

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Geoffrey Holman a prisoner at HMP Norwich on 16 July 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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Geoffrey Holman died on 16 July 2017 of cardiac arrest at HMP Norwich. He was 88 years old. I offer my condolences to Mr Holman's family and friends.

Mr Holman was a frail, elderly man when he entered prison. He was transferred to Norwich from HMP Bure, four months before his death, on account of their 24-hour nursing care. Overall, the care he received in prison was equivalent to that he could have expected to have received in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

January 2018

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Summary

Events

1. On 29 July 2015, Mr Geoffrey Holman was sentenced to six years and six months imprisonment for sexual offences. He was sent to HMP Norwich.
2. At his reception health screen, Mr Holman was noted as being elderly, frail and having a number of health concerns. He had had a triple heart bypass, and he suffered from an enlarged aorta which was deemed too dangerous to operate on.
3. In January 2016, Mr Holman was transferred to HMP Bure. In December that year, his health deteriorated, and healthcare staff at Bure requested that he be transferred back to Norwich, on account of its 24-hour nursing facility.
4. Mr Holman had a number of hospital visits in the early part of 2017 and, on 2 March, he returned to Norwich. A prison GP noted that Mr Holman was now receiving continuous oxygen therapy. He was receiving palliative care only, with further hospitalisation not recommended.
5. Over the next few months, Mr Holman was cared for in the 24-hour healthcare wing at Norwich. On 12 July, his condition declined, and he was moved to a cell closer to the nursing staff, with a request made by the healthcare manager for his door to be left open.
6. On 16 July, at 3.30am, a nurse became concerned about Mr Holman. An officer unlocked his cell, and they discovered him unresponsive, with no signs of life. A community GP was called to make a formal certification of Mr Holman's death.
7. At 6.35am, the duty governor at Norwich contacted Bure to ask that Mr Holman's next of kin were informed of his death. This was done at 9.10am.
8. At 10.37am, an on-call GP formally pronounced Mr Holman dead.

Findings

Clinical care

9. The clinical reviewer found that the care which Mr Holman received at Norwich and Bure was equivalent to that which he could have expected to receive in the community. We are concerned about the delay in Mr Holman being pronounced dead, but accept that staff at Norwich did all they reasonably could to get an on-call GP out to do this. The prison is reviewing its procedures to resolve this in future, so we make no recommendation.

Mr Holman's location

10. While we consider that it would have been desirable for Mr Holman to have been relocated to Norwich earlier, when his condition deteriorated at the end of 2016, we accept that staff did all they reasonably could to facilitate his transfer. Norwich has limited healthcare resources, and decisions about allocation also have to consider the welfare of other prisoners. We find that Mr Holman was

appropriately cared for while at Bure during this period, and a move was expedited when his condition worsened in March 2017.

11. We note that no open door arrangements were put in place, despite being requested four days before Mr Holman's death but understand that the request was put on hold when his condition improved slightly.

Family contact

12. We understand the benefit of continuity in family liaison, but feel that when Mr Holman transferred to Norwich in March 2017, responsibility for these duties should have been reviewed. We are concerned that his family was not informed of his condition for over five hours after he was discovered.

Compassionate release

13. When Mr Holman arrived at Norwich on 2 March, a prison GP discussed compassionate release with him, but he declined to make an application. We consider that the prison acted appropriately in respecting his wishes.

Restraints and security

14. We are concerned that Mr Holman was restrained during an escort to hospital from Bure, despite being elderly and frail. This was inconsistent with previous and subsequent escorts but we are satisfied that the prison has reviewed its policies and practice around restraints, so make no recommendation.
15. We note that Norwich did not restrain Mr Holman on the occasions they provided the escort for him.

Recommendations

We make no recommendations.

The Investigation Process

16. 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.
17. The investigator obtained copies of relevant extracts from Mr Holman's prison and medical records.
18. NHS England commissioned a clinical reviewer to review Mr Holman's clinical care at the prison.
19. We informed HM Coroner for Norwich of the investigation. There was no post-mortem for Mr Holman but the Coroner confirmed Mr Holman's cause of death. We have sent the coroner a copy of this report.
20. The investigator wrote to Mr Holman's daughter to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. She did not respond to our letter.
21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies.

Background Information

HMP Norwich

22. HMP Norwich is a multi-function prison, which predominately serves the courts of Norfolk and Suffolk. The prison holds up to 769 men.
23. Virgin Care provides 24-hour healthcare service at Norwich. There are 23 inpatient beds located above L Wing at the prison, with 10 of these beds being paid for by NHS Commissioners. L Wing also has a social care element.

HMP Bure

24. 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 6.30pm on weekdays and between 8.00am and 6.00pm at weekends. Five GP clinics are scheduled each week. There is an out of hours service.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Norwich was conducted in September 2016. Inspectors reported that an appropriate range of nurse-led clinics included provision for long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease. E wing, which housed some older prisoners, was calm and supportive and the men living there appreciated this environment.

Independent Monitoring Board

26. 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 28 February 2017, the IMB of HMP Norwich reported that the major impact upon the prison stemmed from staff shortages; safety was compromised, prisoners were offered a restricted regime and personal officer duties were extremely constrained. However, overall, prisoners received fair treatment in the establishment.

Previous deaths at HMP Norwich and HMP Bure

27. Mr Holman was the tenth person to die from natural causes at Norwich since January 2016. We have previously made recommendations to Norwich about family liaison contact. We have also previously made recommendations to Bure about the use of restraints.

Compassionate release

28. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000, *Parole Release and Recall*. The criteria include: a minimal risk of re-offending, the view that further imprisonment would reduce life expectancy, adequate

arrangements for the prisoner's care and treatment outside prison, and that release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS).

Key Events

29. On 29 July 2015, Mr Geoffrey Holman was sentenced to six years and six months imprisonment for sexual offences. He was sent to HMP Norwich.
30. A nurse reviewed Mr Holman at a reception health screen on his arrival at Norwich. The nurse noted that Mr Holman was elderly and frail, with multiple health concerns. In 2011, he had had a heart bypass and had an enlarged aorta which was deemed too dangerous to operate on. He also suffered from chronic kidney disease.
31. On 30 July, Mr Holman informed a prison GP that in the event of cardiac arrest, he did not want to be resuscitated. A 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) order (which means that in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made) was put in place.
32. Mr Holman was provided with a number of care plans due to his age and fragility and his condition remained stable for the rest of the year. On 15 January 2016, Mr Holman was transferred to HMP Bure. He had no significant health concerns until November that year, when he spent a week in hospital with pneumonia. His condition gradually deteriorated towards the end of the year.
33. On 22 December 2016, Mr Holman suffered a fall. A nurse spoke to the head of healthcare at Norwich, about a prisoner exchange. She agreed to investigate but the following day she confirmed that an exchange was not possible as the healthcare wing at Norwich was at full capacity. It was agreed that Bure would continue to manage Mr Holman for the time being.
34. On 24 December, Mr Holman was taken to hospital with hypertension. On 29 December, a nurse emailed the head of healthcare at Norwich again enquiring about a transfer, but she confirmed that Norwich still had insufficient capacity to take Mr Holman. On 4 January 2017, Mr Holman was discharged from hospital back to Bure.
35. On 10 January, Mr Holman complained of dizziness, and was taken to hospital. Two days later, he was declared medically fit for discharge but Bure was reluctant to take him back because of their lack of 24-hour nursing care. On 14 January, Mr Holman was discharged from hospital to Norwich. Two days later, Mr Holman was transferred back to Bure. The head of healthcare at Norwich noted that Mr Holman did not require 24-hour healthcare but did require a social care referral, and that Bure were happy to take him back. Mr Holman had two further hospital visits towards the end of January, but otherwise his condition remained stable.
36. On 28 February, Mr Holman complained of stomach and chest pain, and was taken to hospital. The next day, a nurse recorded that his condition was poor and deteriorating, and that he needed 24-hour healthcare. On 2 March, Mr Holman was transferred directly to Norwich from the hospital.

Mr Holman's clinical care

37. On his return to Norwich, a nurse reviewed Mr Holman at a medical screening. He noted that Mr Holman was receiving palliative care, required a frame to mobilise, and was hard of hearing. Mr Holman was located on the older persons unit on L wing, with access to 24-hour nursing care.
38. The same day, a prison GP reviewed Mr Holman and noted that he was now receiving continuous oxygen therapy, and was to receive palliative care only, with further hospitalisation not recommended. The prison GP observed that Mr Holman appeared to be in good spirits and not in any obvious physical pain, but referred him to the community palliative care team. The prison GP discussed compassionate release with Mr Holman, but he declined this. The prison GP recorded that Mr Holman had a current DNACPR in place.
39. Mr Holman's condition remained relatively stable for the next few months, and he was managed with regular reviews and care plans.
40. On 12 July, a nurse reviewed Mr Holman after his condition declined. She moved him to a cell closer to the nursing staff, and noted that the healthcare manager was aware of his situation and would arrange for open door status. This means that Mr Holman would not need to be unlocked to allow healthcare staff to attend to him. A prison GP reviewed Mr Holman the next day and noted that his condition had improved.

16 July 2017

41. On 16 July, at 3.30am, a nurse became concerned about Mr Holman while checking an adjacent cell. An officer unlocked Mr Holman's cell, and they discovered him collapsed in his toilet area. The nurse stated that Mr Holman was "not responsive, not breathing and looked cyanosed". A code blue was called, but resuscitation was not attempted due to Mr Holman's DNACPR. (A code blue call is an emergency radio code which indicates someone is unconscious or having problems breathing and immediately alerts healthcare staff and the control room to call for an ambulance.) A nurse initially called 999 but was advised by the operator to call 111 and to request an out of hours GP to certify Mr Holman's death.
42. By 8.15am, the GP had still not arrived, so a nurse called to chase this up. The GP stated that they did not have to come out to verify a death, and a nurse could do this instead. The nurse explained that they were not qualified to certify a death in custody.
43. At 10.30am, a prison GP arrived at the prison, and Mr Holman was pronounced dead at 10.37am.

Contact with Holman's family

44. Mr Holman's next of kin was his daughter, with a second daughter also involved. When his condition deteriorated in December 2016, HMP Bure appointed an Officer as Mr Holman's family liaison officer. On 21 December, she contacted Mr Holman's daughter and informed her of her father's recent trip to hospital. She remained Mr Holman's family liaison officer following his transfer to Norwich in March 2017.

45. Mr Holman's daughters visited him on three occasions following his return to Norwich, the last visit being on 6 July. These visits were conducted in the visiting hall at Norwich, and the family liaison officer had no involvement in them. On 12 July, following a decline in Mr Holman's condition, a nurse recorded that the Head of Safer Custody was aware of the situation and would speak to his daughters to see whether they would like to visit him. The Head of Safer Custody has subsequently informed us that she tried to call Mr Holman's family but although she did not receive a reply, she did not record this attempted contact at the time.
46. On 16 July, at 6.35am, the duty governor informed the custodial manager (CM) at Bure of Mr Holman's death, and asked for his next of kin to be informed. The CM was unable to contact the family liaison officer so, at 7am, he asked two officers to perform this family liaison duty. At 9.10am, they visited Mr Holman's daughter at home and informed her of her father's death.
47. Mr Holman's funeral was held on 9 August. Bure contributed to the cost in line with national guidance.

Support for prisoners and staff

48. After Mr Holman's death, the duty governor, debriefed the staff involved to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
49. The prison posted notices informing other prisoners of Mr Holman'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 Holman's death.

Post-mortem report

50. There was no post-mortem for Mr Holman but his cause of death was recorded as cardio-respiratory failure (a cardiac arrest). This was caused by pulmonary oedema and congestive cardiac failure.
51. Atrial fibrillation, ischaemic heart disease, mitral valve repair, infra-renal abdominal aortic aneurysm were detailed as underlying conditions which led to Mr Holman's death.

Findings

Clinical care

52. The clinical reviewer considered that the care Mr Holman received at Norwich and Bure was equivalent to that he could have expected to have received in the community. He was appropriately referred to external specialists as required, and care plans were in place to look after all his complex concerns. Throughout his time in prison, he was involved in decisions about his care.
53. We are concerned that Mr Holman was discovered at 3.30am on the day he died, but was not officially declared dead until 10.37am. However, we accept that staff at Norwich did all they reasonably could to get an on-call GP to perform this task, and acknowledge the concerns they themselves expressed about this delay. We also acknowledge that the prison is reviewing its healthcare procedures with a view to training nursing staff to certify deaths as they arise.

Mr Holman's location

54. The healthcare departments at Norwich and Bure liaise with each other to ensure prisoners are located appropriately according to their respective health requirements. The Governor explained in subsequent correspondence, that this is purely a medical decision. Prison staff are rarely involved in decisions about the allocation of beds on L wing.
55. In December 2016, nursing staff at Bure were concerned that Mr Holman needed 24-hour nursing care. At that time, Norwich was unable to accommodate him because the prison had insufficient capacity on its healthcare wing, and there was no prisoner suitable for an exchange. Mr Holman remained at Bure for a further three months before he was relocated to L wing at Norwich. While this delay was not ideal, we accept that the two prisons did everything they reasonably could to ensure Mr Holman was appropriately cared for during that time, and expedited his transfer when it became absolutely necessary.
56. We note that open door arrangements were requested for Mr Holman four days before his death but an officer had to unlock his cell door when a nurse became concerned about his health. We understand and accept that the request was put on hold following an improvement in Mr Holman's condition.

Family contact

57. Prison Rule 22(1) states that when a prisoner becomes seriously ill the Governor shall inform the prisoner's next of kin at once.
58. Under Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, "prisons must ensure that an appropriate member of staff engage with the next of kin of prisoners who are seriously ill", and that "time will be of the essence in order to try to ensure that the family do not find out about the death from another source."
59. (PSI) 64/2011 adds that, "where prisoners have a terminal illness or suffer an unpredicted and/or rapid deterioration in their physical health, they must be encouraged to engage with their families or nominated person where it is

appropriate to do so. "...and that the prison should record, "attempts to contact the family or their representatives, including those without success or which were refused or declined and any reasons given."

60. Both Norwich and Bure have confirmed that it is common practice for the family liaison role to remain with the person who originally made contact with the prisoner's family. In this case, Bure appointed an officer as Mr Holman's family liaison officer when he had a health scare in December 2016. She informed Mr Holman's daughter that he was being transferred to Norwich, and gave her the contact details for the healthcare wing there.
61. However, while we understand the case for continuity in family liaison, we are concerned that following Mr Holman's transfer to Norwich, the function was not adapted to address this change in circumstance. There was no family liaison input to the visits of his family, and no documentation covering family contact during his last few months in Norwich. It is reassuring to note that Norwich has reviewed the policy in light of this case, and that in future the prison will be appointing a family liaison officer to all prisoners on L wing, regardless of whether any other officer has been appointed elsewhere.
62. It is clear from (PSI) 64/2011 that the next of kin must be informed when a prisoner becomes seriously ill, not just after his or her death has been confirmed. We are concerned that after Mr Holman was discovered unresponsive in his cell, there was a delay of over three hours before staff at Norwich informed staff at Bure, and asked them to notify his family. Norwich told us that the process was delayed because Mr Holman had not been pronounced dead.
63. There was a further delay of over two and half hours while Mr Holman's family liaison duties were reassigned because his designated liaison officer was unavailable. This meant that Mr Holman's family was not notified of his death for over five and a half hours.

Compassionate release

64. When Mr Holman arrived at Norwich on 2 March, a prison GP discussed compassionate release with him, but he declined to make an application. We consider that the prison acted appropriately in respecting his wishes.

Restraints and security

65. 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 of 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 such 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.

66. Despite Mr Holman's age and frailty, Bure took the decision to restrain him when he visited hospital on 26 January. The decision was reviewed on 27 January, and restraints promptly removed on the instructions of the Duty Governor. Restraints had not been used when Mr Holman went to hospital on 10 January. It is reassuring that Bure did not restrain Mr Holman during his last escort to hospital on 28 February, and we understand that the prison has since reviewed its policy and updated its risk assessment procedures. In light of that work we make no recommendation.
67. We recognise that Norwich did not restrain Mr Holman on the occasions the prison provided the escort for him.

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