Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Norcliffe a prisoner at HMP Wakefield on 5 February 2017

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 Mark Norcliffe died on 2 February 2017 of a brain tumour while a prisoner at HMP Wakefield. He was 57 years old. I offer my condolences to Mr Norcliffe's family and friends.

Mr Norcliffe received a high standard of clinical care at Wakefield where healthcare staff monitored his condition and reviewed him frequently. Staff treated Mr Norcliffe with respect and agreed an appropriate end of life care plan. I am satisfied that Mr Norcliffe received care equivalent to that which he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. In February 2013, Mr Mark Norcliffe was sentenced to 11 and a half years imprisonment for sexual offences. He had a brain tumour and was subject to ongoing treatment. In September 2015, a consultant oncologist told Mr Norcliffe that his condition was terminal. He was moved to HMP Wakefield in November.

2. Healthcare staff reviewed Mr Norcliffe frequently and prison staff facilitated his hospital appointments. In December, a GP recorded that Mr Norcliffe required end of life care and he moved to the prison's palliative care suite. Over the next six weeks, healthcare staff reviewed his end of life care plan frequently, prescribed appropriate medication and liaised with palliative care specialists for advice and support.

3. On 5 February 2017, at 6.03am, a nurse completed her clinical observations and offered support to Mr Norcliffe's wife, who was present with him in the palliative care suite. At around 10.40am, his wife called for help and a nurse noted that Mr Norcliffe had stopped breathing and did not have a pulse. A GP later confirmed that Mr Norcliffe had died at 10.50am.

Findings

4. The clinical reviewer found that Mr Norcliffe received a high standard of clinical care at Wakefield. Healthcare staff followed specialist advice, reviewed him frequently and treated his condition appropriately. Palliative and end of life care was good. We are satisfied that the care Mr Norcliffe received was equivalent to that which he could have expected to receive in the community.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Wakefield informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Norcliffe's prison and medical records. He interviewed one member of staff by telephone on 14 March 2017.

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

8. We informed HM Coroner for Wakefield of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

9. The investigator wrote to Mr Norcliffe's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

10. The investigation has assessed the main issues involved in Mr Norcliffe's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

11. 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

HM Prison Wakefield

12. HMP Wakefield is a high security prison and holds up to 750 men. There are four main residential wings, a healthcare centre, a segregation unit and a close supervision centre (a small unit aiming to provide a supportive, safe, structured and consistent environment for some of the most challenging offenders).

13. Care UK took over all healthcare provision at Wakefield on 1 April 2016. Prior to this, Spectrum CIC (Community Interest Company) provided primary healthcare services during normal working hours and Humber NHS Foundation Trust (intermediate care) employed the nurses in the inpatient unit, which provides overnight and weekend care for prisoners with physical health problems. There is a dedicated palliative care suite in the healthcare unit.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Wakefield was in July 2014. Inspectors found that health services were good overall but some parts of the healthcare environment, including the inpatient unit, were poor. Primary care services were very good and had an appropriate emphasis on the care of patients with long-term conditions.

Independent Monitoring Board

15. 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 April 2016, the IMB reported that weekly visits to the healthcare departments found the care and treatment of prisoners to be of a very high quality, and they continued to be impressed by the professionalism of the staff.

Previous deaths at HMP Wakefield

16. Mr Norcliffe was the twelfth prisoner to die from natural causes at Wakefield since January 2016. There were no similarities between the circumstances of Mr Norcliffe's death and previous deaths at the prison.

Findings

The diagnosis of Mr Norcliffe's terminal illness and informing him of his condition

17. On 15 February 2013, Mr Norcliffe was sentenced to 11 and a half years imprisonment for sexual offences and was sent to HMP Edinburgh. He had a glioblastoma (brain tumour) and was subject to ongoing treatment. On 16 September 2015, a consultant clinical oncologist at Western General Hospital, Edinburgh, told Mr Norcliffe that his condition was terminal and that he had a prognosis of one year with chemotherapy. He was moved to HMP Wakefield on 27 November.

Mr Norcliffe's clinical care

18. At an initial reception screen, Nurse A recorded that Mr Norcliffe was receiving treatment for a brain tumour and had been referred to St James's University Hospital, Leeds. He arranged a GP appointment and assessed him as suitable for in-possession medication.

19. On 30 November 2015, Mr Norcliffe was sent to St James's Hospital for chemotherapy to try to delay the progression of his tumour. When Mr Norcliffe returned to prison, Nurse B saw him for a review and Dr A prescribed Lomustine and Procarbazine (oral chemotherapy medications), as directed by hospital specialists. A prison manager, A, noted that Mr Norcliffe had not been able to contact his family and arranged a supervised phone call.

20. On 1 December, Dr A saw Mr Norcliffe to review his Do Not Attempt Cardiopulmonary Resuscitation Order (DNACPR – which means that in the event of a cardiac or respiratory arrest, no attempt at resuscitation will be made). Mr Norcliffe signed the order at Edinburgh, but had changed his mind after talking to his wife. The doctor advised another appointment in four weeks to discuss his wishes further. Nurse C introduced herself as his named nurse and offered to arrange a visit from a palliative care specialist. However, Mr Norcliffe did not feel the need for additional support and wanted to remain independent for as long as possible.

21. Dr B met Mr Norcliffe on 16 December to discuss his wishes regarding resuscitation. He went through the resuscitation process in detail and advised him of the implications of not having a DNACPR. Mr Norcliffe said that he understood and subsequently agreed for the order to remain in place. Over the next 10 months, healthcare staff reviewed Mr Norcliffe frequently and discussed his case at regular Gold Standard Framework Meetings (GSF – a systematic, evidence-based approach to support and palliative care). Prison staff facilitated Mr Norcliffe's chemotherapy appointments and GPs reviewed his blood tests as required.

22. On 31 October 2016, Mr Norcliffe reported to Dr C that he was suffering from weakness on his right side and had experienced a loss of balance for the past three weeks. Dr C noted that he had a brain tumour and referred him for an urgent MRI scan. On 12 November, Nurse B noted that Mr Norcliffe's condition had deteriorated and arranged for Nurse D to admit him to the prison's inpatient

unit. He had an MRI scan at St James's University Hospital on 24 November, followed by a CT scan at Pinderfields Hospital, Wakefield, on 5 December.

23. Two days later, Dr D contacted the consultant clinical oncologist overseeing Mr Norcliffe's care to discuss his MRI scan. The consultant reported a significant deterioration in his condition and suggested he receive end of life care. On 9 December, a specialist palliative care nurse saw Mr Norcliffe for an initial assessment and attended a multi-disciplinary GSF meeting with prison staff. Mr Norcliffe's condition did not improve and healthcare staff gave him midazolam (a medication to treat agitation and restlessness in the final stages of end of life care), when required. They moved him to the palliative care suite, reviewed him frequently and assisted with his mobility and personal care. The chaplaincy also provided Mr Norcliffe with some additional emotional and spiritual support.

24. On 1 February 2017, Dr D examined Mr Norcliffe following concerns about his ability to swallow and requested urgent advice form the palliative care team. The next day, a specialist nurse examined Mr Norcliffe and advised to stop oral medication and commence midazolam via a syringe driver (a battery operated pump that delivers medication continuously under the skin). On 3 February, prison manager, B, agreed to leave Mr Norcliffe's cell door unlocked, making it easier for nurses to provide him with end of life care.

25. On 5 February, at 6.03am, Nurse E recorded that although Mr Norcliffe remained peaceful, his breathing had increased and his condition had deteriorated. She completed her clinical observations and provided support to Mr Norcliffe's wife, who was present in the palliative care suite. At around 10.40am, Mrs Norcliffe wife called for help and Nurse F noted that Mr Norcliffe had stopped breathing and did not have a pulse. At 5.26pm, an on call GP confirmed that Mr Norcliffe had died at 10.50am.

26. The clinical reviewer considered that Mr Norcliffe received a high standard of care at Wakefield. Healthcare staff managed his terminal illness well and followed instructions from specialists regarding his chemotherapy treatment and end of life care. Staff planned his care using the Gold Standards Framework, prescribed appropriate medication and supported his independence where possible. The clinical reviewer has made a number of recommendations that the head of healthcare will need to consider, but we do not repeat them in this report.

27. Overall, we are satisfied that the care Mr Norcliffe received was equivalent to that which he could have expected to receive in the community.

Mr Norcliffe's location

28. Shortly after Mr Norcliffe arrived at Wakefield, staff moved him to a more easily accessible cell on a lower level that was closer to staff so they could provide suitable support on the wing, in line with his wish to remain largely independent. As Mr Norcliffe's condition deteriorated, Nurse B arranged for his admission to the prison's healthcare unit where he received 24 hour care. We are satisfied that Mr Norcliffe was appropriately located while at Wakefield.

Restraints, security and escorts

29. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

30. When Mr Norcliffe was taken to hospital on 5 December, a prison manager, C, decided that three officers should escort him using an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to a prison officer). A full risk assessment indicated that he presented a high risk to the public and a medium risk to hospital staff. There were no medical objections to the use of restraints, but the medical section highlighted that restraints may need to be removed during the scan. He told the investigator that he considered the level of restraint in conjunction with Mr Norcliffe's assessed risk, deteriorating health and limited mobility. He said that he increased the escort to three officers so that Mr Norcliffe's restraints could be removed for the scan.

31. We are satisfied that the prison's use of restraints was appropriate.

Liaison with Mr Norcliffe's family

32. On 23 November 2016, the prison appointed Senior Officer (SO) A as family liaison officer and prison manager, D, as her deputy. They visited Mr Norcliffe later the same day to explain their roles and to confirm his next of kin details. On 9 December, the SO introduced herself to Mr Norcliffe's wife and updated her on his condition. Prison manager, E, told the investigator that the delay making contact was due to waiting for the result of Mr Norcliffe's MRI scan. The SO and prison manager, D, provided Mrs Norcliffe with ongoing support by facilitating visits and providing her with updates. Mrs Norcliffe visited her husband in the palliative care suite on 12 December and 4 January.

33. On 5 January 2017, SO A contacted Mrs Norcliffe to offer her support following an emotional visit the previous day. She asked Mrs Norcliffe to notify her of her next day off work so that a further visit could be arranged. The records indicate that the SO made several attempts to speak with Mrs Norcliffe between 19 and 23 January but was unable to make contact. On 4 February, prison manager, D, contacted Mrs Norcliffe to advise her of her husband's deteriorating health and arranged for her to visit that afternoon. Healthcare and prison staff supported Mrs Norcliffe overnight and after Mr Norcliffe had died.

34. Prison Service Instruction (PSI) 64/2011, Safer Custody, says, in respect of terminally ill prisoners, "it is important that prisoners are able to maintain closely [sic] contact with their family or a nominated person. With the prisoner's agreement, the family should be kept informed and updated on the prisoner's condition particularly if there is deterioration in their condition". Once Mr Norcliffe's wife was contacted on 9 December, the prison's liaison with her was good, but there was a delay in making the initial contact. Mr Norcliffe was admitted to the prison's inpatient unit on 12 November after deterioration in his condition and a family liaison officer was appointed on 23 November. We are concerned that Mrs Norcliffe was not contacted until over two weeks later. While

this did not have a significant impact in Mr Norcliffe's case, such a delay might in future cases.

35. On 9 February, SO A, and prison manager, D, visited Mrs Norcliffe at her home address to offer their condolences and provide support. In line with national policy, the prison paid for Mr Norcliffe's funeral, which took place on 8 March, and was attended by the SO and prison manager E. On 25 April, the prison held a memorial service for Mr Norcliffe, which was attended by his wife, prisoners and staff.

Compassionate release

36. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.

37. Staff started an application for early release on compassionate grounds on 7 December and discussed the process during a multidisciplinary meeting two days later. Dr B indicated that Mr Norcliffe had a life expectancy of six weeks to three months. SO A noted that Mr Norcliffe could not be released to his wife's address as the family felt they would not be able to cope. Prison staff submitted the early release application on 17 January 2017, although there is no evidence that healthcare staff had started the process of establishing Mr Norcliffe's care needs or liaising with NHS England with regards to adequate care arrangements.

38. Following submission of the early release application, it became apparent that as a Scottish prisoner, Mr Norcliffe was subject to release provisions as applicable in Scotland. On 19 January, the Scottish Prison Service requested additional documents and an updated medical report as the original was five weeks old. Three days later, Dr B signed a report indicating that Mr Norcliffe had less than six weeks to live. The deputy head of healthcare liaised with NHS England regarding appropriate health provision and submitted an ongoing care needs assessment on 27 January. The prison maintained regular contact with the Scottish Prison Service, but they were unable to complete the application before Mr Norcliffe died.

39. While we consider that healthcare staff may have been able to start the process of liaising with the NHS with regards to adequate care arrangements more promptly, we recognise that the application was pursued despite Mr Norcliffe not having a suitable release address and that an attempt to address his care needs in the community was made. Therefore, we do not make a recommendation.

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