Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Howell a prisoner at HMP Norwich on 13 August 2017

A report by the Prisons and Probation Ombudsman

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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.

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 Trevor Howell died on 13 August 2017 of sepsis, pneumonia and dementia complications at HMP Norwich. He was 72 years old. We offer our condolences to his family and friends.

Mr Howell generally received a good standard of care for his chronic health conditions.

However, we share the clinical reviewer's concerns about the delays in obtaining a memory assessment and the covert administration of his medication. This meant that, overall, the care he received was not 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 staff and prisoners involved in my investigation.

Elizabeth Moody
Acting Prisons and Probation Ombudsman **February 2018**

Contents

Summary

Events

1. On 5 November 1973, Mr Trevor Howell was sentenced to life in prison for murder. After spending time in a number of different prisons, he was transferred to HMP Norwich on 22 December 2016.

2. Staff noted that he had a number of chronic health problems, including type 2 diabetes, ischaemic heart disease, hypertension and asthma. He was a smoker who declined help to stop smoking. Healthcare staff at Norwich created care plans to manage Mr Howell's health concerns.

3. Staff monitored his memory and cognitive abilities, as he was occasionally confused. He also saw a prison physiotherapist. There was progressive deterioration in his general health, including refusing food and swallowing problems.

4. Healthcare staff sent him to hospital on 21 July. Doctors found that he had a chest infection, pneumonia, a urinary tract infection and a number of pressure sores. Mr Howell received antibiotics and intravenous fluids.

5. Mr Howell returned to Norwich and he was nursed with open door arrangements in place (his cell door was not locked). Nurses made Mr Howell comfortable and monitored him. He deteriorated and became unresponsive and died in the early hours of 13 August.

Findings

6. The clinical reviewer said the care Mr Howell received was satisfactory but was not equivalent to that which he could have expected to receive in the community. He should have received prompt attention from the memory clinic and other health and social care teams.

7. We are satisfied that the prison appropriately monitored Mr Howell's mental and physical condition and made adjustments to ensure that he was comfortable. They created an older person's care plan. We agree with the clinical reviewer that when Mr Howell was unable to make decisions about his care and treatment, healthcare staff should have contacted an advocacy service and should have recorded the decisions they made to administer his medication in his food.

Recommendations

- The Head of Healthcare should ensure that staff understand when to contact an independent mental capacity advocate.
- The Head of Healthcare should ensure that there is a clearly defined policy for the covert administration of medication and that the reasons for doing so are fully recorded.

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 her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Howell's prison and medical records.

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

11. 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.

12. The investigator contacted Mr Howell's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She had no questions or concerns for us to consider.

13. Mr Howell's family were informed the initial report was available, but did not wish to receive a copy or make any comment.

14. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

Background Information

HMP Norwich

15. HMP Norwich is a local 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.

16. L Wing is a 15-bed unit that houses elderly men. The wing has 24 hour nursing and support from healthcare assistants. Social care support is also available. The prisoners have outdoor access all day, with a patio and pond area.

HM Inspectorate of Prisons

17. The most recent inspection of Norwich was in December 2016. Inspectors reported that the prison had made progress since their last inspection and the leadership team was strong and stable. Relationships between staff and prisoners were good and, overall, healthcare services were reasonably good. While inspectors said that the healthcare centre was in need of refurbishment, they were impressed with the support that prisoners received from prison and healthcare staff.

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 February 2017, the IMB reported that a high number of prisoners with mental health issues dominated the healthcare unit's caseload. Virgin Care was generally considered to provide good social care for prisoners on L wing.

Previous deaths at HMP Norwich

19. Mr Howell's was the fifth death from natural causes at HMP Norwich since the beginning of 2017. Given the palliative function the prison provides this is not a disproportionate number. There were no similarities between Mr Howell's case and the previous four deaths. There have been two further deaths since Mr Howell died which are under investigation.

Key Events

Background

20. On 5 November 1973, Mr Trevor Howell was sentenced to life in prison for murder. During his sentence, Mr Howell developed a number of chronic health problems including type 2 diabetes, ischaemic heart disease, hypertension and asthma. He was a smoker who declined help to stop smoking.

21. In 2012, Mr Howell was at HMP The Verne. His prison records note concerns that he was forgetting to collect and take his medication, and was having problems caring for himself. By 2013, he was at HMP Littlehey and his memory was becoming worse. He refused to attend many GP and hospital appointments. He signed disclaimers to say that he was refusing treatment. He said that hospital appointments were a waste of time and nothing new was said. Healthcare staff saw him frequently.

22. On 4 June 2015, Mr Howell was transferred to HMP Warren Hill. In July 2015, a prison GP completed a memory test as Mr Howell did not know the date and was forgetful. She diagnosed him as having declining memory function. Healthcare staff completed a referral to a memory clinic.

2016

23. In September 2016, a senior nurse attended a meeting with the commissioner for social care at Suffolk County Council due to concerns about Mr Howell's significant social care needs. She said he did not have capacity to retain information or consider information due to his memory problems, and he was doubly incontinent. She said that he needed a social care assessment and a transfer to another prison to meet his needs. Discussions began with prison managers about the possibility of Mr Howell transferring to HMP Norwich.

24. Later that month, a senior nurse contacted an advocacy service who said that they would liaise with the social care team to complete an assessment. The social care assessment visit was completed on 5 October and the assessor recommended 24 hour care for Mr Howell due to the unpredictable nature of his needs. She said she would complete a Social Services report but this was not received.

25. On 25 October, a prison GP referred Mr Howell to a memory clinic but there was a considerable delay as the clinic was initially unable to offer its services at the prison. This was because there was no contract for them to provide a service at the prison as they offered a community service. They offered to provide telephone advice. Mr Howell was on a waiting list for a place at HMP Norwich, which was considered to have better facilities for elderly, frail prisoners.

HMP Norwich

26. On 22 December 2016, Mr Howell was transferred to HMP Norwich. At his initial health screen, a nurse noted Mr Howell's health problems. He was doubly incontinent, needed social care and appeared confused. The nurse referred him to a prison GP.

27. A prison GP reviewed Mr Howell and noted that he was unable to remember when he arrived at the prison. The GP diagnosed him as having memory impairment and a depressed mood. A nurse created an older person's care plan to help Mr Howell maintain his hygiene, check for any changes in his mobility, check for pressure sores and assist him with his eating and drinking. Healthcare staff saw him several times a day.

28. In April 2017, Mr Howell had several periods when he refused to take any medication or get out of bed. On 16 April, a nurse noted that there was an acute deterioration. Mr Howell was unable to urinate, appeared chronically confused and was unable to stand. She arranged for a non-urgent ambulance to take Mr Howell to hospital to investigate the reasons. Hospital staff said that Mr Howell had diarrhoea and they were concerned about his confused state.

29. On 18 April, hospital staff discharged Mr Howell. A prison GP examined him on his return to Norwich. He noted that Mr Howell still had diarrhoea so should not have any contact with other prisoners until this stopped, but should have increased fluids. Later that evening, Mr Howell collapsed in his cell. A nurse called for an ambulance. Paramedics took Mr Howell back to hospital.

30. On 19 April, hospital staff discharged him back to the prison, where a nurse checked him. She noted that he had a small knee abrasion and was still confused. She completed a falls risk assessment. That day, a nurse from the continence clinic examined Mr Howell. She suggested that his medication should be reviewed to check if this was a cause of his ongoing diarrhoea. Mr Howell said that he did not want any bowel investigations.

31. A prison GP completed the review, and noted that Mr Howell looked frail and dishevelled. Mr Howell told him that he was not in pain and could move slowly. The prison GP said that Mr Howell should be monitored.

32. On 27 April, Mr Howell slipped in his cell. A nurse called an ambulance. Paramedics arrived and examined Mr Howell. He had a bump on his forehead and a grazed arm. He did not go to hospital. The nurse arranged for a GP review and completed a falls assessment. A prison GP completed the review later that day. He said that Mr Howell was elderly, frail and had dementia. He said that the physiotherapist should consider if mobility aids would help. The physiotherapist concluded that no aids were needed.

33. On 19 May, a nurse noted that staff from the memory clinic had completed an assessment and concluded that Mr Howell had vascular dementia and would need a place in a specialist dementia unit on release.

34. On 20 June, a nurse helped Mr Howell to use the toilet and noted that his penis was bleeding. The results of a urine dipstick test showed that Mr Howell had a urinary tract infection. A prison GP prescribed trimethoprim (an antibiotic).

35. From July, there were increasing records of Mr Howell hardly eating, refusing his medication and becoming more confused. Mr Howell was nursed in line with national instructions on open door arrangements (which meant that his cell door was not locked). Nurses turned him every two hours in his bed and elevated his

legs. They noted his fluid intake was poor as he could only manage a few sips of fluid throughout the day.

36. On 8 July, a nurse noted that Mr Howell refused all meals and only ate a small yoghurt. Healthcare staff crushed his medication into the yoghurt.

37. On 21 July, a prison GP examined Mr Howell and noted that Mr Howell was struggling to take anything orally as he choked when he drank. He said Mr Howell was barely able to communicate and was clinically dehydrated. Healthcare staff arranged for a non-urgent ambulance to take Mr Howell to hospital.

38. Hospital staff diagnosed dehydration, acute kidney injury as a consequence and a lung infection (aspiration pneumonia). The hospital consultant nephrologists (kidney specialists) said that this was likely due to his poor swallow mechanism because of his progressive dementia. Mr Howell also had a urinary tract infection and a number of pressure areas on his skin. They gave him intravenous fluids and antibiotics to treat these concerns. Hospital staff conducted a mental capacity assessment and concluded that Mr Howell lacked capacity. His prognosis was poor.

Events in August 2017

39. Mr Howell's condition improved slightly and on 4 August, he returned to Norwich. Hospital doctors told prison healthcare staff that no further treatment was possible. On 7 August, he returned to hospital as his condition continued to decline. The hospital palliative care team noted that Mr Howell should have treatment for end of life care. As he appeared to be in pain, they recommended the use of a syringe driver to assist with his pain management. Hospital staff completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) form.

40. On 10 August, hospital staff discharged Mr Howell for end of life care. A nurse noted that on return to the prison, his breathing appeared laboured. Mr Howell could not communicate, eat or drink. She noted that the DNACPR was in place and referred him to a GP.

41. A prison GP reviewed Mr Howell and noted that he had advanced dementia and should receive palliative care. Nurses made Mr Howell comfortable and monitored him hourly.

42. When a nurse checked on Mr Howell at 1.26am on 13 August, she noted that he appeared to be taking his final breaths. She asked a senior nurse to assist her. When his breaths stopped, a nurse noted that he had no pulse. The staff at Norwich were fully aware of the DNACPR and did not attempt resuscitation when they found him unresponsive. A nurse removed the syringe driver protective cover. She asked the duty GP to attend. She contacted the duty manager, and the prison managers. The duty GP, certified Mr Howell's death at 9.40am.

Contact with Mr Howell's family

43. On 5 July 2017, Norwich appointed the Head of Safer Prisons and Equalities, as the family liaison officer (FLO) as Mr Howell's health was deteriorating. There was information about Mr Howell's sister in his records, but he had lost contact

with her and had not given Norwich any next of kin details. He did not have any visits or make any telephone calls. The prison contacted the police and Mr Howell's solicitor but neither had any contact details for his sister.

44. The day after Mr Howell's death, the FLO liaised with the Coroner to place an advertisement in a local paper to ask any family members to contact the Coroner. From the advert, Mr Howell's sister contacted them. The FLO contacted her and explained what had happened. Mr Howell's sister had not seen him for several years but agreed to act as his next of kin.

45. The prison arranged and paid for Mr Howell's funeral, which was held on 8 September.

Support for prisoners and staff

46. After Mr Howell's death, the FLO debriefed the staff involved in Mr Howell's care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Howell'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 Howell's death.

Cause of death

48. The Coroner confirmed that the cause of Mr Howell's death was sepsis, recurrent chest infection secondary to aspiration pneumonia, chronic obstructive airway disease and general debility/frailty caused by severe mixed dementia (Alzheimer's disease and a component of vascular dementia), type 2 diabetes and essential hypertension.

Findings

Clinical care

49. The clinical reviewer said that the care Mr Howell received in prison was satisfactory. Prison and healthcare staff cared for and supported Mr Howell in difficult and challenging circumstances, as he did not comply with his treatment and declined to attend many of his appointments.

50. However, the clinical reviewer said that Mr Howell's care was not equivalent to that which he could have expected to receive in the community as he should have received prompt attention from the memory clinic and other health and social care teams.

51. The clinical reviewer said that Mr Howell's physical health began to deteriorate in 2012 and, by 2013, his GP assessment of cognition indicated that he had cognitive impairment.

Mental health needs

52. The Care Act 2014 outlines the social care needs of elderly and infirm prisoners. The Act makes local authorities responsible for assessing and meeting the eligible social care needs of adult prisoners once prisons refer prisoners to their services. The clinical reviewer said that the prison healthcare teams struggled to obtain a memory assessment from the Community Memory Assessment Service. The initial discussions started in August 2015 and they did not visit until May 2017. The clinical reviewer also said there were delays in obtaining other health and social care assessments.

53. Our Learning Lessons Bulletin on dementia, published in July 2016, acknowledged the challenges of managing elderly prisoners with dementia in the prison setting and highlighted the need for personalised care.

54. Over time, Mr Howell lost the capacity to make important decisions about his care and treatment. His mental capacity was frequently monitored. Care plans were in place covering his needs. The emphasis was on maintaining his comfort and keeping him pain free. Staff gave thought to the best location for Mr Howell and the move to the inpatient unit at Norwich ensured healthcare staff could provide the 24 hour care he needed. However, the clinical reviewer said that, at Norwich, when it was felt Mr Howell did not have capacity to make decisions, the local Independent Mental Capacity Advocate (IMCA) service could have provided support. There was no evidence that staff considered this option. We therefore recommend that:

    The Head of Healthcare should ensure that staff understand when to contact an independent mental capacity advocate.

Administering medication

55. Towards the end of Mr Howell's life, healthcare staff administered his medication by crushing it in yoghurt. The NHS England HM Prisons Medicines Standards says that providers need to consider current legal and best practice frameworks

and fully assess the patient's capacity to refuse their medication before undertaking covert administration. The clinical reviewer said that it was unacceptable that there was no documentary evidence in Mr Howell's clinical record to support such administration or explain why it was done covertly, without assessment. We agree and recommend that:

The Head of Healthcare should ensure that there is a clearly defined policy in place for the covert administration of medication and that the reasons for doing so are fully recorded.

56. On at least two occasions, there were significant delays in ambulances responding to transfer Mr Howell to hospital, one of over 12 hours. The clinical reviewer has raised a number of concerns, including about the length of time it took the ambulance to arrive, which the Head of Healthcare will need to address.

Compassionate release

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

58. Hospital doctors said Mr Howell's prognosis was poor in July 2017. In August, they said that no further treatment was possible. However, as Mr Howell had not received a terminal diagnosis or a confirmed prognosis, we consider it reasonable in the circumstances that compassionate release was not considered.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141