Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Victor Goodrum a prisoner at HMP Norwich on 4 September 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 Victor Goodrum died on 4 September 2018 of heart failure at HMP Norwich. He was 84 years old. I offer my condolences to Mr Goodrum's family and friends.

Although much of the care Mr Goodrum received at Norwich was equivalent to that he could have expected to receive in the community, there were notable exceptions.

Prison staff did not query why Mr Goodrum was returned from hospital in May without warning and with unexplained marks and sores.

I am also concerned that, three days before Mr Goodrum died, he went without palliative anti-vomiting medication for over 24 hours because the prison did not have any available.

We have raised the lack of access to palliative care medication with Norwich before. We were assured then that processes were in place to stop a recurrence, so it is disappointing that I must raise it again.

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

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **January 2019**

## Contents

# Summary

## Events

1. On 10 January 2017, Mr Victor Goodrum was sentenced to six years imprisonment for sexual offences and sent to HMP Bure. He was moved to HMP Norwich on 24 February 2017.

2. Mr Goodrum had several long-term conditions affecting his heart, lungs and kidneys. He also had type 2 diabetes. Staff drew up care plans to help manage his conditions. He was located on L Wing, a designated wing for elderly prisoners.

3. In May 2018, Mr Goodrum was diagnosed with heart failure after being taken to hospital. He arrived back at the prison without warning and had marks to his head and sores on his feet. No detailed handover information accompanied him. Receiving staff at the prison did not raise an incident with the hospital.

4. In June 2018, staff held a multidisciplinary meeting to plan Mr Goodrum's care and community palliative care services were consulted. A specialist assessed that Mr Goodrum no longer had mental capacity and healthcare staff assumed responsibility for taking decisions in his best interests.

5. Towards the end of July, nurses started to administer palliative care medicine to Mr Goodrum. On Saturday 1 September, when Mr Goodrum started to show signs of distress and was vomiting, healthcare staff were unable to administer the relevant palliative care medication because the prison had none available. The medication was not obtained until the following evening.

6. Mr Goodrum died on 4 September. A prison GP recorded his cause of death as congestive heart failure, myocardial infarction (heart attack), heart disease and atrial fibrillation (heart condition that causes an irregular heart rate).

## Findings

7. The clinical reviewer concluded that much of the care Mr Goodrum received at HMP Norwich was equivalent to that he could have expected to receive in the community. However, an incident should have been raised when Mr Goodrum was returned from hospital unexpectedly, with no proper handover information and with unexplained marks and sores. Also, it is not acceptable that the prison did not have key palliative care medication available when Mr Goodrum required it.

## Recommendations

- The Head of Healthcare should ensure that a process is in place for raising concerns with local hospitals or care establishments and that staff know how to initiate this process.

- The Head of Healthcare should ensure that there is an effective process in place to obtain essential palliative care medication without delay when required.

## 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 Goodrum's prison and medical records.

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

11. We informed HM Coroner for Norwich of the investigation. The coroner informed us of the cause of death but there was no post-mortem. We have sent the coroner a copy of this report.

12. The investigator contacted Mr Goodrum's named next of kin, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not respond.

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

# Background Information

## HMP Norwich

14. 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

15. 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.

16. 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. 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. Inspectors found that the palliative care pathway was well developed and had achieved external accreditation in recognition of the team's practice standards.

## Independent Monitoring Board

17. 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

18. Mr Goodrum was the 17th prisoner to die at Norwich from natural causes since September 2015. We have made a recommendation relating to non-availability of palliative medication before. In that case, like Mr Goodrum's, the medication was not available over a weekend.

# Key Events

19. On 10 January 2017, Mr Victor Goodrum was sentenced to six years imprisonment for sexual offences and sent to HMP Bure. He was moved to HMP Norwich on 24 February 2017.

20. A nurse conducted Mr Goodrum's initial health screen at Norwich. Mr Goodrum had complex long-term conditions affecting his heart, lungs and kidneys and he had type 2 diabetes. His short-term memory was also impaired. He arranged for Mr Goodrum's needs to be thoroughly assessed with a view to implementing tailored care plans. A prison GP prescribed all medication required.

21. Mr Goodrum's vital observations were all normal and his nutritional intake was adequate, but he clearly had needs in other areas. Mr Goodrum did not have any pressure sores but was at risk of developing them, he was at risk of falling and required a walking frame and wheelchair and he also required assistance with managing his self-care and maintaining continence.

22. Mr Goodrum was located on L Wing (the older prisoners' unit) and several care plans were implemented as a result of the above assessments. Staff went on to update the plans monthly.

23. On 29 August, a nurse recorded that Mr Goodrum's weight had dropped. Staff had been trying to encourage him to eat but he continued to leave food. She arranged for him to have a nutritional supplement.

24. On 14 October, a nurse conducted the 'Addenbrooke's Cognitive Examination' and Mr Goodrum scored 31/100. The clinical reviewer said that this indicated increased memory impairment and that dementia was diagnosed. Staff had noticed, the previous month, that he had become increasingly confused and challenging. He regularly expressed concerns about his care despite staff and other prisoners regularly reassuring him that he was being looked after well. His confusion deepened although he was eating and his vital observations were normal.

25. By March 2018, a nurse (his named nurse) had noted that he was becoming more unsettled and vague and on 20 March he fell in his cell, dislocating his shoulder. This was despite measures that had been put in place to prevent falls.

26. On 15 April, the nurse arranged a soft diet for Mr Goodrum as he was finding chewing difficult. He developed anaemia but further investigations by the gastrointestinal team at a hospital that month did not reveal anything of concern.

27. On 2 May, his named nurse's colleagues, asked her to review Mr Goodrum as he appeared particularly confused and agitated. She was unhappy with his presentation, fearing a stoke, and arranged for him to be taken to hospital as an emergency. He was not restrained.

28. Mr Goodrum stayed at hospital until 8 May, and during this time he was diagnosed with heart failure. Hospital staff discussed resuscitation with him and he signed a DNACPR (Do Not Attempt Cardiopulmonary Resuscitation) order while he was there.

29. Mr Goodrum's return to L Wing was brief. He presented as more confused, more susceptible to falls and, after abnormal blood tests, a prison GP arranged for him to be readmitted to hospital on 10 May. He was not restrained.

30. Mr Goodrum was returned to the prison on 27 May. However, the hospital had not pre-warned the prison and little information accompanied him when he arrived. His named nurse recorded that Mr Goodrum had marks to his head, had sores on his feet and an inflamed groin. She did not record it as an 'incident' or report it to the hospital. Mr Goodrum was cared for largely in bed and turned hourly.

31. After Mr Goodrum's admission, hospital staff had concluded that his condition was difficult to treat and his prognosis 'short'.

32. On 5 June, his named nurse discussed Mr Goodrum's case at L Wing's multi-disciplinary team meeting. She suggested that his DNACPR should include an assessment by an independent mental capacity advocate. (The assessment was done on 19 June and concluded he lacked capacity. The team, therefore, assumed responsibility for taking decisions in his best interests, which included an enduring DNACPR order.)

33. On 8 June, his named nurse completed a palliative care plan and on 14 June, Mr Goodrum was assessed by a palliative care nurse. She gave the staff guidance about anticipatory palliative care medication including oral and syringe driver options for when this might be needed.

34. On 24 July, staff started the oral palliative care medication (morphine) as Mr Goodrum had developed shingles. The community palliative care nurse visited throughout August and Mr Goodrum was regularly reviewed by GPs.

35. On 30 August, a prison GP decided that it was time for Mr Goodrum to receive medication via a syringe driver. He had become increasingly agitated and refused to eat or drink. The palliative care nurse gave healthcare nurses guidance on how to administer a combination of haloperidol, midazolam, buscopan and diamorphine via a syringe driver. The medication would treat end of life symptoms such as nausea, agitation and pain.

36. On 1 September, a nurse recorded that Mr Goodrum was vomiting but she was unable to find any haloperidol in the pharmacy stock. However, Mr Goodrum settled and was comfortable for the rest of the day.

37. On the morning of 2 September, a nurse recorded that Mr Goodrum vomited again and once more she could not find any haloperidol in stock. She contacted the out of hours GP service at a hospital, but no one could supply any. She was unable to contact the community palliative care team. Mr Goodrum eventually settled but only until the afternoon when he began vomiting again. He became increasingly distressed, and the nurse was forced to consider arranging his transfer to hospital so he could be administered haloperidol.

38. At 3.40pm, a nurse recorded that a pharmacy in Norwich had been located which had the medication in stock. She went to collect it and by 6.00pm administered the medication, following which Mr Goodrum quickly settled.

39. Mr Goodrum's condition continued to deteriorate. At 9.28am on 4 September, a prison GP recorded that he had died.

### Contact with Goodrum's family

40. On 2 May, the prison appointed a prison manager as the family liaison officer (FLO). The FLO contacted Mr Goodrum's named next of kin (a friend) as Mr Goodrum had been sent to hospital and there were concerns about his health. Although she left many messages, Mr Goodrum's friend did not make contact until June.

41. The FLO kept Mr Goodrum's next of kin informed of developments, helped to arrange visits and established that when the time came he would prefer to be told of Mr Goodrum's death by telephone. The FLO did so on the morning of 4 September. She, and FLO colleagues, stayed in contact to offer advice and support and arrange the funeral.

42. Mr Goodrum's funeral was held on 24 September 2018. A FLO attended and, in line with national policy, the prison contributed to the costs.

### Support for prisoners and staff

43. After Mr Goodrum's death, the duty governor debriefed the staff involved that day to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

44. The prison posted notices informing other prisoners of Mr Goodrum's death, and offering support. There were no prisoners on L Wing who were being monitored under suicide and self-harm prevention procedures so no one required a review to check whether they had been adversely affected by Mr Goodrum's death.

### Cause of Death

45. There was no post-mortem examination as the coroner accepted the prison GP's opinion on the cause of death. The prison GP recorded that Mr Goodrum died from congestive cardiac failure (where the heart stops pumping efficiently because of fluid build-up), acute myocardial infarction (heart attack), ischaemic heart disease (narrowing of arteries that supply the heart) and atrial fibrillation (heart condition that causes an irregular heart rate). The GP listed immobility and severe wasting, dementia and type 2 diabetes as contributory factors.

# Findings

46. The clinical reviewer concluded that while some of the care Mr Goodrum received at Norwich was good, not all his care was equivalent to that he could have expected to receive in the community.

47. On 27 May 2018, the hospital unexpectedly discharged Mr Goodrum back to the prison. Mr Goodrum arrived back with unexplained marks on his head, sores on his feet and an inflamed groin. There was no evidence of a care plan from the hospital. This is unacceptable practice and an incident should have been raised by prison healthcare staff for further investigation by the hospital.

    **The Head of Healthcare should ensure that a process in in place for raising concerns with local hospitals or care establishments and that staff know how to initiate this process**.

48. Towards the end of Mr Goodrum's life, he required medication to manage his vomiting but none was available. A nurse first noticed this on 2 September and again on 3 September. On the first occasion, she managed to settle Mr Goodrum relatively quickly. However, on the second occasion, it is clear Mr Goodrum was in significant distress for some time before any medication could be sourced.

49. We are aware that the healthcare provider intends to conduct a 'root cause analysis' to identify what went wrong and how best to avoid a recurrence of this situation. In the meantime, we make the following recommendation:

    **The Head of Healthcare should ensure that there is an effective process in place to obtain essential palliative care medication without delay when required.**

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