

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Richard Norman a prisoner at HMP Littlehey on 16 November 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 Richard Norman died of lung cancer on 16 November 2017 while a prisoner at HMP Littlehey. He was 70 years old. We offer our condolences to his family and friends.

We agree with the clinical reviewer that Mr Norman received a good standard of care at Littlehey. Healthcare staff at the prison maintained good contact with him when he was in hospital and after he was transferred to a hospice.

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

June 2018

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Summary

Events

1. Mr Richard Norman had been at Littlehey since 1 September 2016. In October 2017, a doctor referred him urgently to a colorectal specialist under the NHS pathway, which requires a person suspected of having cancer to be seen by a specialist within two weeks. However, the day after the referral was sent, Mr Norman had breathing difficulties. Prison staff arranged for him to go to hospital.
2. In hospital on 7 November, a palliative care consultant told Mr Norman that he had lung cancer. Mr Norman refused treatment so the hospital arranged for him to move the next day to a hospice, where he died on 16 November.

Findings

3. The clinical reviewer concluded that Mr Norman received care that was equivalent to that which he could have expected to receive in the community.
4. We are satisfied that prison GPs appropriately referred Mr Norman to hospital to investigate his symptoms. Mr Norman had declined investigations but this did not affect the outcome as the cancer was untreatable. After his diagnosis, staff supported Mr Norman appropriately.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Littlehey informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
6. The investigator obtained copies of relevant extracts from Mr Norman's prison and medical records.
7. NHS England commissioned the clinical reviewer to review Mr Norman's clinical care at the prison.
8. We informed HM Coroner for Cambridgeshire and Peterborough of the investigation who gave us the cause of death. We have sent the coroner a copy of this report.
9. The investigator wrote to Mr Norman's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked for details of Mr Norman's diagnosis, hospital referrals and how his care was managed after his diagnosis. She also asked whether he had any delays in attending appointments or being seen by the healthcare team.
10. The investigation has assessed the main issues involved in Mr Norman's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family and whether compassionate release was considered.
11. Mr Norman's daughter received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Littlehey

13. HMP Littlehey is a medium security prison in Cambridgeshire, holding approximately 1,200 men. A large proportion of the population have been convicted of sexual offences.
14. Northamptonshire Health Care Foundation NHS Trust commissions healthcare services. The prison healthcare centre is open from 7.30am to 7.30pm, Monday to Friday, and from 8.30am to 5.30pm at weekends. A local practice provides GP services, and there is a range of nurse-led clinics. There are no inpatient beds at the prison.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Littlehey was conducted in March 2015. Inspectors reported that regular GP surgeries had significantly improved patient care. Lifelong medical conditions were identified effectively and there was an appropriate range of clinics, led by specialist nurses. Hospital appointments in the community were rarely cancelled. The risk assessments of prisoners keeping medications in-possession were not always appropriate.

Independent Monitoring Board

16. 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 January 2017, the IMB reported that the prison's agreement with the local hospice to provide decent and dignified end of life care was recognised in the local hospital Care Quality Commission report as an outstanding initiative. They said that end of life and audiology clinics had been introduced, though the End of Life suite, completed in 2013, continued to be unused due to a lack of funding.

Previous deaths at HMP Littlehey

17. Mr Norman was the fifth prisoner to die of natural causes at HMP Littlehey, since January 2017. There are no significant similarities with the previous deaths.

Findings

The diagnosis of Mr Norman's terminal illness and informing him of his condition

18. Mr Richard Norman was serving a 15-year sentence for sexual offences and had been at HMP Littlehey since 1 September 2016.
19. At his initial health reception screen, Mr Norman told a senior nurse that he had no concerns about his physical health as he was fit and well. He said that he smoked 25 cigarettes a day and declined help to stop. She noted that he walked with a limp and had hip pain.
20. On 21 December 2016, prison staff began suicide and self-harm prevention procedures (known as ACCT), and started a food log as Mr Norman said that he was not eating in protest about his conviction. After speaking to Mr Norman, a nurse made an appointment for a prison GP to review him but Mr Norman refused to attend. She rescheduled another appointment which Mr Norman also refused to attend.
21. As Mr Norman declined to attend his appointments, a prison GP went to visit Mr Norman in his cell on 29 December. Mr Norman refused to engage with her and told her that his aim was for newspapers to highlight his plight and trigger an appeal against conviction. She noted that he was drinking sweetened drinks and that he had the capacity to make decisions. She arranged for the mental health inreach team to visit him.
22. A mental health nurse visited Mr Norman in his cell the next day. Mr Norman told her that he was angry about his situation and was drinking but not eating. He said that he did not wish to attend any health appointments as he believed in leaving things to chance. She felt that Mr Norman had the mental capacity to make this decision.
23. A senior nurse, assessed Mr Norman on 31 December and 1 January 2017. Mr Norman refused to allow the nurse to check his observations and only agreed to a daily weight check. He created a care plan for weekly weight checks and daily nurse reviews.
24. Mr Norman frequently refused to engage with nurses. He said that he was not eating and only having fluids. However, wing staff had seen other prisoners passing him packets of crisps. Mr Norman told a prison GP, that he was drinking tea with milk and sugar and he used bourbon biscuits to make hot drinks. He said that he did not leave his cell and felt well. She told him that nurses would continue checking on him in his cell. On 7 January, Mr Norman accepted fortisip (a high protein supplement). On 31 January, staff stopped the ACCT reviews as Mr Norman made it clear that the food refusal was a protest to gain media attention and was not an intention to self-harm.
25. On 10 February, the prison GP reviewed Mr Norman. She noted that he had the mental capacity to make decisions, there was no evidence that he had psychotic or suicidal thoughts and he was not in pain.

26. On 3 March, Mr Norman told a senior nurse that he had bought food (soups and chocolate) as he did not want to eat prison food. The food log was stopped on 18 March and Mr Norman began collecting his prison meals in April. His medical records contain no further entries about contact with healthcare staff.
27. On 23 June, wing staff asked a nurse to visit Mr Norman in his cell as he had lumps, sores and swollen feet. A nurse told him that he needed to move.
28. On 27 June, Mr Norman refused to attend a heart scan. He told staff that he was not interested. Wing staff noted that Mr Norman's health was deteriorating but he refused help from healthcare staff. He chose to stay in his cell, and only moved to collect his meals.
29. On 6 August, wing staff asked two nurses to check on Mr Norman but he refused to engage with them.
30. In September and October, wing staff noted that Mr Norman appeared unwell but continued to refuse healthcare examinations. On 3 October, an officer made an appointment for Mr Norman to see the healthcare team but he refused to attend. On 14 October, wing staff noted that healthcare staff had given Mr Norman medication for his leg infections.
31. On 15 October, Mr Norman had breathing difficulties. Prison staff arranged for him to go to hospital but he refused treatment and was returned to Littlehey.
32. On 20 October, a prison GP referred Mr Norman urgently to the Colorectal Department at the hospital under the NHS pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.
33. On 21 October, Mr Norman told wing staff that he had breathing difficulties. They arranged for an ambulance to take him to the hospital, where he was admitted.
34. On 7 November, a hospital palliative care consultant told him that he had lung cancer. Mr Norman refused treatment so the hospital arranged for him to be moved to a hospice.
35. We are satisfied that Mr Norman's initial care was of a good standard and the doctor appropriately referred him for suspected cancer. While we note that Mr Norman had declined investigations, this would not have affected the outcome for him as his cancer was widespread and untreatable.
36. The clinical reviewer said that the healthcare staff followed good practice during Mr Norman's period of food refusal, putting in place a process to maintain clinical monitoring and engagement. They were satisfied that he had the mental capacity to make decisions.

Mr Norman's clinical care

37. Hospital doctors told Mr Norman that with medication, his life expectancy was up to six months but without medication, it was a number of weeks.
38. Mr Norman said that he did not want to be resuscitated if his heart or breathing stopped.

39. Mr Norman refused treatment and further tests. The hospital consultant noted that his cancer was advanced and he was classed as palliative. Mr Norman said that he was happy to die in a hospice.
40. On 7 November, a senior nurse visited Mr Norman in hospital. He said that he did not want to die a convicted prisoner and that he wanted to see his daughters before he died. She passed this information to the family liaison officer.
41. On 8 November, Mr Norman was transferred to the hospice. On 13 November, a senior nurse visited Mr Norman in the hospice. She was unable to speak to him as he was sleeping soundly but she spoke to hospice staff who told her that Mr Norman's condition had deteriorated. He died there on 16 November.
42. The Coroner confirmed that Mr Norman died of disseminated carcinoma of the bronchus (lung cancer). Mr Norman also had chronic obstructive disease (lung disease).
43. We are satisfied that Mr Norman's clinical care after his diagnosis was equivalent to that which he could have expected to receive in the community. Mr Norman was appropriately reviewed and prison staff supported him. Healthcare staff offered appropriate support and advice to Mr Norman.

Mr Norman's location

44. On 7 November, staff arranged for Mr Norman to transfer to the hospice for end of life care in line with his wishes.
45. We are satisfied that Littlehey appropriately took into account Mr Norman's location preferences during his illness and that his accommodation met his needs.

Restraints, security and escorts

46. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk, taking into account factors such as the prisoner's health and mobility.
47. When Mr Norman attended hospital appointments, a full and extensive risk assessment were conducted, and his risks were noted in the assessments. Mr Norman's risk assessments considered his history of sexual violence, and he was assessed as being a medium risk to the public and a low risk of escape. Healthcare staff did not raise any objections to the use of restraints.
48. When Mr Norman went to hospital on 21 October 2017, two escort officers accompanied him and applied a single handcuff for the journey. After his admission to hospital, managers reviewed this and authorised the use of an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Managers appropriately reviewed the use of handcuffs and removed Mr Norman's handcuffs on 6 November. They were never reapplied. We are satisfied that the prison appropriately reviewed, adjusted and removed the restraints.

Liaison with Mr Norman's family

49. On 7 November, the prison appointed the family liaison officer (FLO) and his deputy. The FLO deputy visited Mr Norman in hospital and contacted his daughter, who he had named as his next of kin. The FLO and his deputy kept in touch with Mr Norman's daughter. They met her at the hospice, updated her on Mr Norman's condition, and arranged visits.
50. When Mr Norman died in the early hours of 16 November, the FLO and his deputy visited Mr Norman's daughter to break the news, as they had agreed in advance. In line with Prison Service policy, the prison contributed to the funeral costs.
51. We are satisfied that the prison kept Mr Norman's family informed when his condition deteriorated significantly, and that contact after he died was appropriate.

Compassionate release

52. 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 a life expectancy of less than three months.
53. On 8 November 2017, the prison started an application for compassionate release as Mr Norman's prognosis was then less than three months. Staff collated relevant information but Mr Norman died before a decision was made. We are satisfied that compassionate release was appropriately considered.

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