Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robin Blewett a prisoner at HMP Norwich on 12 February 2018

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 Robin Blewett died on 12 February 2018 of pneumonia and heart failure at HMP Norwich. He was 51 years old. I offer my condolences to Mr Blewett's family and friends.

I am satisfied that the nursing care Mr Blewett received was equivalent to that which he could have expected to receive in the community.

I am disappointed, however, that although Norwich has a record of delivering good end of life care, the investigation found delays in implementing an end of life care plan in Mr Blewett's case. There were also delays in applying for release on compassionate grounds.

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 **August 2018**

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Summary

Events

1. On 14 December 2007, Mr Robin Blewett was given an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of four years and 225 days. He was sent to HMP Northumberland and then HMP Bure before being transferred to HMP Norwich on 11 September 2017.

2. Mr Blewett arrived at Norwich following a six-week hospital stay due to fluid retention and heart problems. During his hospital stay, he was diagnosed with restrictive cardiomyopathy (disease of the heart muscle). When he was discharged, he was transferred to Norwich because it had 24-hour healthcare and was more suitable for Mr Blewett's needs. Healthcare staff created care plans to monitor Mr Blewett's mobility, sleep, fluid restriction, diet, pressure area care and catheter management.

3. On 2 January 2018, Mr Blewett was told he had a raised white blood count and stage one kidney failure. The next day, his cardiologist advised the prison that they should discuss end of life issues with Mr Blewett. On 4 January, prison healthcare staff discussed his wishes on resuscitation. He agreed to a Do Not Attempt Resuscitation (DNAR) order on 16 January.

4. On 11 February, after a decline in Mr Blewett's health, staff decided that he should be nursed in his bed and an end of life care plan was started. The next day, a nurse found that Mr Blewett was not breathing. At 2.27pm on 12 February, a prison doctor confirmed that he had died.

5. A post-mortem examination showed that Mr Blewett died from bronchopneumonia and congestive cardiac failure. Hypertensive heart disease was a contributory factor.

Findings

6. The clinical reviewer commented that Mr Blewett's heart condition was complex and life-limiting in nature and would have been difficult to manage in any healthcare setting. We agree with the clinical reviewer that the nursing care Mr Blewett received was equivalent to that which he could have expected to receive in the community. We are concerned, however, with some aspects of end of life arrangements.

7. Although Mr Blewett's wishes on resuscitation were discussed with him on 4 January, an end of life care plan was not created until 11 February, the day before his death. The palliative and end of life care plan should have been started at the same time to ensure good advanced planning for his known short prognosis.

8. A Do Not Attempt Resuscitation (DNAR) order was agreed on 16 January. However, this form was not scanned within the SystmOne notes and the form was not fully completed as advised by the Resuscitation Council. Mr Blewett was also not seen by the community palliative care team before he died. This is not equivalent to what is expected in the community.

9. On 23 January 2018, a prison manager emailed the Deputy Healthcare Manager asking that a doctor complete the healthcare report required to apply for early release on compassionate grounds. This report was not completed and Mr Blewett died before the application could be submitted. The prison's Health Operations Manager was unable to explain the reasons for the delay.

Recommendations

- The Head of Healthcare should ensure that palliative and end of life care pathways are implemented in line with NICE guidelines.
- The Head of Healthcare should ensure that DNAR forms are completed in line with Resuscitation Council guidelines.
- The Governor and Head of Healthcare should ensure that applications for early release are progressed without delay.

The Investigation Process

10. 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.

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

12. We informed HM Coroner for Greater Norfolk District 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 Blewett's mother, his next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. We did not receive a reply.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report

Background Information

HMP Norwich

15. HMP Norwich is a multi-function prison, which predominately 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

16. The most recent inspection of HMP Norwich was in September 2016. Inspectors reported that health services were reasonably good overall. An appropriate range of nurse-led clinics included provision for long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease.

17. Inspectors noted that the prison population had a complex range of needs and as a result, permanent health care was available at the prison, including continuous nursing support for some men on L wing where Mr Blewett was based. L wing, which was directly underneath the inpatient facility, offered 24-hour nursing and social care packages for a mainly older group of prisoners with chronic health conditions. Care was of a high standard and prisoners they spoke to valued it. The palliative care pathway was found to be well developed and had achieved external accreditation in recognition of the team's practice standards.

Independent Monitoring Board

18. 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 2018, the IMB reported that 53% of prisoners considered the healthcare provision to be good or better. The Board found that despite the "worn out" appearance of L wing, the end of life care provided by the nursing staff was excellent as they were knowledgeable, caring and compassionate.

Previous deaths at HMP Norwich

19. Mr Blewett was the 26th prisoner to die at Norwich since February 2015, and the 20th to die from natural causes, which is not remarkable, given the prison's function and population. Six prisoners took their own lives over the same period. There have been no deaths since. There were no similarities between the investigation into Mr Blewett's death and the previous deaths at Norwich.

Key Events

20. On 14 December 2007, Mr Robin Blewett was given an Imprisonment for Public Protection (IPP) sentence with a minimum tariff of four years and 225 days. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release.) He was sent to HMP Northumberland.

21. Mr Blewett was transferred to HMP Bure on 21 February 2013. He had type two diabetes, a history of high blood pressure and used a catheter because of a bladder abnormality. On 13 May, he suffered a stroke and was taken to hospital, but returned to Bure on 16 May.

22. On 1 August, Mr Blewett complained of shortness of breath, and pitting oedema (swelling caused by fluid retention) to his left leg and groin. An echocardiogram (an ECG, a test to check the heart's rhythm and electrical activity) showed an atrial flutter (abnormal heart rhythm). A urine test was also abnormal. Mr Blewett was taken to Norfolk and Norwich University Hospital for possible renal or heart failure. He was later diagnosed with a chest infection and urosepsis (bladder infection) with bladder stones. He was discharged back to Bure on 7 August.

23. On 10 August, Mr Blewett complained of swelling to both his legs. A prison GP did a blood test and gave furosemide (a diuretic) to help reduce his fluid retention. Mr Blewett's leg swelling continued and on 27 September, when he became unwell and the swelling spread to his groin he was admitted to hospital. He was discharged the following day with antibiotics and an increased prescription of furosemide with a diagnosis of urine infection and possible heart failure. Mr Blewett weighed 16st 1lb and now needed to be weighed weekly to monitor his fluid retention. On 28 October his weight had reduced to 15st 8lb.

24. In November 2016, Mr Blewett declined a referral to the cardiology department as he 'felt fine', but later agreed and a referral was sent on 25 January 2017. Advice was also sought from a cardiologist at Norfolk and Norwich University Hospital who suggested starting spironolactone (another diuretic).

25. Mr Blewett saw a cardiologist on 16 February. He confirmed that his leg swelling had become progressively worse despite taking his prescribed medication. Mr Blewett also complained of breathlessness on exertion. The cardiologist asked in a letter to the prison that Mr Blewett's frusemide be increased. He also asked that the prison GP monitor Mr Blewett's kidney function and limit his fluid intake to 1 ½ litres a day. He should be weighed regularly and if his kidney function became difficult to manage he should be admitted for inpatient review.

26. On 29 March, Mr Blewett had another cardiology review. Due to ongoing symptoms the cardiologist suspected that Mr Blewett had either pericardial constriction (inflammation of the heart) or cardiomyopathy (disease of the heart muscle). His blood pressure was now relatively low and the cardiologist asked that his Ramipril (blood pressure medication) be reduced. He also requested that Mr Blewett have a magnetic resonance imaging (MRI) scan (a type of scan that produces detailed images of the inside of the body) to review his heart health with a further review in four months' time. Mr Blewett had his MRI scan on 16

May but the results were inconclusive. A computerised tomography (CT) scan, (uses a computer and X-rays to create detailed images of the inside of the body) was arranged to help reach a more definitive diagnosis.

27. Mr Blewett was due to have an operation to remove his bladder stones on 17 May, but this had to be postponed due to his heart condition and excessive fluid retention.

28. On 23 June, a prison GP reviewed Mr Blewett. He was unable to walk long distances due to his leg swelling and came to the healthcare department in a wheelchair. He weighed 16st 10lb. Mr Blewett had a CT scan on 11 July, the results of which would be discussed at his next cardiology review.

29. On 21 July, Mr Blewett complained of shortness of breath and continued swelling of his legs. He was admitted to Norfolk and Norwich University Hospital where he received intravenous (IV) furosemide (to help reduce fluid build-up) and antibiotics when he developed urosepsis, an infection. While in hospital Mr Blewett was diagnosed with restrictive cardiomyopathy. Metolazone (a diuretic) once a week was added to his prescription. Mr Blewett was discharged from hospital on 11 September after spending a total of six weeks as an inpatient. While in hospital Mr Blewett lost more than 3st in fluid (fluid retention) after receiving IV furosemide. The same day, he was transferred to HMP Norwich, which has 24-hour healthcare facilities better suited to his needs.

30. When he arrived at Norwich, Mr Blewett was independently mobile but slow when walking, requiring rest and being short of breath, a symptom of his heart failure and muscle wastage from an extended period in hospital. He weighed 12st 12lbs and healthcare staff created care plans to monitor his mobility, sleep, fluid restriction, diet, pressure area care and catheter management.

31. Mr Blewett had a blood test on 2 October when a urine test showed raised urea and creatinine levels (suggesting his kidneys may not be working as well as they should be). He now weighed 13st 13lbs. A nurse started a fluid balance chart to monitor both the input (how much he was drinking) and output (urine) of fluids. His left lower leg was red, hot and swollen and leaking fluid with pitting oedema. A prison GP reviewed Mr Blewett the following day. His blood test results showed that his potassium and sodium levels were normal and he had lost 3lbs overnight, now weighing 13st 10lb. The GP asked that, as his potassium and sodium levels were fine, staff should continue with the fluid balance chart and monitor his weight.

32. Mr Blewett attended Norfolk and Norwich University Hospital on 24 October to see his cardiologist. He told Mr Blewett that to keep his fluid retention and congestion under control he would need to increase his current metolazone prescription from once a week to taking it on alternate days. He would review him again in three months' time. Mr Blewett saw a prison GP later that day to discuss the cardiologist's recommendations. The GP said that he would wait until he received the hospital letter before making any changes to his prescription.

33. Mr Blewett's weight continued to increase and on 28 October it was recorded as 14st 13lb. On 7 November, Mr Blewett was taken to Norfolk and Norwich University Hospital for a bladder stone removal procedure. However, the

anaesthetist was unhappy for the operation to go ahead explaining that Mr Blewett's excessive fluid retention made him high risk and could result in complications during the procedure. Mr Blewett would need to have a formal anaesthetic pre-operative assessment, and should be admitted as an inpatient prior to the operation. The anaesthetist also noted that, although the cardiologist had said that two weeks earlier that Mr Blewett's metolazone prescription should be increased (to reduce the fluid retention), this had not been done. Mr Blewett's metolazone was increased later that day when he returned to the prison.

34. On 14 December, Mr Blewett weighed 13st 4lb. His weight had reduced following changes to his medication but he was still significantly short of breath and reported a dry cough that was worse on exertion and on lying flat. On 20 December, Mr Blewett's blood pressure was low at 83/53. This reduced further on 23 December when it was recorded as 60/37. A prison GP reviewed Mr Blewett and apart from his blood pressure all other medical observations were within normal range. He told Mr Blewett he would contact his cardiologist to seek advice about his low blood pressure. Mr Blewett now weighed 12st 13lbs.

35. On 2 January 2018, a prison GP received a call from Norfolk and Norwich University Hospital. A recent blood test showed that Mr Blewett had a raised white blood count and stage one kidney failure. The GP telephoned the cardiologist's secretary to express concern about Mr Blewett's deteriorating kidney function and the need to revisit his current diuretics regime. In view of his raised white blood count indicating an infection, the GP prescribed Mr Blewett antibiotics.

36. The cardiologist telephoned the prison GP the next day, 3 January. He said that he thought Mr Blewett's kidney function had deteriorated because of his high dose of metalozone. He asked the GP to reduce Mr Blewett's spironolactone and to stop his metalozone temporarily. This should then allow his kidney function to improve without a deterioration in heart failure control. He said that achieving a balance between his kidney function and heart failure would be difficult and would need to be kept under review with adjustments to his medication. The cardiologist said that, as Mr Blewett's heart condition was incurable and his prognosis was poor, it would be a good time to speak to him about advanced directives (a legal document in which a person specifies what actions should be taken for their health if they are no longer able to make decisions for themselves because of illness or incapacity) including a DNAR. (A Do Not Attempt Resuscitation (DNAR) order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

37. On 4 January, a prison GP spoke to Mr Blewett about his declining kidney function. He discussed a DNAR and he said he would speak to his family before deciding. Mr Blewett later agreed to a DNAR on 16 January.

38. On 28 January, while having routine healthcare observations, Mr Blewett's breathing became laboured, he turned grey in colour and was clammy. He was transferred to a wheelchair and within minutes he recovered. His oxygen levels were normal at 97% and his temperature was 38.1. He refused to go to hospital.

Healthcare staff suspected a hypotensive attack where his blood pressure had suddenly dropped.

39. Mr Blewett had a cardiology review on 30 January. The cardiologist noted that Mr Blewett's weight was increasing (now 13st 7lb) but his kidney function had improved since the reduction of his medication. Mr Blewett had leg swelling up to his thighs and lower back. The cardiologist sent a letter to the prison to explain that Mr Blewett's life expectancy was very short and under normal circumstances he would explore hospice options. He understood that this was probably unlikely given the circumstances and said that a palliative approach would be appropriate. He was aware of the recent hypotensive episode and suggested stopping Mr Blewett's bisoprolol to allow his blood pressure to increase. To try and keep his weight steady, he asked that his metolazone be reintroduced once or twice weekly. The cardiologist said that he did not need to see Mr Blewett again unless requested by the prison.

40. The letter from the cardiologist arrived at the prison on 7 February. A prison GP changed Mr Blewett's prescription in line with the cardiologist's suggestion the next day. He also sent a referral to the Community Specialist Palliative Care Team asking for advice on future management. In his referral he said that Mr Blewett had a poor prognosis and required end of life care. The palliative care team acknowledged the referral the following day and said they would discuss Mr Blewett at their multidisciplinary meeting before arranging a visit.

41. On 11 February, Mr Blewett fainted. He was also now incontinent. It was decided that Mr Blewett should now be nursed in his bed and an end of life care plan was started. Mr Blewett had full mental capacity and was aware of his deterioration in health. He told healthcare staff that he wanted early release on compassionate grounds so he could transfer to a hospice to spend more time with his family.

42. At about 1.46pm on 12 February, a nurse asked a prison GP to see Mr Blewett as his health appeared to have deteriorated. His oxygen levels were on the low side at 94% and his catheter did not appear to be working. The nurse also contacted the Community Palliative Care Team to chase up Mr Blewett's referral. A healthcare assistant went to check on Mr Blewett at 2.10pm and found he was not breathing. Mr Blewett had agreed to a DNAR order, so resuscitation was not attempted. At 2.27pm, a prison GP confirmed that Mr Blewett had died.

Contact with Mr Blewett's family

43. Mr Blewett's mother, his next of kin, lived in Belgium. On 17 January 2018, the Head of Safer Prisons, acting as the family liaison officer, telephoned Mr Blewett's mother to introduce herself and discuss her son's health. Mr Blewett's mother asked to be contacted by phone with any updates on his condition.

44. On 22 January, the family liaison officer arranged for a prison nurse to speak to Mr Blewett's mother on the phone to answer a number of questions she had. On 3 February, Mr Blewett's mother, stepfather and sister travelled to the UK to visit him.

45. A second visit was arranged for 1 March but Mr Blewett died on 12 February before the visit could take place. The family liaison officer telephoned Mr Blewett's mother that afternoon to inform her of her son's death. She kept in regular contact to help arrange Mr Blewett's funeral and offer support.

46. Mr Blewett was cremated on 5 March. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

47. After Mr Blewett's death, the Head of Safer Prisons 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 Blewett'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 Blewett's death.

Post-mortem report

49. A post-mortem examination showed that Mr Blewett died from bronchopneumonia and congestive cardiac failure. Hypertensive heart disease was a contributory factor.

Findings

Clinical care

50. Mr Blewett had significant health needs. His heart condition was of a complex and life limiting nature and the clinical reviewer acknowledges that this would have been difficult to manage in any healthcare setting.

51. The primary cause of death for Mr Blewett was bronchopneumonia and congestive heart failure. Prior to his death there were no recorded symptoms to suggest that Mr Blewett had a chest infection.

52. The post-mortem report showed that hypertensive heart disease was also a contributing factor to his death. Mr Blewett's blood pressure was monitored while at Norwich with evidence of good control for some time prior to his death.

53. Appropriate care plans were created and these were kept under review with new ones being created when new health issues arose.

54. We consider that the nursing care Mr Blewett received was equivalent to that which he could have expected in the community. However, some aspects of end of life arrangements were not equivalent, as set out below. In addition, the clinical reviewer has made a number of other findings and recommendations which are not covered in this report but which the Head of Healthcare will need to address.

End of Life Care

55. On 3 January 2018, the cardiologist said that end of life issues should be discussed with Mr Blewett. A prison GP discussed a DNAR order with Mr Blewett on 4 January 2018 but an end of life care plan was not created until 11 February 2018, the day before Mr Blewett's death. The clinical reviewer considers that the palliative and end of life care plan should have been started at the same time to ensure good advanced planning for his known short prognosis.

56. A DNAR order was agreed on 16 January. However, this form was not scanned into Mr Blewett's SystmOne notes and had to be requested from healthcare separately during the investigation. The form was not fully completed as advised by the Resuscitation Council. The prison GP did not complete any details for the reason for the DNAR decision or the record of discussion of decision. For good clinical governance this needs to be addressed.

57. The cardiologist advised that a palliative care referral should be considered when he reviewed Mr Blewett on 30 January, due to his rapid deterioration. A referral was made on 7 February but Mr Blewett was not seen by the community palliative care team before he died. The GP referral to community palliative care services was not sent until a week after Mr Blewett was seen by the cardiologist. This is not equivalent to what is expected in the community. We make the following recommendations:

    The Head of Healthcare should ensure that palliative and end of life care pathways are implemented in line with NICE guidelines.

The Head of Healthcare should ensure that DNAR forms are completed in line with Resuscitation Council guidelines.

Restraints

58. 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.

59. Mr Blewett was still able to walk but used a wheelchair to attend his hospital appointments due to mobility problems caused by fluid retention in his legs. The prison sought healthcare opinion on the appropriateness of restraints for all Mr Blewett's escorts to hospital.

60. Mr Blewett was restrained by an escort chain for cardiology appointments between October and November 2017. (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.) In October he was assessed by the prison as being a medium risk to the public and of escape. When he was reassessed in preparation for his next appointment on 1 November his risk had reduced, now being low risk. The level of restraints used during an appointment on 8 December 2017 is unclear as the risk assessment is incomplete and the prison escorting log does not specify the type of restraint used. Healthcare opinion was sought and there were no medical objections to the use of restraints.

61. On 1 February, Mr Blewett's mobility had reduced significantly. He was no longer able to stand unaided. Mr Blewett was not restrained during this escort.

62. Mr Blewett had a Sex Offender Prevention Order against him which prevented him from approaching, seeking or communicating by whatever means directly or indirectly with any child or young person under 18 years. In 2014 intelligence suggested that, following a Parole Board decision to not direct his release, Mr Blewett could use illness as an opportunity to abscond from hospital.

63. A sentence planning and review report dated 4 October 2017 showed that Mr Blewett had completed the sex offender treatment programme which should have reduced the high risk of serious harm he presented to children. However, it said that not all his treatment needs would have been addressed by this programme and therefore further treatment was required to reduce the high risk of serious harm Mr Blewett presented. Mr Blewett had been unable to complete the work required due to ill health. His Offender Supervisor concluded that, while this work remained outstanding, Mr Blewett's risk of serious harm would not be manageable in the community if he was to make a full recovery.

64. Mr Blewett was not an elderly man and although he was unwell, he was mobile up to February 2018. He presented a high risk to children. On balance, we consider the level of restraints used prior to February was appropriate. The prison reviewed the use of restraints when Mr Blewett's mobility declined

significantly in February and decided he should no longer be restrained. We consider that the prison reviewed the use of restraints appropriately.

Compassionate release

65. 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 indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. Among the criteria is that the risk of reoffending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and 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 HM Prison and Probation Service (HMPPS).

66. On 17 January 2018, Mr Blewett's Offender Supervisor sent an email to PPCS to seek advice about applying for early release. On 23 January, the family liaison officer emailed the Deputy Healthcare Manager asking that they complete the healthcare report required. She followed this email up on 30 January and 12 February when the report had not been received. Mr Blewett died before the application for early release could be completed.

67. The prison's Health Operations Manager was asked to explain the delay in completing the early release paperwork. He was unable to do so but commented in an email dated 25 April, that "there was clearly a failure in the way the paperwork moved through the system and I have asked the team to review this urgently so there is an audit trail on initiation progression, discussion and action". Nevertheless, we make the following recommendation:

The Governor and Head of Healthcare should ensure that applications for early release are progressed without delay.

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