

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Harry Bushell a prisoner at HMP Norwich on 31 March 2019

A report by the Prisons and Probation Ombudsman

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.

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 Harry Bushell died of old age on 31 March 2019 at HMP Norwich. He was 81 years old. I offer my condolences to those who knew him.

Mr Bushell had been in prison for 42 years and at Norwich for 14 years. He had several health conditions, and was diagnosed with Alzheimer's dementia in 2015. The investigation found that Mr Bushell received a very good standard of care at Norwich, equivalent to that he could have expected to receive in the community.

I have made just one recommendation. Mr Bushell lost a lot of weight as his health declined. While staff were aware of this and tried to give Mr Bushell high calorie food and drink, he would not always cooperate. It would have been good practice for staff to use a nutritional screening assessment tool, with the aim of improving Mr Bushell's overall nutritional intake in challenging circumstances.

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

August 2019

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Summary

Events

1. On 17 December 1976, Mr Harry Bushell was sentenced to life imprisonment for serious sexual offences. On 5 April 2005, he was moved to HMP Norwich.
2. Mr Bushell had several health conditions including chronic obstructive pulmonary disease (COPD - a group of lung conditions), type 2 diabetes, psychotic illness and Alzheimer's dementia. He needed regular care from prison healthcare staff.
3. In August 2016, and in March 2017, Mr Bushell was admitted to hospital with pneumonia and not expected to survive. Staff referred him to palliative care services for end of life planning but on both occasions his condition improved. An end of life care plan remained in place.
4. As Mr Bushell's Alzheimer's dementia progressed and his physical condition worsened, he needed increased levels of nursing care. He could not walk, eat or dress without help and eventually lost control of his bladder and bowel functions. He became very distressed when required to take his medication and was often violent towards healthcare staff. In October 2018, a prison GP reduced his medications to the minimum required to keep him pain free and comfortable.
5. Mr Bushell lived on a wing for mainly older prisoners with chronic health needs. He had access to 24-hour nursing and social care and his cell door was kept unlocked.
6. In February 2019, Mr Bushell deteriorated significantly and a nurse made another referral to the palliative care services who advised anticipatory medication (medication, usually given by injection, to promote comfort at the end of life).
7. On 30 March at 6.45pm, Mr Bushell became increasingly wheezy and distressed. A nurse gave him medication to open his airways but his condition did not improve and the nurse called the out of hours GP service for advice. Mr Bushell continued to deteriorate, his breathing became increasingly slow and shallow and on 31 March at 6.30am, he died.
8. There was no post-mortem examination. The coroner accepted that Mr Bushell died of old age. It was considered that Alzheimer's dementia, type 2 diabetes and COPD were contributing factors.

Findings

9. The clinical reviewer was satisfied that overall, the care Mr Bushell received at Norwich was of a very good standard and equivalent to that he could have expected to receive in the community.
10. Mr Bushell suffered significant unexplained weight loss for many years which, until September 2017, staff monitored using a nutritional screening tool to support a nutritional care plan. The clinical reviewer considered that staff should have continued its use. It would have helped them to proactively set nutritional goals with the aim of improving Mr Bushell's overall nutritional intake. A referral to a dietician would also have been beneficial.

Recommendations

- The Head of Healthcare at HMP Norwich should ensure that clinical staff:
 - are aware of the relevant guidance on identifying and caring for adults who are malnourished or at risk of malnutrition;
 - use the MUST five-step screening tool when appropriate; and
 - make a referral to specialist services when expert advice would be beneficial.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Bushell's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Bushell's clinical care at the prison.
14. We informed HM Coroner for the Greater Norfolk District of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.
15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Norwich

16. 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

17. 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.
18. Inspectors noted that the prison population had a complex range of needs and as a result permanent health care was available, including continuous nursing support for some men on L Wing. L Wing, which is directly underneath the inpatient facility, offers 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

19. 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

20. Mr Bushell was the 12th prisoner to die at Norwich since March 2017. Of the previous deaths, seven were from natural causes and four were self-inflicted. There were no similarities between Mr Bushell's death and the previous deaths.

Key Events

21. On 17 December 1976, Mr Harry Bushell was sentenced to life imprisonment for serious sexual offences.
22. On 5 April 2005, Mr Bushell was moved to HMP Norwich. He had chronic obstructive pulmonary disease (COPD – the term for a group of lung diseases including chronic bronchitis and emphysema), which had been diagnosed in 2003. In 2007, he was diagnosed with type 2 diabetes, and in October 2015, with Alzheimer’s dementia. He needed regular input from the healthcare team at Norwich to manage his conditions.
23. On 8 February 2016, a prison GP spoke to Mr Bushell about resuscitation if his heart or breathing stopped. Mr Bushell, who at that time still had the mental capacity to make the decision, said that he did not want to be resuscitated.
24. Mr Bushell remained relatively stable until August 2016, when he was admitted to hospital with aspiration pneumonia (a type of lung infection). Mr Bushell was discharged back to Norwich but hospital specialists advised that he was probably approaching the end of his life and would not benefit from further hospital admissions. Prison healthcare staff referred him to palliative care services for assessment and end of life care planning.
25. In March 2017, Mr Bushell’s condition deteriorated and he was once again admitted to hospital with a lung infection. He was again discharged back to Norwich for supportive care only. Staff considered that any future hospital admission would not be in his best interests and a further referral was made to palliative care services for support and end of life care planning. This support ensured that specialist and more complex care problems were managed effectively. An end of life care plan was initiated.
26. Alzheimer’s dementia is a progressive condition and despite supportive care, Mr Bushell’s mental and physical condition worsened, as did his ability to communicate. He required assistance with eating and dressing himself and could not walk independently. Mr Bushell eventually lost control of his bladder and bowel functions and therefore required increased nursing support.
27. As his dementia progressed, Mr Bushell experienced significant cognitive impairment and his behaviour deteriorated. He regularly refused to take his medication and became distressed when healthcare staff tried to administer it. He was often violent towards them. On 17 October 2018, a prison GP reduced his medications to those considered a priority to keep him pain free and comfortable.
28. Although it appears to have occurred gradually, Mr Bushell suffered significant weight loss (almost 50kg between December 2006 and his death). Despite investigations, no definitive underlying cause was ever established. Healthcare staff attempted to help him put on weight by providing a high calorie diet with high protein supplements, but Mr Bushell regularly refused to accept the food offered. Up until September 2017, staff used a nutritional screening tool to monitor Mr Bushell’s weight and to support a nutritional care plan. After

September 2017, though staff continued in their attempts to help Mr Bushell gain weight, the screening tool was no longer used.

29. Mr Bushell's weight loss, sedentary lifestyle and inability to move position easily put him at risk of developing pressure sores. Staff used the 'Waterlow Score', a validated risk assessment tool, that identified his risk as very high. An airflow mattress was provided and healthcare staff helped him to move and change positions. They reviewed him regularly and conducted visual skin inspections.
30. As his condition deteriorated, Mr Bushell was susceptible to falls. Healthcare staff completed a falls risk assessment which the medical records indicate was regularly reviewed. To reduce the risk of falls the area around Mr Bushell was cleared of potential hazards, his bed was lowered and a crash mat and sensor mat put in place.
31. Mr Bushell spent his later years on L Wing, a wing mainly for older prisoners with chronic health needs. Healthcare staff on L Wing provided him with 24-hour nursing and social care. During the months before his death, and at other times when his condition required it, Mr Bushell had an 'open door policy', meaning his cell was unlocked, allowing healthcare staff immediate and easy access.
32. Although Mr Bushell's condition gradually declined from around 2016, there was a significant deterioration in February 2019.
33. On 15 February 2019 at 9.00pm, a nurse examined Mr Bushell who had a high temperature. He was struggling to breathe and said his chest was tight. The nurse tried to give him oxygen but Mr Bushell would not wear the oxygen mask. She gave him two paracetamols to reduce his temperature.
34. Mr Bushell remained unwell; he slept periodically, ate and drank little and refused to take his medication. Healthcare staff monitored him regularly, day and night, in accordance with his various care plans, including his end of life plan. Mr Bushell developed a urine infection and a prison GP prescribed antibiotics but Mr Bushell refused to take them and spat them out. He became increasingly aggressive towards staff.
35. On 19 February, a prison GP stopped the prescription of antibiotics due to the obvious distress they were causing. Mr Bushell was clearly in decline and a nurse made another referral to the Palliative Care Services. A specialist palliative nurse reassured healthcare staff that they were doing all they could.
36. On 28 February, the specialist palliative nurse reviewed Mr Bushell and advised the prescription of anticipatory medication (medication, usually given by injection, to promote comfort at the end of life). She noted that Mr Bushell was comfortable and did not appear to be in any pain or distress. A prison GP prescribed the medication.
37. Healthcare staff continued to monitor and support Mr Bushell with end of life care. On 28 March at 4.00pm, a prison GP reviewed Mr Bushell in his cell. Mr Bushell was awake and alert but he did not communicate with the doctor. Mr Bushell had a fungal infection in his mouth and the GP prescribed Nystatin (antifungal medication). He described Mr Bushell as frail but well and not in any discomfort.

He noted that Mr Bushell was obviously receiving good end of life care. This was the last occasion that a doctor saw Mr Bushell alive.

38. On 30 March at 6.45pm, a nurse examined Mr Bushell in his cell after he became increasingly wheezy and distressed. The nurse gave him Salbutamol (medication that opens the airways in the lungs) but his condition did not improve and he remained short of breath. A nurse attended to assist and gave Mr Bushell Midazolam (used to decrease anxiety) and oxygen. Another nurse called the out of hours GP service (111).
39. Night duty healthcare staff checked Mr Bushell regularly. He appeared more settled but his breathing remained laboured. At 11.00pm, a nurse called the out of hours service again as they had not replied to the earlier call. At 12.59am on 31 March, a nurse practitioner from the out of hours service spoke to the nurse and said she was happy with their actions and the medication prescribed.
40. Mr Bushell continued to deteriorate throughout the night. At 6.00am, a nurse noted that despite being on oxygen his breathing was very shallow and getting worse. A nurse attended at 6.10am. Mr Bushell's breathing was very slow but he did not appear in any distress. They remained with Mr Bushell until 6.30am when he died. A GP from the out of hours service confirmed death at 10.10am.

Consideration of Mr Bushell's release

41. On 21 April 2018, a Parole Board panel considered Mr Bushell's release and alternatively, his suitability for open conditions. This was the 14th parole meeting during Mr Bushell's imprisonment.
42. The panel heard evidence of Mr Bushell's unpredictable, aggressive and violent behaviour, generally as result of frustration and confusion. They considered a change of environment to be destabilising and not in Mr Bushell's best interests.
43. The panel noted that Mr Bushell had no support in the community and would not be able to understand any licence conditions that might be imposed on him. Despite considerable efforts, no suitable accommodation that could meet Mr Bushell's healthcare needs and manage his ongoing risks, while also ensuring that staff were not placed at risk of violence, could be identified. As with previous decisions, the panel was satisfied that Mr Bushell should remain in custody at Norwich.

Contact with Mr Bushell's family

44. Mr Bushell initially named his mother as his nominated next of kin. After her death, he did not name anyone else. HMP Norwich arranged and paid for Mr Bushell's funeral which was held on 16 April 2019.

Support for prisoners and staff

45. After Mr Bushell's death, a custodial manager 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.

46. The prison posted notices informing other prisoners of Mr Bushell'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 Bushell's death.

Cause of death

47. There was no post-mortem and the coroner accepted that Mr Bushell died of old age. It was considered that Alzheimer's dementia, type 2 diabetes and COPD were contributing factors.

Findings

Clinical care

48. The clinical reviewer was satisfied that overall, the care Mr Bushell received at Norwich was of a very good standard and equivalent to that he could have expected to receive in the community.
49. Mr Bushell's long term health conditions were managed appropriately and in line with national guidance. As Mr Bushell's health deteriorated he received good nursing care and appropriate care plans were implemented and regularly reviewed. Palliative care services were consulted when needed and were involved in Mr Bushell's end of life care plan. The clinical reviewer found that the nursing care was appropriate, compassionate and responsive.
50. However, Mr Bushell suffered significant, unexplained weight loss. Between December 2006 and March 2019, he lost almost 50kg. The National Institute for Health and Care Excellence (NICE) guidance recommends the use of a screening tool to assist in identifying and caring for adults who are malnourished or at risk of malnourishment and that they have a management care plan that aims to meet their complete nutritional requirements.
51. Mr Bushell's medical records indicate that such a screening tool was used until the end of September 2017, but not afterwards. Healthcare staff continued in their attempts to assist Mr Bushell to gain weight by providing a high calorie diet with high protein supplements, but there was no improvement in Mr Bushell's weight.
52. We recognise that Mr Bushell was reluctant to take any of the food or supplements offered but we agree with the clinical reviewer that the continued use of a nutritional assessment tool would have clearly defined his medical status, supported staff to monitor any changes, proactively set nutritional goals and potentially improved and increased nutritional intake.
53. In addition, once it became clear that the strategies in place were insufficient, a referral to a dietician for specialist advice and support would have been beneficial. We make the following recommendation:

The Head of Healthcare at HMP Norwich should ensure that clinical staff:

- **are aware of the relevant guidance on identifying and caring for adults who are malnourished or at risk of malnutrition;**
- **use the MUST five-step screening tool when appropriate; and**
- **make a referral to specialist services when expert advice would be beneficial.**

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