Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Wills a prisoner at HMP Norwich on 31 January 2016

A report by the Prisons and Probation Ombudsman
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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 Alan Wills died of pneumonia and lung disease at HMP Norwich on 31 January 2016. Mr Wills was 88 years old. I offer my condolences to those who knew him.

The investigation found that Mr Wills received very good care at HMP Norwich, with appropriate and timely referrals to secondary care. He had lived with dementia and several other chronic conditions for many years, and the day before he died hospital doctors diagnosed bronchopneumonia. I am satisfied that there was nothing the prison could have done to prevent his death.

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 **August 2016**

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Summary

Events

1. In 1961, Mr Alan Wills was sentenced to life imprisonment. He was released on licence in 1984 but recalled to prison in 1988 and was subsequently sentenced to seven years in prison for further offences. He had been at HMP Norwich since 17 November 2004.

2. Mr Wills had complex medical needs. He had been diagnosed with progressive and advanced dementia, heart disease, lung disease and diabetes. Healthcare staff produced detailed care plans and managed his conditions in consultation with specialists. Towards the end of his life, they provided constant medical and social care.

3. On 30 January 2016, Mr Wills stopped eating and drinking and appeared to be generally unwell. A nurse spoke to an out of hours GP who arranged for Mr Wills to go to hospital. At the hospital, doctors diagnosed bronchopneumonia with no chance of recovery. Mr Wills returned to the prison that night and he died in the early hours of 31 January.

Findings

4. Mr Wills had a long history of chronic health problems. He lived in a special unit for elderly prisoners and healthcare staff closely monitored and assisted him. When his health deteriorated, a GP sent him to hospital quickly. We are satisfied that Mr Wills received a good standard of care at the prison, at least equivalent to that he could have expected to receive in the community. Staff at Norwich could not have prevented his death.

The Investigation Process

5. 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.

6. The investigator obtained copies of relevant extracts from Mr Wills' prison and medical records.

7. NHS England commissioned a clinical reviewer to review Mr Wills' clinical care at the prison.

8. 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.

9. Mr Wills had not named any next of kin and had not been in contact with members of his family while he was in prison. Enquiries with his offender manager in the community indicated that he had no known family.

10. The prison considered our initial report and did not identify any factual inaccuracies.

Background Information

HMP Norwich

11. 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

HM Inspectorate of Prisons

12. The most recent inspection of Norwich was in August 2013. Inspectors reported that the prison had progressed since the last inspection. Relations between staff and prisoners were mostly positive, and the inpatient and older prisoner units provided good care. However, although the nurse practitioner service was very good, there was a concern about the high level use of locum GP's, which could lead to inconsistencies in treatment, care and prescribing.

Independent Monitoring Board

13. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2015, the IMB reported that Norwich continued to improve. The IMB considered that the healthcare centre was outdated and lacked facilities but noted that the older prisoner unit continued to improve. The level of staff care was commendable but the use of agency staff compromised continuity of care.

Previous deaths at HMP Norwich

14. As Norwich has a special unit for older prisoners, there are a relatively high number of deaths from natural causes. Mr Wills was the eighth of 11 prisoners to die from natural causes at the prison since September 2014. In many of the other cases we have found that the prison provides very good care for older prisoners at the end of their lives.

Key Events

15. In 1961, Mr Alan Wills was sentenced to life in prison. He was released on life licence in 1984, but he was recalled to prison on 6 May 1988, after breaching the conditions of his licence. On 9 September 1988, Mr Wills was sentenced to seven years in prison for further offences. He had been at HMP Norwich since 17 November 2004.

16. Mr Wills had suffered poor health for several years. He had advanced dementia, heart disease, lung disease, diabetes and was doubly incontinent. He smoked, but declined all help to stop. Mr Wills lived in a specialist unit for elderly prisoners at Norwich. Healthcare staff saw him daily as part of his care plan, and nurses and care assistants helped him with daily living, including helping him eat, get dressed and with his personal care.

17. On 15 July 2011, Mr Wills told a prison GP that he did not want to be resuscitated if his heart or breathing stopped. Healthcare staff reviewed this decision with him periodically. In February 2014, they concluded that he no longer had the capacity to make decisions about his care.

18. Over the following years, Mr Wills became increasingly frail and his dementia worsened. He often had infections, mini-strokes, falls and bowel problems. He had limited mobility and used a walking frame. Mr Wills' medical and social care needs increased, but he was often uncooperative and refused medication and physical examinations. Healthcare staff continued to care for him in line with his care plan, including action to prevent pressure sores.

19. On 15 April 2015, a GP tried to discuss his views about resuscitation with Mr Wills, but he refused to speak to him. The GP consulted other healthcare staff and completed a form to confirm that he should not be resuscitated. After an assessment on 1 May, another GP noted that Mr Wills had advanced dementia and needed constant care. A nurse reviewed his resuscitation status and confirmed it was appropriate.

20. Towards the end of 2015, healthcare staff replaced Mr Wills' cigarettes with e-cigarettes. A nurse noted that this was a healthier and safer alternative to tobacco, as he often dropped cigarettes on himself and burnt his fingers.

21. On 30 January 2016, a nurse noted that Mr Wills refused to eat or drink, had a "rattling chest" and appeared to be unwell. His blood oxygen saturation level was low at 86%. The nurse rang the on call GP, who arranged for Mr Wills to go to hospital. Hospital consultants diagnosed bronchopneumonia and considered that no active treatment was possible. They also noted that he did not want to be resuscitated.

22. Mr Wills returned to the prison at 11.00pm that night. A healthcare assistant spoke to him and arranged a prescription for pain relief (oramorph) with another out of hours GP. She checked Mr Wills during the early hours of 31 January. At 3.50am, she found that he had stopped breathing. She informed a nurse, who found no pulse. A GP later confirmed Mr Wills' death.

Contact with Mr Wills' family

23. Mr Wills had no contact with his family and had never received any visits from family members. His next of kin in his prison records was a probation officer who had worked at a homeless offenders' resettlement unit 30 years before. The prison enquired with the Probation Service, who said that Mr Wills had no family ties or contacts.

24. In line with national policy, the prison arranged and paid for Mr Wills' funeral, which was held on 2 March.

Support for prisoners and staff

25. After Mr Wills' death, a prison manager debriefed the healthcare staff to ensure they had the opportunity to discuss any issues arising. She offered her support and that of the staff care team.

26. The prison posted notices informing prisoners of Mr Wills' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Wills' death.

Post-mortem report

27. The report of the post-mortem examination indicated that Mr Wills had died of bilateral lobar pneumonia (pneumonia in the lungs) due to chronic obstructive pulmonary disease (lung disease); arising against a background of diabetes mellitus and old age.

Findings

Clinical care

28. Mr Wills had complex medical needs and needed constant medical and personal care. Healthcare staff at Norwich liaised effectively with hospital specialists about his care and implemented good, clear, holistic care plans, which were well communicated within the healthcare team and discussed with Mr Wills. The clinical reviewer noted that there were many examples of positive and thoughtful care, respect for Mr Wills as an individual, and acts of kindness by staff.

29. Mr Wills' final deterioration was rapid, and the speed of his decline meant that an end of life care pathway was not necessary. The clinical reviewer considered that his care was at least equivalent to that he could have expected to receive in the community. We are satisfied that Mr Wills' care and treatment at Norwich was of a high standard.

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