Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Cowan a prisoner at HMP Norwich on 15 August 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 John Cowan died on 15 August 2017 of sepsis and a chest infection, while a prisoner at HMP Norwich. He was 75 years old and was suffering from Motor Neurone Disease. We offer our condolences to Mr Cowan's family and friends.

We do not consider that Mr Cowan's transfer from HMP Edinburgh to HMP Norwich, 6 days before he died, was well managed. He was very unwell and his health was deteriorating, tests taken at Edinburgh remained outstanding and he arrived at Norwich in a poor physical state. It is questionable whether the move should have taken place in such circumstances.

Our remit does not extend to prisons in Scotland, so we will be sharing our report with the office of the Lord Advocate/Procurator Fiscal.

Norwich should satisfy themselves that appropriate fitness to travel assessments are completed before accepting prisoners to their palliative care unit.

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**

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Summary

Events

1. Mr John Cowan was serving an eight year sentence for historic sex offences and had been in custody since 2014. In September 2016, he was transferred to Scotland to stand trial for further historic offences.

2. On 5 April 2017, Mr Cowan was diagnosed with Motor Neurone Disease (MND). His condition deteriorated rapidly and on 9 August 2017, he was transferred from HMP Edinburgh to HMP Norwich for palliative care. He was wheelchair bound, needed full assistance with personal care and was unable to speak. He used an alphabet board to communicate.

3. On arrival at Norwich Mr Cowan was appropriately referred to dietics, continence and occupational therapy services for an urgent review. However, there is no evidence of a referral to speech and language therapy (SALT), or any contact with MND specialists or consideration of transfer to a local hospice.

4. Healthcare staff had daily regular interaction with Mr Cowan, to help meet his personal and physical care needs. On 14 August, he became unwell with a chest infection and as his condition deteriorated throughout the day, healthcare staff sent him to hospital for treatment. Mr Cowan's health continued to deteriorate and he died at 3.50am on 15 August.

Findings

5. The clinical reviewer concluded that the clinical care Mr Cowan received at HMP Edinburgh was not equivalent to that which he could have expected to receive in the community. There was no appropriate assessment of Mr Cowan's clinical condition before his transfer to HMP Norwich, and Norwich did not request a formal fitness to travel assessment which would have made explicit Mr Cowan's very poor and deteriorating physical condition. Given that he was displaying advanced and end stage symptoms of Motor Neurone Disease, the clinical reviewer concluded that it was not appropriate to transfer Mr Cowan over 370 miles. She considered that it would have been preferable for healthcare staff at Edinburgh to have identified a local hospice to provide end of life care (although it appears that legal restrictions would have prevented him being released into the community in Scotland).

6. The clinical reviewer also concluded that healthcare staff at Edinburgh should have given Mr Cowan precautionary antibiotics when they sent samples of his sputum for testing the day before he was transferred, rather than waiting for the results. There is no evidence that healthcare staff at Norwich were told that samples had been sent for testing.

7. The Scottish Prison System is not within the scope of our investigations. However, the clinical reviewer makes recommendations to the Scottish Prison Service and NHS Lothian, which they and the Lord Advocate/Procurator Fiscal will wish to consider.

8. We make the following recommendation to HMP Norwich.

Recommendation:

- The Governor and Head of Healthcare should ensure that the transferring prison has completed a fitness to transfer assessment before accepting a prisoner with significant medical conditions.

The Investigation Process

9. 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.

10. The investigator visited HMP Norwich on 21 August. She obtained copies of relevant extracts from Mr Cowan's prison and medical records and met with staff on the wing in which Mr Cowan lived.

11. NHS England commissioned a clinical reviewer to review Mr Cowan's clinical care in prison.

12. We informed HM Coroner for Norwich of the investigation who informed us of the cause of death. We have sent the coroner a copy of this report.

13. The investigator wrote to Mr Cowan's friend, his 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 to our letter.

14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

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 services are reasonably good overall. There were sound governance arrangements and effective relationships between all stakeholders. A partnership board was established and healthcare staff attended a number of important prison meetings where their contribution was valued. Nursing and operational leadership arrangements were impressive and there were dedicated lead staff for a number of functions, including for older adult care. Prisoners in the healthcare unit and on L wing received excellent social care. The prison had a clear social care referral process and staff were trained to identify prisoners with potential needs. The care provided was good and appropriate equipment supported prisoners' independence. L wing, which was directly underneath the healthcare inpatient facility, offered 24-hour nursing and social care packages for a mainly older group of prisoners with chronic health conditions. 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 February 2017, the IMB reported that 57% of prisoners surveyed believed it was easy to see a doctor. Observing the figures from Virgin Care, access to a GP should be given within 2 working days of request. Out of 195 referrals in February 2017, 81 were booked later than this. The longest wait was 6 days and the GP missed 1 day (i.e. 2 sessions). L wing housed up to 15 elderly prisoners needing specialised nursing care and was overseen by Healthcare. L wing prisoners displayed the majority of social care needs and these were well provided for by Virgin Care.

Previous deaths at HMP Norwich

18. Mr Cowan is the thirteenth prisoner to die of natural causes at Norwich since January 2016. This number is not remarkable given the palliative service offered by the prison. There are no similarities with previous investigations.

Key Events

19. Mr John Cowan was sent to HMP Wormwood Scrubs in November 2014, after receiving an eight year sentence for historic sexual offences. Mr Cowan was transferred to HMP Littlehey in January 2015, before being transferred to Scotland in September 2016, to stand trial for additional charges.

20. When Mr Cowan first entered custody in 2014, he appeared to be a reasonably well man who had asthma, arthritis and used hearing aids. Aside from treatment and investigation of recurrent ear infections, he did not have any significant interactions with healthcare staff.

21. On 12 September 2016, Mr Cowan told a prison GP at Littlehey that he had been having trouble with his balance for about three months. He said it had come on gradually and was getting worse and he was not able to walk in a straight line. On the same day, Mr Cowan was transferred from Littlehey to HMP Edinburgh. Mr Cowan's physical condition deteriorated quickly and he was diagnosed with Motor Neurone Disease (MND) on 5 April 2017. At this point, he had no function in his right hand, could not mobilise any significant distance and needed help to self-care and eat a 'mashed diet'.

22. Mr Cowan's condition quickly deteriorated. As the charges against him in Scotland were dropped, he had to be transferred back to England. On 19 June, Scottish Prison Service staff were concerned that Mr Cowan would soon not be fit enough to travel. The Cross Border Section also highlighted this concern to Littlehey on 4th July. It was noted that Mr Cowan had deteriorated significantly and it was the Scottish Prison Service's plan to transfer him as soon as possible, provided Edinburgh healthcare staff confirmed he was fit to transfer.

23. Edinburgh asked Littlehey to take him back, but they did not have the healthcare facilities to meet his needs. Mr Cowan was dependent on a wheelchair, had minimal mobility and was fed via a tube. Towards the end of July, Mr Cowan lost the ability to speak and started to use an alphabet board to communicate.

24. On 8 August, Mr Cowan was producing thick yellow sputum and Edinburgh sent sputum samples to the laboratory for analysis in case of infection.

25. On 9 August 2017, Mr Cowan was transferred to HMP Norwich as they had 24-hour healthcare provision and a palliative care unit. He left Edinburgh at 7am, accompanied by a nurse, to catch a 9am flight to England. The flight was delayed and the plane left Scotland shortly after 12pm. Mr Cowan arrived at Norwich at 3.52pm, after a journey of 8 hours and 52 minutes.

26. MND is rapidly progressive and patients with MND require complex care. Although Norwich had the facilities to meet Mr Cowan's physical needs, there is no evidence that healthcare staff at Norwich contacted local MND specialists or considered referral to palliative care services in a local hospice at any time before or after his transfer.

27. On his arrival at Norwich, a staff nurse examined Mr Cowan and completed a Full Older Persons Risk Assessment and Care Plan. She noted his feeding tube site was not clean, with signs of over granulation (when scar tissue starts to be made,

there are various causes including infection and irritation). The base of the tube plate was too close to his stoma (an opening in the abdomen to divert the flow of faeces, which is collected in a pouch). She removed Mr Cowan's urinary sheath and found an abrasion. She cleaned and dressed the feeding tube site and a prison GP, prescribed a topical antifungal and antibiotic cream.

28. Mr Cowan was placed on 'L' wing, a wing for prisoners who have significant social care needs or need palliative care. He was in one of two high dependency cells next to the wing office, which had a hoist, hospital bed and large floor space for his wheelchair. Mr Cowan had an open door policy so there were no security restrictions in providing medical care.

29. On 10 August, a prison GP saw Mr Cowan and was concerned that he was dehydrated. Nursing staff included extra fluid flushes to each feed and over night. A nurse referred Mr Cowan to the dietics, continence and occupational therapy services for an urgent review, however there is no evidence that she referred him for speech and language therapy (SALT).

30. On 14 August, a nurse took Mr Cowan's basic observations at about 6:00am because he was coughing. She noted his oxygen saturations were low and his pulse and blood pressure were high. His temperature was within the normal range. She booked an appointment with the GP.

31. At 9.00am a prison GP, told the nursing staff on L wing that he would not have time between clinics and his segregation round to see Mr Cowan. He told them to monitor him and, if needed, to send him to hospital or a GP would see him on the wing rounds the following day.

32. At 11.28am, a nurse noted that Mr Cowan needed regular suction and was producing more sputum. He was pale and warm to touch. She took Mr Cowan's basic observations, which showed his saturations were slightly low, his pulse was high and she could hear crackles on both sides of his chest. She increased his fluids and gave him antibiotics. The nursing staff planned to continue monitoring Mr Cowan until he could see the GP the following morning.

33. At 7.10pm, a nurse reviewed Mr Cowan. She noted he had lots of saliva and sputum. She gave him suction and put him on a nebuliser. Mr Cowan was hot to touch and sweaty, and his breathing was rapid. His oxygen saturations were low and she gave him oxygen. She observed him but he did not improve. She asked the landing officer to request an ambulance, which was called at 7.55pm.

34. The ambulance arrived at 8.05pm and the paramedics took Mr Cowan to hospital at about 8.30pm. A hospital doctor admitted him to the acute medical unit.

35. 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. A prison manager authorised escort officers not to use restraints on Mr Cowan.

36. At 2.30am on 15 August, a nurse telephoned the hospital for an update. Hospital staff were still attending to Mr Cowan, he was very unwell and a hospital doctor had implemented a 'do not attempt cardiopulmonary resuscitation' (DNACPR) order (in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made, all other appropriate treatment and care would continue to be provided).

37. At 3.15am, a hospital nurse told the bedwatch officers that Mr Cowan had died. A hospital doctor confirmed his death at 3.45am.

38. The results of the sputum samples taken (to see whether he had an infection) on 8 August, the day before Mr Cowan left Edinburgh, arrived at Norwich later that day. The results were positive for haemophilus influenzae bacteria (pneumonia) and staphylococcus aureus (pneumonia/sepsis) and the hospital laboratory recommended administering antibiotics.

Contact with Mr Cowan's next of kin

39. When Mr Cowan transferred to Norwich, the prison appointed a family liaison officer for Mr Cowan's next of kin, his friend. He contacted Mr Cowan's friend during the morning of 14 August, to introduce himself and to let him know Mr Cowan had moved to Norwich and that he could accommodate any visits.

40. At 8.20pm that evening, the family liaison officer telephoned Mr Cowan's friend and explained Mr Cowan was in hospital. He said he would keep him updated and would help organise any visits.

41. On 15 August, the family liaison officer telephoned Mr Cowan's friend at 6.30am to inform him of Mr Cowan's death. He explained what would happen next and provided on-going support.

42. Mr Cowan's funeral was held on 4 September. The prison contributed to the cost of the funeral in line with Prison Service policy.

Support for prisoners and staff

43. After Mr Cowan's death, the prison manager debriefed the staff involved in the bedwatch 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 Cowan'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 Cowan's death.

Cause of death

45. The Coroner informed us that the cause of death recorded by a hospital doctor was sepsis, caused by a chest infection.

Findings

Clinical care

46. Mr Cowan was diagnosed with Motor Neurone Disease in April 2017, and his condition deteriorated quickly. He transferred to Norwich from Edinburgh on 9 August, but died in hospital six days later from sepsis caused by a chest infection.

47. The clinical reviewer concluded that the care Mr Cowan received at HMP Edinburgh was not equivalent to that which he could have expected to receive in the community. As respiratory complications, such as infections, are common in Motor Neurone Disease, it was appropriate to send a sputum sample for analysis when a chest infection was suspected on 8 August. However, precautionary antibiotics should have been started to treat Mr Cowan's symptoms and to alleviate any distress Mr Cowan might have been experiencing. The clinical reviewer went on to say, however, that she did not believe that treatment with antibiotics would have altered the outcome for Mr Cowan, given the disease pathway and his clinical condition at this point.

48. It is not within our remit to investigate the Scottish Prison System. However, the clinical reviewer makes recommendations to the Scottish Prison Service and NHS Lothian, which they and the Procurator Fiscal/Lord Advocate will wish to consider.

Transfer to HMP Norwich

49. HMP Edinburgh made contact HMP Norwich to enquire if they would accept Mr Cowan for their palliative care unit. Norwich accepted Mr Cowan on the basis they could meet his physical needs. The Deputy Head of Healthcare (L wing clinical lead at the time), liaised with healthcare staff at HMP Edinburgh about Mr Cowan's physical condition and his needs.

50. The clinical reviewer concluded that healthcare staff at Edinburgh did not conduct an appropriate assessment of Mr Cowan's clinical condition before his transfer to HMP Norwich. Given that he was displaying advanced and end stage symptoms of Motor Neurone Disease, the clinical reviewer concluded that it was not appropriate to have transferred Mr Cowan over 370 miles, and that healthcare staff at Edinburgh should have attempted to identify a local hospice to provide end of life care. In addition, although healthcare staff at Edinburgh shared Mr Cowan's care plan, prescribed medications and latest occupational therapy assessment with staff at Norwich, there is no evidence that they informed Norwich that Mr Cowan was producing thick yellow sputum and that sputum samples had been sent for testing the day before his transfer.

51. Based on the information that Edinburgh shared with Mr Scott, we are satisfied that Norwich was well equipped to manage Mr Cowan's complex physical needs. We understand that there were questions about the legality of continuing to detain Mr Cowan in Scotland once it had been decided not to proceed with charges against him there, and that the Scottish Prison System did not have the power to grant Mr Cowan compassionate release or to release him on temporary licence. However, Mr Cowan's condition had clearly deteriorated significantly in

the two weeks before his transfer and there is no evidence that Norwich was in receipt of a fitness to transfer assessment at the time he transferred. We share the clinical reviewer's concerns that healthcare staff at Norwich should have challenged whether it was appropriate to send a man with advanced and end stage Motor Neurone Disease such a distance, and should have questioned whether more appropriate arrangements could have been made for Mr Cowan's end of life care at Edinburgh or elsewhere.

52. We make the following recommendation to HMP Norwich:

The Governor and Head of Healthcare should ensure that the transferring prison has completed a fitness to transfer assessment before accepting a prisoner with significant medical conditions.

53. The clinical reviewer also considered that healthcare staff at Norwich should have made contact with local Motor Neurone Disease specialists and explored the possibility of a hospice transfer before Mr Cowan transferred to them, and that they should have referred him for speech therapy after his arrival. We have not made any recommendations on these points as we are satisfied that staff at Norwich were not aware how ill Mr Cowan was until he arrived at Norwich six days before his death.

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