Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Nunn, a prisoner at HMP Norwich, on 22 October 2019

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 Peter Nunn died on 22 October 2019 from old age at HMP Norwich. He was 82 years old. I offer my condolences to Mr Nunn's family and friends.

The clinical reviewer found that the care Mr Nunn received at Norwich was equivalent to that which he could have expected to receive in the community. Mr Nunn was located on the older person's unit at Norwich, care plans were in place to support him and he received 24-hour care.

However, I am concerned that Mr Nunn's next of kin was contacted by telephone straight after his death and no attempt was made to tell her in person.

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 **March 2020**

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Summary

Events

1. On 27 April 2014, Mr Peter Nunn was recalled to custody for breaching his licence conditions. He was moved to HMP Norwich on 14 June 2017.

2. Mr Nunn had several long-term health conditions including chronic obstructive pulmonary disease (COPD – the term for a collection of lung diseases such as chronic bronchitis and emphysema), high blood pressure, type 2 diabetes, Crohn's disease and heart disease.

3. In September 2017, a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order was discussed with Mr Nunn who agreed that if he stopped breathing he did not want to be resuscitated.

4. On 11 July 2019, it was documented that Mr Nunn was frail and dependent upon others for his daily care needs. Enhanced plans were put in place to support Mr Nunn.

5. Over the next few months Mr Nunn's health gradually deteriorated. On 1 October, a referral was made to the palliative care team who put care plans in place to manage Mr Nunn's deteriorating health.

6. On 20 October, Mr Nunn became increasingly agitated and seemed to be in pain. It was agreed with the palliative care team that they would start a syringe driver (a small infusion pump that slowly administers medication) to help to control pain and agitation.

7. On 22 October, at 2.00pm, Mr Nunn died. A prison GP recorded Mr Nunn's cause of death as old age.

Findings

8. We are satisfied that Mr Nunn received appropriate care and treatment for his health conditions. The clinical reviewer considered that the standard of care he received at Norwich was equivalent to that he could have expected in the community.

9. After Mr Nunn died, the prison's family liaison officer telephoned his next of kin, and told her of his death. National guidelines say that if a prisoner dies in custody, their next of kin should be informed in person wherever possible. We are concerned that the family liaison officer telephoned Mr Nunn's next of kin straightaway without making any attempt to visit her.

Recommendation

- The Governor should ensure that when a prisoner dies in custody, an attempt is made to visit the prisoner's next of kin to tell them of the death in person, in line with national guidelines.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Norwich informing them of the investigation and asked anyone with relevant information to contact her. No one responded

11. The investigator obtained copies of relevant extracts from Mr Nunn's prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Nunn's clinical care at the prison.

13. We informed HM Coroner for Norfolk of the investigation. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Nunn's next of kin to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. She did not reply.

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

Background Information

HMP Norwich

16. HMP Norwich serves the courts of Norfolk and Suffolk and holds a mix of up to 769 remanded and sentenced prisoners and young adults. The main site houses Category B and C prisoners. A local discharge unit (LDU) is on another site, housing Category C prisoners. Virgin Care provides healthcare services, including mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Norwich was in October 2019 but has not yet been published. The previous inspection was completed in September 2016. Inspectors reported that an appropriate range of nurse led clinics included provision for long-term conditions such as asthma, diabetes and chronic obstructive pulmonary disease. A nurse practitioner provided specialist support and there were daily GP clinics.

18. Inspectors also reported that L Wing offered 24-hour nursing and social care packages for a mainly older group of prisoners with chronic conditions. Care was of a high standard.

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 2019, the IMB reported that the prison no longer had plans for an end of life suite for L Wing. Although the environment was dated, the standard of care continued to be compassionate and sensitive. The Board considered that the healthcare service within HMP Norwich was comparable to that in the community.

Previous deaths at HMP Norwich

20. Mr Nunn was the ninth prisoner to die at Norwich since October 2017. Of the previous deaths, five were from natural causes and three were self-inflicted. There are no similarities between Mr Nunn's death and previous deaths at Norwich.

Key Events

21. On 27 April 2014, Mr Peter Nunn was recalled to custody for breaching his licence conditions. He was sent to HMP Pentonville. He was moved to HMP Norwich on 14 June 2017.

22. A nurse completed the initial health screen. She noted that Mr Nunn had several chronic health conditions, including chronic obstructive pulmonary disease (COPD – the term for a collection of lung diseases such as chronic bronchitis and emphysema), high blood pressure, type 2 diabetes, Crohn's disease and heart disease. Healthcare staff created multiple care plans including an older person's care plan. Doctors prescribed appropriate medication and Mr Nunn was located on L Wing, which is a social and palliative care unit for older prisoners with 24-hour nursing cover.

23. On 7 September 2017, a prison GP and a nurse discussed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order with Mr Nunn, who agreed that if he stopped breathing he did not want to be resuscitated. Mr Nunn signed the document and said that he did not wish to review this decision and wanted it noted that this was an indefinite instruction.

24. Over the next two years, healthcare staff monitored and reviewed Mr Nunn frequently and discussed his care needs at multidisciplinary meetings. These meetings noted a steady decline in Mr Nunn's health.

25. On 28 May 2019, Mr Nunn was granted parole. A social worker was asked to find an appropriate placement for Mr Nunn which would meet all his enhanced care needs. Mr Nunn was aware of the Parole Board's decision but was recorded as not really retaining the information.

26. On 30 June, a nurse found Mr Nunn on the floor of his cell, after he had fallen while trying to get to the toilet. Mr Nunn was taken to hospital, where he was admitted with a fractured hip. He had an operation and returned to prison on 9 July.

27. On 11 July, a prison GP and a nurse reviewed Mr Nunn's DNACPR document. Mr Nunn maintained that he did not wish to be resuscitated if he stopped breathing. This decision was recorded as indefinite.

28. On the same day, the nurse recorded that Mr Nunn was frail and completely dependent on others for his daily care needs. Staff put in place enhanced care plans to try to reduce the risk of Mr Nunn falling, but he was reluctant to get out of bed and was becoming increasingly confused.

29. On 8 August and again on 19 September, staff noted that an appropriate place for Mr Nunn to be released to had still not been found.

30. On 30 September, it was noted that there was further deterioration in Mr Nunn's health. He was not recognising staff that he had known for a long time and was having difficulty swallowing his medication and fluids.

31. On 1 October, healthcare staff made a referral to the Norfolk palliative care team. Plans were put in place to manage Mr Nunn's deteriorating health. It was

decided that oral medication would be stopped due to the risk of aspiration pneumonia (a lung infection that develops as the result of inhaling fluid into the lungs) and Mr Nunn was recorded as being for end of life care. His care plans reflected this and Mr Nunn was cared for with an open-door policy (the cell door was left open at all times).

32. Between 8 and 14 October, Mr Nunn was noted to have improved slightly. He was taking oral fluids and staff were moving him to his chair to provide relief to his pressure areas.

33. Overnight on 17 October, Mr Nunn appeared to be deteriorating. He was checked half hourly and regular mouth care was given in accordance with his end of life care plans.

34. On 18 October, Mr Nunn saw a palliative care nurse. Mr Nunn was no longer able to swallow and he appeared agitated.

35. On 20 October, Mr Nunn became increasingly agitated and seemed to be in pain with any movement. A nurse spoke to the palliative care team and they decided that they would start a syringe driver (a small infusion pump that slowly administers medication) to help to control pain and agitation.

36. Over the next couple of days, Mr Nunn remained agitated. Further discussions with the palliative care team suggested adding haloperidol (treatment for agitation) to the syringe driver. At 11.16am on 22 October, haloperidol was added to the syringe driver. At 2.00pm, Mr Nunn was found to have stopped breathing. A prison GP confirmed that Mr Nunn had died.

Contact with Mr Nunn's family

37. On 22 October, shortly after Mr Nunn had died, the prison appointed a Custodial Manager (CM) as the family liaison officer (FLO). Mr Nunn's daughter was listed as his next of kin. The CM called her to break the news and offer support.

38. Mr Nunn's funeral was on 7 November. The prison paid for Mr Nunn's funeral in line with national guidelines.

Support for prisoners and staff

39. After Mr Nunn's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

40. The prison posted notices informing other prisoners of Mr Nunn's death, and offered support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Nunn's death.

Cause of death

41. The coroner accepted the cause of death provided by the Lead GP at Norwich. He gave Mr Nunn's cause of death as old age.

Findings

Clinical Care

42. Mr Nunn had several health conditions including COPD, high blood pressure, diabetes, Crohn's disease and heart disease. The prison made sure that all care plans were in place and when Mr Nunn's health deteriorated he was cared for appropriately. He was located in the older person's care unit where he received 24-hour nursing care.

43. We are satisfied that Mr Nunn received appropriate care and treatment at Norwich. The clinical reviewer considered the standard of care was equivalent to that he could have expected to receive in the community.

Contact with Mr Nunn's family

44. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. …If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."

45. When Mr Nunn died, the family liaison officer promptly contacted Mr Nunn's next of kin, by telephone and told her of his death. He said he did this because Mr Nunn's next of kin lived in Cambridge (approximately 60 miles away). However, the next of kin's distance from the prison is not a reason to telephone them rather than visit. PSI 64/2011 says that where the prisoner's next of kin lives a long distance away, consideration should be given to asking staff from a nearer prison to visit instead.

46. In the event, it turned out that Mr Nunn's next of kin was on holiday and we accept that in these circumstances, she could not have been told in person. However, we are concerned that the family liaison officer only knew this after he had contacted her by telephone and no attempt at a visit was made. We therefore make the following recommendation:

    The Governor should ensure that when a prisoner dies in custody, an attempt is made to visit the prisoner's next of kin to tell them of the death in person, in line with national guidelines.

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