Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Willis a prisoner at HMP Norwich on 14 December 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*

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 Keith Willis died on 14 December 2016, of bronchopneumonia and Chronic Obstructive Pulmonary Disease (COPD) at HMP Norwich. Mr Willis was 82 years old. I offer my condolences to Mr Willis' family and friends.

Mr Willis was a frail man with poor health and reduced mobility. Healthcare staff managed Mr Willis' many chronic conditions well and treated him promptly. I consider he received very good care at the prison, at least equivalent to that he could have expected to receive in the community.

However, I am concerned that prison managers did not appropriately take into account Mr Willis' reduced mobility and poor health when deciding that he should be restrained for a hospital escort in August 2016 and that liaison with his next of kin could have been better.

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 **May 2017**

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Summary

Events

1. In September 2009, Mr Keith Willis was charged with sexual offences and remanded to HMP Norwich, though he spent time at a number of prisons. In July 2010, Mr Willis was sentenced to seven years in prison. In October 2011, Mr Willis received a further sentence of 13 years and five months. That same month, Mr Willis was returned to Norwich.

2. Mr Willis had a number of long term health problems including epilepsy, diabetes, asthma, Parkinson's disease and heart disease. In December 2009, Mr Willis was diagnosed with Chronic Obstructive Pulmonary Disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema). In August 2013, Mr Willis was diagnosed with prostate cancer, though hormone injection treatment successfully stopping the growth of the cancer. Mr Willis was also registered disabled and required walking aids to mobilise.

3. When entering Norwich, Mr Willis moved to the elderly care unit and healthcare staff created care plans to manage his many conditions.

4. In May 2015, Mr Willis' health began to deteriorate and he required help with his personal care. At the beginning of October 2015, Mr Willis was admitted to hospital and treated for aspirational pneumonia (a lung condition where a person inhales food or fluid, which becomes infected). Mr Willis refused intervention from the speech and language team and he signed an order confirming that he did not want staff to resuscitate him if his heart or breathing stopped.

5. Mr Willis' health began to deteriorate further from May 2016 and he began to refuse food, fluid and medication. On 24 May, Mr Willis became unresponsive so paramedics attended the prison and administered intravenous fluids. He remained at the prison for treatment and his health improved.

6. On 24 August, Mr Willis attended a hospital appointment for a gastroscopy procedure. Officers restrained him with an escort chain, which caused bruising to his wrist.

7. On 8 December, a prison nurse noted that Mr Willis' ability to stand and transfer had declined, which made it difficult for healthcare staff to provide personal care, so a social care referral was made.

8. On 13 December, Mr Willis stopped eating and drinking and his mobility declined further. The following day at 9.15am, a prison nurse found Mr Willis in his bed unresponsive but breathing. She gave Mr Willis oxygen but a prison doctor said it provided no benefit as his death was imminent. Mr Willis died at 10.55am.

Findings

9. Prison healthcare staff managed Mr Willis' medical conditions to a high standard over many years and referred him to secondary care when necessary. We agree with the clinical reviewer that the care Mr Willis received at Norwich was at least equivalent to that he could have expected to receive in the community.

10. However, we are concerned that Mr Willis was subject to the use of restraints on 24 August, despite his poor health and reduced mobility.

11. We are also concerned that the prison did not inform Mr Willis' friend, his next of kin, in person of his death, as the family liaison officer relied upon hearsay evidence from another prisoner that their friendship had broken down.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that a member of Prison Service staff informs a prisoner's family or next of kin in person of their death, in line with national guidance.

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 her. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Willis' prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Willis' clinical care at the prison.

15. The clinical reviewer and another of the Ombudsman's investigators interviewed one member of staff at Norwich on 9 January 2017.

16. We informed HM Coroner for Norwich 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 Willis' next of kin, his friend, to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He did not respond to our letter.

18. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

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.

HM Inspectorate of Prisons

20. The most recent inspection of Norwich was in September 2016. Inspectors reported that the prison population had a complex range of needs and that not all areas of the prison were accessible to those with mobility difficulties. Waiting times for most clinics were reasonable and staff provided clinically effective interventions and interacted positively with prisoners. They added that the care staff provided in the inpatient unit and on the elderly care unit was impressive.

Independent Monitoring Board

21. 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 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 was provided on the elderly care unit with consideration and sensitivity and palliative care was considered to be of a high standard.

Previous deaths at HMP Norwich

22. Mr Willis was the seventh prisoner to die of natural causes at HMP Norwich since January 2016. There has been one subsequent death. We have made recommendations about restraints before.

Key Events

23. In September 2009, Mr Keith Willis was charged with sexual offences and remanded to HMP Norwich, although he spent time at a number of prisons. In July 2010, Mr Willis was sentenced to seven years in prison for sexual offences. In October 2011, Mr Willis received a further sentence of 13 years and five months. That same month, Mr Willis was returned to Norwich.

24. Mr Willis had multiple medical problems before entering custody, including epilepsy, diabetes and asthma. He was diagnosed with Chronic Obstructive Pulmonary Disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and Parkinson's disease in 2009 and heart disease, which required the insertion of a pacemaker, in 2010. In August 2013, Mr Willis was diagnosed with prostate cancer, which was treated with regular hormone injections that successfully controlled the growth of the disease. He was also registered disabled and needed walking aids including a walking frame and a wheelchair.

25. Prison doctors prescribed a number of medications for Mr Willis' conditions and he often went to hospital for treatment. Healthcare staff implemented care plans, including an older person care plan, to manage Mr Willis' many conditions and reviewed him frequently.

26. When he arrived in Norwich, the prison placed Mr Willis on a specialist unit for older prisoners with 24-hour healthcare.

27. In February 2012, Mr Willis signed a 'preferred priorities of care' form and confirmed that he wanted to be resuscitated, although he wanted this to be reviewed if his health deteriorated.

28. Between 2012 and 2015, healthcare staff reviewed Mr Willis frequently to manage his conditions. In May 2015, Mr Willis' health began to deteriorate and he became unable to manage his personal care, as he became doubly incontinent. He was seen by the incontinence advisory service and healthcare staff managed his personal care needs.

29. During July, Mr Willis had periods of food refusal. Healthcare staff encouraged Mr Willis to eat and monitored his health and his appetite improved.

30. At the beginning of October, Mr Willis was admitted to hospital and diagnosed with aspirational pneumonia. The speech and language team assessed him and recommended an additive for his food and fluids to thicken them and avoid potential food inhalation. This was discussed with Mr Willis but he declined.

31. On 13 October, a prison GP noted Mr Willis' deterioration and asked him about his resuscitation wishes. Mr Willis said that he did not want staff to attempt resuscitation if his heart or breathing stopped.

32. Between October 2015 and May 2016, Mr Willis' condition did not change and healthcare staff continued to review him frequently.

33. On 16 May 2016, a healthcare assistant noted that Mr Willis was becoming increasingly unsteady while using a walking frame and when transferring to his

wheelchair and bed. She made a social care referral, though there was no record that anyone assessed Mr Willis before his death.

34. From 18 May, Mr Willis' appetite and fluid intake decreased and his health began to deteriorate. Healthcare staff continued to monitor him.

35. On 23 May, a nurse found Mr Willis unresponsive in his cell. After a discussion with the on-call manager they decided to call an ambulance. Paramedics attended and provided intravenous fluids to rehydrate Mr Willis. It was agreed that Mr Willis would remain at the prison for treatment and monitoring. Mr Willis' food and fluid intake improved over the following days and he began to show improvement.

36. On 24 August, Mr Willis attended a hospital appointment at hospital for a gastroscopy procedure. Officers restrained Mr Willis with an escort chain during the transfer and the procedure, which resulted in red marks and bruising to his right wrist.

37. Between September and December, healthcare staff continued to care for Mr Willis, encouraging him to eat and take his prescribed medications. They also managed his care plans and personal care.

38. On 1 December, Mr Willis attended for a gastroenterology appointment at hospital. A consultant saw Mr Willis and said he looked pale and almost cachectic (wasting of the body). The consultant suggested further investigations for malignancy and suggested nutritional supplements. These investigations did not take place before Mr Willis' death.

39. On 8 December, a nurse made a second social care referral because Mr Willis had not been assessed following the referral in May. The nurse also made an occupational therapy referral for an assessment of whether extra equipment would help Mr Willis and healthcare staff with his personal care.

14 December 2016

40. At 9.15am on 14 December, a nurse found Mr Willis unresponsive in his cell during routine checks. She asked for assistance and a senior nurse responded. The senior nurse was unable to get a blood pressure reading but gave Mr Willis oxygen. The nurse then asked for the Head of Healthcare and a doctor to attend.

41. At approximately 10.00am, the Head of Healthcare and a prison GP arrived at Mr Willis' cell. The GP determined that Mr Willis was in the end stages of life and that the oxygen should be stopped, as it did not offer any benefit. As Mr Willis did not want to be resuscitated, the GP asked healthcare staff to keep him comfortable. The prison chaplain also attended to offer comfort and support.

42. At 10.55am, Mr Willis stopped breathing and the prison GP confirmed that there was no pulse. The GP certified that Mr Willis had died at 11.00am.

Contact with Mr Willis' family

43. Mr Willis had no contact with his family and had nominated a friend as his next of kin.

44. On 14 December, staff on the elderly care unit told a senior prison manager that Mr Willis was very unwell. At this point, she decided to act as the prison's family liaison officer.

45. At 12.25pm on 14 December, the senior prison manager telephoned Mr Willis' next of kin and told him that Mr Willis had died. She made this decision because the next of kin was not a blood relative and another prisoner had raised doubts that Mr Willis wanted to keep his friend as his next of kin. She offered her condolences and support, and remained in contact with Mr Willis' friend until the funeral was held.

46. Mr Willis' funeral was held on 11 January 2017, which the prison arranged and paid for in line with national instructions.

Support for prisoners and staff

47. After Mr Willis' death, the senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

48. The prison posted notices informing other prisoners of Mr Willis' death, and offering support. Staff reviewed all prisoners on the elderly care unit in case they had been adversely affected by Mr Willis' death.

Post-mortem report

49. The post-mortem report confirmed that Mr Willis died from bronchopneumonia and Chronic Obstructive Pulmonary Disease.

Findings

Clinical care

50. We agree with the clinical reviewer that Mr Willis received good, compassionate care that was supported by a number of active care plans. We agree that healthcare staff cared for his complex needs well and that he was the elderly care unit was a suitable location for him. We note that Mr Willis was involved in discussions about his care and had made staff aware of his resuscitation wishes.

51. During our investigation, we noted that Mr Willis did not receive a social care assessment after a referral was made in May 2016. While it is regrettable that the social care assessment did not take place, we note that healthcare staff saw Mr Willis on a daily basis to review him as part of an older person care plan. As a result, we are satisfied that healthcare staff supported Mr Willis' social and care needs.

52. Overall, we agree that Mr Willis received a good standard of healthcare at the prison that was at least equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

54. When Mr Willis went to hospital on 24 August, a prison manager reviewed his risk assessment and authorised two officers to escort Mr Willis using an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) The assessment identified Mr Willis as presenting as an unknown risk to children and the medical section did not indicate any objections to the use of restraints, despite Mr Willis requiring a wheelchair.

55. We have asked the prison on several occasions to explain why Mr Willis was restrained on 24 August but have not received a response. The Head of Healthcare told the clinical reviewer that the decision was made because of a national incident of escape, which caused a change in the prison policy. She stated that all prisoners needed to be restrained at this time but explained that this has since changed for the elderly care unit and that medical staff can advise against cuffing.

56. Mr Willis had not been restrained for any of his previous hospital visits, due to his poor health and mobility, and was not restrained for a final appointment on the 1 December. It is disappointing that Mr Willis was restrained on this occasion, without any evidence that his risks had increased or his health had improved to justify this decision. The restraints left bruising and red marks to Mr Willis' right wrist, due to the fragility and thinness of his skin and there is no doubt that they caused discomfort. We are not aware of and have not received any documentation to support the asserted change in national policy.

57. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that staff took sufficient account of Mr Willis' physical condition and limited mobility when completing the initial risk assessment on this occasion. This is disappointing given that his poor health was taken into account on all other occasions and that his risks were managed effectively without the use of restraints. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Contact with Mr Willis' next of kin

58. Prison Rule 22 requires that the governor should inform a prisoner's next of kin at once when a prisoner dies. Prison Service Instruction (PSI) 64/2011 requires that wherever possible, the family liaison officer and another member of staff visit the next of kin to break the news of the death.

59. Mr Willis had chosen his friend as his next of kin and had given him power of attorney. While another prisoner told the senior prison manager that Mr Willis was not happy with their friendship, Mr Willis had not taken steps to amend his next of kin his prison records or to remove the power of attorney. Without definitive evidence to show that Mr Willis wanted to change his next of kin, we consider that she should have visited the next of kin in person to break the news of Mr Willis' death, in line with Prison Rule 22 and PSI 64/2011. This view is strengthened by the fact that Mr Willis' next of kin only lived approximately 22 miles from the prison and the time of his death. We make the following recommendation:

The Governor should ensure that a member of Prison Service staff informs a prisoner's family or next of kin in person of their death, in line with national guidance.

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