Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dennis Dean a prisoner at HMP Norwich on 18 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*

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 Dennis Dean died of cardio respiratory failure at HMP Norwich. He was 85 years old. I offer my condolences to Mr Dean's family and friends.

Healthcare staff appropriately monitored his physical and mental condition (which at times fluctuated but eventually took a sustained downward turn). They considered how best to keep him safe and comfortable and arranged hospital admissions and transfers between the prison establishments where necessary.

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 4 March 2011, Mr Dennis Dean was convicted of sexual offences and on 25 March sentenced to thirteen years imprisonment. He was sent to HMP Highdown. Staff noted he had asthma, high blood pressure and had suffered a stroke in the past.

2. Mr Dean transferred to Bure on 10 December 2014 and then to Norwich on 26 May 2015 after a fall had led to him being hospitalised. Norwich was considered to have better facilities for elderly, frail prisoners. Staff monitored his memory and cognitive abilities as hospital staff had voiced some concerns that he was occasionally confused and he saw a prison physiotherapist. On 7 August 2016, Mr Dean had to transfer back to Bure because his bed at Norwich was needed for a palliative care case.

3. Staff at Bure continued to monitor Mr Dean's memory and there were more incidents of confusion and falls. However, he did seem to present quite differently from week to week. On 21 October, a mental health nurse examined him thoroughly and decided he was mentally well enough to discharge from the team's caseload. On 21 November, a prison GP felt he was confused and when a nurse conducted a medication in possession assessment a week later, she concluded he was too high risk to have control of his own medication.

4. On 3 December, Mr Dean banged his head and seemed slightly muddled. A nurse arranged for hospital to admit him as aside from his confusion he had inflamed legs and a weeping foot. The hospital kept him in overnight and discharged him with medication for his legs. Staff at Bure reopened negotiations with Norwich for him to transfer back there. Mr Dean was readmitted to hospital on 13 December for two days because of more issues with his feet. On 15 December he was discharged back to L Wing at Norwich. After a further fall on 9 January 2017, he was diagnosed with Alzheimer's.

5. Mr Dean continued to deteriorate and during a further hospital admission from 5 – 11 May 2017 a Do Not Attempt Resuscitation Order was arranged with the consent of Mr Dean's family. From 18 May 2017, Mr Dean was nursed in line with open door arrangements (his cell door was not locked). On 6 July, in conversation with Mr Dean's family, a decision was made that he would not have any more hospital treatment and he eventually died on 18 July.

Findings

6. The clinical reviewer was content that the care Mr Dean received was equivalent to that which he could have expected to receive in the community. We are satisfied that the prison appropriately monitored his mental and physical condition and made adjustments or sought hospital admissions or prison transfers when appropriate.

The Investigation Process

7. 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.

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

9. We informed HM Coroner for Greater Norfolk District of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.

10. The investigator contacted Mr Dean's stepson to explain the investigation and to ask if he had any matters they wanted the investigation to consider. He did not respond.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Norwich

12. 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.

13. L Wing is a 15-bed unit that houses men with palliative care needs. The wing has 24-hour nursing and healthcare assistant support. Social care support is also available. All the men have access to the outside all day, with a patio and pond area. Healthcare also arrange for Age UK to attend and a group called the 'Forget me Nots', who work with prisoners with dementia. Community palliative care services who also attend the unit.

HM Inspectorate of Prisons

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

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to February 2017, the IMB reported that a high number of prisoners with mental health issues dominated the healthcare unit's caseload. A survey conducted by the board revealed that 57% or prisoners thought it was easy to get a GP appointment and the target was a two day wait – although almost half were later than this. Some hospital appointments had to be cancelled due to a lack of escorts. Virgin care were considered to generally provide good social care for prisoners on L wing.

Previous deaths at HMP Norwich

16. Mr Dean's was the fourth death from natural causes at HMP Norwich since the beginning of 2017. There are no similarities with Mr Dean's case.

Key Events

17. On 4 March 2011, Mr Dennis Dean was convicted of sexual offences and on 25 March sentenced to 13 years imprisonment. He was sent to HMP Highdown. Staff noted he had asthma, high blood pressure and had suffered a stroke in the past.

18. On 16 December 2014, Mr Dean transferred to HMP Bure. A nurse noted his medical history (including an incident six or seven years prior to prison where his heart had stopped beating), that he currently wore hearing aids in both ears and had asthma and hypertension. She conducted a secondary screen on 18 December and noted Mr Dean did not smoke cigarettes and that members of his family suffered from asthma and hypertension. A prison GP prescribed salbutamol (an inhaler), beclometasone (nasal spray) and rampiril (for high blood pressure) and noted that Mr Dean did not have any signs of cognitive or memory issues that might affect his ability to manage medications.

19. On 5 January 2015, the clinical support access role completed an older person's NSF assessment. The 'National Service Framework for Older People' sets quality standards for health and social care. It helps older people to stay as healthy, active and independent as possible. As a result, he opened an over 55's care plan stipulating that Mr Dean should be given an outlet to discuss any issues affecting him and referrals should be made to outside agencies if necessary (for issues such as podiatry, continence and hearing).

20. On 22 May, Mr Dean was admitted to hospital after he had had a fall. He cut his head and had heavy bruising.

21. On 23 May 2015, a nurse from the hospital contacted a nurse at the prison to tell her that Mr Dean was very confused, not knowing where he was. A CT (computerised tomography) scan had not revealed anything remarkable. The prison nurse noted that there was nothing in the records about any previous issues of this kind. She telephoned the ward for an update the next day and staff told her Mr Dean required assistance with washing and dressing and had a catheter. Given the obvious deterioration in his condition, healthcare staff at Bure arranged for Mr Dean to be discharged to HMP Norwich where there were better facilities for caring for older prisoners.

22. L Wing is a 15-bed unit that houses men with palliative care needs. The wing has 24-hour nursing and healthcare assistant support. Social care support is also available. L Wing prisoners have access to the outside all day where there is a patio and pond area. Age UK representatives attend the wing as do a group called 'The Forget Me Nots', who work with prisoners with dementia.

23. On 26 May 2015, Mr Dean was discharged from hospital and transferred for management of his physical needs to L Wing at HMP Norwich. His first night screen by a nurse, was thorough and included assessment of his mobility (could walk unaided but not steadily) and his skin condition. Another nurse noted that he should be referred to the mental health team if he showed signs of depression or dementia and his DNAR status should be updated every 6 months or at Mr Dean's request. (A Do Not Attempt Resuscitation order was ultimately organised

for him by the hospital and his family on 5 May 2017 when he was admitted there.)

24. On 28 May, a nurse noted that she had checked Mr Dean's memory and he was aware of where he was, the month, time, his own age and exact date of birth.

25. On 29 May, Mr Dean went back to hospital for an X-ray because he said he still had pain in his shoulder following his fall. The hospital confirmed that he had in fact fractured his arm. A physiotherapist saw Mr Dean on 19 July. He was happy using a walking frame at that time and took on board the exercises she taught him.

26. On 7 August, Mr Dean transferred back to Bure because his bed on L Wing was needed for another prisoner who had palliative care needs. Healthcare staff conducted similar memory checks to those done at Norwich (in December 2015 and February and April 2016) and Mr Dean was able to give correct answers.

27. On 25 April 2016, a prison GP saw Mr Dean for a medication review and noted he was using a wheelchair by this time. Further notes indicate he went on to use a mixture of a walking frame and a wheelchair.

28. On 12 May, Mr Dean fell when he tripped over an electrical cord on the wing. He cut an eyebrow and his finger and passed out when a nurse was dressing it. Another nurse had to give him oxygen to help him regain consciousness.

29. On 13 May, a nurse saw Mr Dean for a general 'check'. He was able to answer the usual questions about the date and where he was etc but she did note that his short-term memory seemed impaired. She did a memory test with Mr Dean on 15 June and asked questions about important events and individuals as well as the usual questions about the date. He did not have any problems answering the questions and she did not repeat her previous conclusions about his short-term memory. (A similar test in a July did not reveal any issues either.)

30. On 6 September, a healthcare assistant went to see Mr Dean in his cell as he had not been to the pharmacy to collect his medication. She recorded in his notes that he seemed confused, refused his medication and would not get up. He kept saying that he was 'in the middle of a situation that required an officer'. It is not known what he meant or if she called for an officer but she did go back to see Mr Dean two hours later (at approximately 11am) and he was up and dressed.

31. A prison GP saw Mr Dean the next day and Mr Dean told him he was being bullied by certain individuals on the wing. The doctor took this seriously and did not think the claims were a result of any mental issues. He noted that he had suggested to a colleague that the matter be discussed with prison staff and Mr Dean moved but it is not clear exactly what happened but subsequent reports from wing officers suggest he was in fact quite confused.

32. On 19 October, officers contacted healthcare as they were concerned about Mr Dean's increasing confusion. A nurse visited him in his cell and he expressed concerns that other offenders were 'after him' and he had to keep his cell door locked. She assured him that he was safe. She noted that offenders on the same wing had in fact told healthcare staff that they were worried about him. On

20 October, a nurse noted that she saw Mr Dean and arranged for someone to see him the next day to run a dementia test.

33. On 21 October, a mental health nurse examined Mr Dean. She asked him lots of questions about himself including his history and his interests. She closely observed the way he interacted, his appearance and the condition of his cell. She concluded there were no concerns. On 31 October, she discharged him from the mental health team's caseload as after discussion with colleagues they felt he did not present any risks and his mental state was stable. A subsequent memory test on 11 November did not reveal any obvious issues. However, on 21 November, Mr Dean told a prison GP that he was confused and worried that he had a 'large duvet'. The doctor physically examined him but didn't think he was dehydrated (which might cause confusion) and thought he seemed alert and rational. He arranged for bloods to be taken which showed low sodium levels which can also contribute to confusion. However, the records do not show that he did anything further at that point in response to those results.

34. On 28 November, a nurse conducted an assessment to decide if Mr Dean could cope with having his own medication in possession. She noted he was vulnerable to bullying and that he had some difficulty understanding the responsibilities outlined in the patient agreement. She concluded that he was 'too high risk' and should not be in charge of his own medication.

35. On 3 December, Mr Dean saw a nurse and she noted that he had banged his head and seemed slightly muddled - she also noted that this was not unusual for him. She noted that the low sodium in his blood taken in November and more recent results showing a further drop concerned her. She called 111 for advice and the GP on the line told her it would be okay for Mr Dean to stay in the prison overnight. She was worried he might have further falls and asked wing officers to check on him overnight. However, later that day she decided to arrange an emergency admission to the hospital because she felt he was even more confused and his physical condition was also deteriorating (he had been seen previously for swollen legs which were now inflamed and in addition his foot was weeping pus). The hospital returned him the hospital the next day with some medication for his foot. Staff arranged for him to have a fall mat by his bed and, in time, a sensor mat in his bed (so they knew when he'd left it). Staff also lowered his bed.

36. On 7 December, two nurses discussed with a prison GP their concerns and feelings that Mr Dean should be cared for at HMP Norwich. A nurse contacted L Wing and a possible prisoner 'swap' was discussed but more detailed discussions were required with Norwich staff.

37. Before the transfer was confirmed, Mr Dean was admitted to hospital on 13 December. His legs and feet had deteriorated and he was not responding to antibiotics. When he was discharged on 15 December, it was to L Wing at HMP Norwich.

38. On 15 December, a nurse and a prison GP did the reception health screen and noted that Mr Dean knew his own birthday and the year but was confused about which month it was. He also got confused about who the prime minister was.

39. On 9 January 2017, Mr Dean had another fall and was unconscious when a prison officer found him. He was taken to A&E and admitted until 13 January. He had suffered a head injury from the fall which was thought to have been caused by an epileptic seizure - although again a CT scan revealed nothing new. During his stay, hospital staff also diagnosed dementia 'probably of the Alzheimer's type' and said that he had had 'seizures'. He was prescribed medication to treat epilepsy.

40. On 8 February 2017, prison healthcare received feedback from the hospital falls clinic (it is unclear what date the actual appointment was). The specialist suspected that Mr Dean's falls were due to his age and perhaps his past stroke. The specialist also advised that the prison prescribe folic acid (which they did) and Mr Dean continue with exercises that the hospital physiotherapist was going to give him that day.

41. On 28 March, Mr Dean had a cardiac appointment at a hospital and in April the specialist wrote to the prison advising that although Mr Dean's arteries were narrowed, surgery was not in his interests given his frailties.

42. On 5 May, a nurse noted that Mr Dean had another fall and was found unresponsive by a healthcare assistant. Mr Dean had suffered a large seizure and was taken to A&E and admitted to hospital. A hospital consultant discussed a Do Not Attempt Resuscitation order with Mr Dean's family who agreed that to not try to revive him if he lost consciousness was in his best interests, and the paperwork was signed. Mr Dean was discharged on 11 May on antibiotics as he had acquired pneumonia in hospital.

43. Mr Dean was very weak. On 17 May, a nurse noted he could stand but only walk a short distance if supported. Healthcare staff negotiated that Mr Dean's cell be left open at all times to ensure they could deliver care as efficiently as was required. The open-door policy came into effect on 18 May.

44. On 4 July, a prison GP saw Mr Dean in his cell as nurses had reported that he was refusing to take his medication. The doctor established that Mr Dean was not confused and explained to him the importance of taking his tablets.

45. On 6 July, a prison GP noted that Mr Dean seemed weaker and that he had opted for no more hospital treatment. His family and the hospital were involved in the decision. The doctor also noted that Mr Dean's breathing was heavier and he treated him for a suspected chest infection with antibiotics and short bursts of oxygen.

46. By 15 July, Mr Dean had weakened further and was only able to take very small sips of fluid. He was nursed intensively and received family visits but he was unable to recover.

47. On 18 July at 4.30am, a nurse was doing her regular checks and noticed Mr Dean was not breathing. As he had a DNAR in place resuscitation was not attempted. An on-call GP verified Mr Dean's death at 7.18am.

Contact with Dean's family

48. The prison's family liaison officer (FLO) contacted Mr Dean's next of kin, his stepson, on 10 July 2017 to introduce herself as the point of contact given Mr Dean's rapidly failing health. Mr Dean's stepson had been kept updated by healthcare staff in the past regarding his stepfather's fluctuating health. The FLO arranged a visit for Mr Dean's stepson to L Wing, but he asked the prison to tell him of his stepfather's actual death, when it occurred, by telephone. On 18 July at 6.00am, the FLO telephoned Mr Dean's stepson to inform him of Mr Dean's death.

49. Mr Dean's funeral was on 10 August 2017. No one from the prison attended at the family's request. The prison offered to make a contribution to the funeral costs in line with national policy but the family declined assistance.

Support for prisoners and staff

50. After Mr Dean'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.

51. The prison posted notices informing other prisoners of Mr Dean'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 Dean's death. None of the prisoners who Mr Dean lived with on L Wing were on ACCTs but staff spoke to them and offered support after his death.

Post-mortem report

52. We were not provided with the post-mortem report but given details of the cause of death as 1a) cardio respiratory failure 1b) pneumonia 1c) chronic obstructive airways disease and 2) advanced dementia.

Findings

Clinical care

53. We are satisfied that the care Mr Dean received at Norwich was equivalent to that which he could have expected to receive in the community. His mental capacity was frequently monitored and although he had a number of falls staff did their best to assess his mobility and provided appropriate equipment. Care plans were in place covering his needs including a Gold Standards Palliative care plan even though he had not been given a formal terminal prognosis. The emphasis was on maintaining his comfort and keeping him pain free.

54. While it is unfortunate that Mr Dean had to move from Norwich back to Bure when his bed was needed for an urgent palliative care case, we are satisfied that staff remained vigilant regarding his capacity and mobility. We note that his abilities in these areas fluctuated, anyway.

55. Hospital staff had arranged a DNAR with the involvement of Mr Dean's family when he was admitted there in May 2017. The staff at Norwich were fully aware of this and did not attempt resuscitation when they found him unresponsive on 18 July.

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