

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr James McIntosh a prisoner at HMP Norwich on 3 October 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.

The 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 James McIntosh died on 3 October 2016 of widespread bowel cancer while a prisoner at HMP Norwich. He was 77 years old. I offer my condolences to Mr McIntosh's family and friends.

Mr McIntosh received a good standard of clinical care at HMP Bure and HMP Norwich. We are satisfied that the care he received was at least equivalent to that he could have expected to have received in the community.

However, the investigation found a need for better arrangements to help elderly and infirm prisoners keep in touch with their families.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

March 2017

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Summary

Events

1. In October 2014, Mr James McIntosh received 14 years imprisonment for sexual offences. He progressed through his sentence and was moved to HMP Bure in November 2015.
2. At an initial reception screen, a nurse recorded that Mr McIntosh did not have any health problems and was not taking any prescribed medication. On 26 November, an older person assessment identified that his weight, appetite and gut function were all normal.
3. On 9 September, prison staff took Mr McIntosh to the prison's healthcare unit in a wheelchair, concerned that he had no strength and could not walk. A prison GP examined him and suspecting cancer, requested urgent blood tests, a chest X-ray and abdominal CT and ultrasound scans. The next day, a nurse received notification that Mr McIntosh had abnormal blood test results and sent him to hospital, where staff diagnosed inoperable bowel cancer that had spread to his liver and lungs.
4. On 19 September, Mr McIntosh told hospital doctors that he did not want anyone to resuscitate him if his heart or breathing stopped. He transferred that day to the older prisoners unit at HMP Norwich for palliative care. Over the next two weeks, healthcare staff monitored Mr McIntosh frequently, created appropriate care plans and followed instructions from specialist palliative care nurses. Doctors reviewed his medication regularly and prescribed appropriate pain relief.
5. On 3 October, at 4.08am, a nurse noticed that Mr McIntosh had stopped breathing, radioed for medical assistance and requested a GP to verify death. At 8.10am, a doctor confirmed that Mr McIntosh had died.

Findings

6. We are satisfied that healthcare staff at Bure sent Mr McIntosh to hospital promptly and that there was no delay in his diagnosis. Palliative care at Norwich was good and staff appropriately involved Mr McIntosh in decisions about his care. The clinical reviewer considered that his care was at least equivalent to that he might have expected to receive in the community.
7. The investigation identified a need to improve arrangements for elderly and infirm prisoners who are unable to get to a telephone to keep in touch with their families.

Recommendation

- The Governor of HMP Norwich should ensure that reasonable adjustments are made to allow elderly and infirm prisoners to keep in contact with their families.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr McIntosh's prison and medical records.
10. The investigator interviewed one member of staff from HMP Bure and one member of staff from HMP Norwich by telephone on 4 October 2016.
11. NHS England commissioned a clinical reviewer to review Mr McIntosh's clinical care at the prison.
12. 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.
13. The investigator wrote to Mr McIntosh's daughter 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.
14. The investigation has assessed the main issues involved in Mr McIntosh'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.
15. 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 Bure

16. HMP Bure is a medium security prison near Norwich, which holds over 600 men, convicted of sexual offences. Virgin Care provides healthcare services. Healthcare staff are on duty between 8.00am and 7.30pm on weekdays and between 8.00am and 6.00pm at weekends. Six GP clinics are scheduled each week. There is an out of hours service.

HM Prison Norwich

17. 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

18. The most recent inspection of HMP Bure was in May 2013. Inspectors reported that prisoners were positive about healthcare services and there was a good range of nurse-led clinics. Provision for older prisoners was well developed. Some cells were adapted for prisoners with mobility problems and to allow wheelchair access.
19. 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 use of locum GPs, which could lead to inconsistencies in treatment, care and prescribing.

Independent Monitoring Board

20. 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 Bure, for the year to July 2016, the IMB reported difficulties retaining healthcare staff and high levels of staff sickness. To achieve a good service staff regularly work additional days and staff levels need to be kept under review. A good out of hours service is in place, allowing healthcare staff to speak to out of hours service directly.
21. In the IMB's latest annual report for Norwich, 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 L wing with care and sensitivity and palliative care was considered to be of a high standard.

Previous deaths at HMP Norwich

22. Mr McIntosh was the fifth prisoner to die of natural causes at HMP Norwich since January 2016. We have consistently found that Norwich has provided good palliative care.

Findings

The diagnosis of Mr McIntosh terminal illness and informing him of his condition

23. On 24 October 2014, Mr James McIntosh received a 14 year sentence for sexual offences and was sent to HMP Thameside. He was transferred to HMP Bure on 4 November 2015.
24. At an initial reception screen, a nurse noted that Mr McIntosh did not have any physical or mental health conditions and that he was not taking any prescribed medication. On 26 November, a healthcare assistant saw Mr McIntosh for a routine older person's assessment and recorded that his weight, appetite and gut function were normal.
25. Mr McIntosh had history of hygiene related difficulties and prison staff frequently encouraged him to clean his cell and to have a shower. On 29 June 2016, prison staff took Mr McIntosh to the prison's healthcare unit concerned that he appeared weak. A nurse conducted an examination and Mr McIntosh reported that he only felt weak when having a shower. She took his clinical observations, which were normal, and booked him a GP appointment.
26. Two days later, Mr McIntosh told a prison GP that he was allergic to water. Although he insisted that having a shower made him feel weak, he did not provide any information that would have enabled healthcare staff to confirm such a condition. She told us that Mr McIntosh did not look ill or indicate any symptoms suggestive of weight loss, abdominal pain, or changes in his bowel habit. His pulse was recorded as 86bpm (which is within the normal range) and there is no record of a follow up appointment.
27. On 8 September, Mr McIntosh fell over while in the prison's exercise yard and hurt his ankle. During a medical review that afternoon, he told a nurse that he had been feeling weak for the last month and that he had been buying nutritional drinks from the canteen to gain strength. She recorded that Mr McIntosh's ankle appeared slightly bruised and booked him a GP appointment to review his symptoms.
28. The next day, prison staff took Mr McIntosh to the healthcare unit concerned that he had lost his strength and could no longer walk. Mr McIntosh arrived in a wheelchair and told a prison GP that he had been losing weight and that his abdomen had been swelling for about six weeks. She conducted an examination and suspecting cancer, requested urgent blood tests, a chest X-ray and abdominal CT (computerised tomography) and ultrasound scans.
29. On 10 September, a nurse reviewed Mr McIntosh's blood results which indicated that he was very anaemic and had liver damage. She recorded that wing staff had said that he had stopped eating and sent him to hospital. Hospital staff assessed Mr McIntosh, admitted him under the care of a consultant surgeon and diagnosed inoperable lower bowel cancer that had spread to his liver and lungs.
30. Mr McIntosh had a history of personal hygiene difficulties and frequently refused to have a shower, putting his increased weakness down to a water allergy. While we recognise that there may have been an opportunity for routine blood tests in

June, Mr McIntosh did not report or display any worrisome symptoms. The clinical reviewer considered that a prison GP appropriately referred Mr McIntosh for further investigations that resulted in his transfer to hospital and subsequent diagnosis. We are satisfied that healthcare staff acted in a timely manner and without delay.

Mr McIntosh's clinical care

31. Healthcare staff maintained daily contact with the hospital for updates on Mr McIntosh's condition. On 14 September, a nurse recorded that he had refused an MRI scan to stage his cancer and liaised with the Head of Healthcare at HMP Norwich, regarding a transfer. On 19 September, Mr McIntosh told hospital doctors that he did not want anyone to resuscitate him if his heart or breathing stopped and had a signed order to that effect. He transferred to the older prisoner unit at Norwich for palliative care later that evening.
32. On 20 September, healthcare staff assessed Mr McIntosh as requiring full nursing care with mouth care, fluid monitoring, turning him every two hours and constant pain relief. A prison GP reviewed his hospital transfer letter and prescribed appropriate medication. The Head of Healthcare and a prison manager agreed to leave his cell door unlocked, allowing easy access for nurses. Over the next two weeks, healthcare staff monitored Mr McIntosh frequently, created appropriate care plans and liaised with specialist palliative care nurses regarding his end of life care. Prison GP's regularly reviewed his medication and prescribed appropriate pain relief.
33. On 3 October, at 1.06am, a nurse turned Mr McIntosh and issued medication in accordance with his care plan. At 4.08am, she noticed that Mr McIntosh had stopped breathing, radioed for medical assistance and requested a GP to verify death. At 8.10am, a doctor confirmed that Mr McIntosh had died.
34. The clinical reviewer considered that Mr McIntosh received a good standard of care in prison. Healthcare staff managed his terminal illness well and followed instructions from specialist palliative care nurses in relation to his end of life care. Staff put in place care plans, prescribed appropriate medication and involved Mr McIntosh in discussions about his ongoing care. We are satisfied that the care Mr McIntosh received was equivalent to that he could have expected to have received in the community.

Mr McIntosh's location

35. We are satisfied that staff at Bure appropriately took account of Mr McIntosh's declining health and facilitated his transfer to the older prisoner unit at Norwich, which was appropriate for his needs.

Restraints, security and escorts

36. When prisoners have to travel outside of 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.

37. When Mr McIntosh went to hospital on 10 September, a prison manager reviewed his risk assessment and authorised two officers to escort Mr McIntosh 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 McIntosh as presenting a high risk to children and the medical section did not indicate any objections to the use of restraints. At 2.20pm, shortly after Mr McIntosh was admitted, the manager reviewed his assessment and decided that restraints should be removed due to the seriousness of his condition and lack of mobility. They were not reapplied at any time.
38. We are satisfied that the prison manager made an appropriate and humane decision to remove Mr McIntosh's restraints.

Liaison with Mr McIntosh's family

39. On 13 September, Bure appointed an officer and a prison manager as the prison's family liaison officers. The prison manager informed Mr McIntosh's daughter of his condition, explained the role of the family liaison officer and agreed to update her following any change in circumstance. The next day, the officer visited Mr McIntosh in hospital to explain her role and arranged for him to have telephone contact with his family. Although Mr McIntosh moved prisons, the family liaison officers continued in their roles.
40. On 20 September, a week after she had been appointed, the officer contacted Mr McIntosh's daughter to introduce herself and to let her know that he had moved to HMP Norwich. She told the investigator that she did not contact her earlier, because escort officers were facilitating phone calls and there was some uncertainty as to where he was going. She said that hospital staff were aware that Mr McIntosh's daughter was his next of kin and she and the prison manager assumed his daughter would be updated on his condition. However, she recorded that Mr McIntosh's daughter said that she received limited information about her father's cancer diagnosis throughout his hospital admission.
41. Prison Service Instruction (PSI) 49/2011, 'Prisoner Communication Services', states that all prisoners should be able to communicate with family and friends, that prisons should actively encourage prisoners to maintain outside contact and that prisoners should normally have access to phones for at least two hours each day. The PSI also requires Governors to ensure that prisoners with disabilities are able to make a telephone call. While we are pleased to note that the officer offered to facilitate numerous family visits to Norwich, evidence suggests that Mr McIntosh was only able to speak to his daughter once. The Head of Healthcare told us that he made a telephone call when he first arrived, but as his condition and mobility deteriorated, it was not possible to get him into an office for a call.
42. The officer provided Mr McIntosh's daughter with a telephone number for the older prisoners unit at Norwich, but she told the officer that she often had difficulty getting through and was unsure of her father's condition. The officer told us that she advised Mr McIntosh's daughter to call Norwich because she often wanted in-depth medical information that she could not provide.

43. On 3 October, at 6.30am, the Head of Healthcare broke the news to Mr McIntosh's daughter over the telephone as previously agreed. At 12.15pm, the officer called Mr McIntosh's daughter to offer her condolences and provided ongoing support until his funeral, which took place on 31 October. Bure contributed towards the costs, in line with national policy.

44. We make the following recommendation:

The Governor of HMP Norwich should ensure that reasonable adjustments are made to allow elderly and infirm prisoners to keep in contact with their families.

Compassionate release

45. 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.

46. Prison staff at Bure started the early release on compassionate grounds process on 14 September. However, Mr McIntosh later changed his mind and decided to withdraw the application. We are satisfied that Bure appropriately considered compassionate release.

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