillett was at Norwich for 18 days. Assessment, care planning and delivery of care was of a good standard as would be expected within a unit specifically designed for elderly complex prisoners. Regular dressings were appropriately performed. However there was no documented evidence of pressure ulcer measurement or visual appearance to objectively monitor progress in line with national quality guidance. We make the following recommendation;

The Head of healthcare at Dovegate and Norwich should ensure that healthcare staff follow NHS best practice for preventing and treating pressure sores.

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