Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Kadri, a prisoner at HMP Norwich, on 3 June 2021

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*

Summary

1. 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.

2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

3. Mr Anthony Kadri died from heart failure at HMP Norwich on 3 June 2021. He was 67 years old. I offer my condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Kadri received at Norwich was of a good standard and was equivalent to that which he could have expected to receive in the community. She found that the care delivered was safe, effective, compassionate, caring and responsive.

5. However, there were delays in prison staff passing information to the ambulance service because they did not have accurate information about Mr Kadri's condition. We are also concerned that healthcare staff carried out cardiopulmonary resuscitation (CPR) despite being aware that Mr Kadri had signed an order not to be resuscitated.

6. We also had a number of non-clinical concerns. Prison staff did not complete a compassionate release application form and the investigator was, therefore, unable to identify why this did not progress. Mr Kadri's friend was not kept up to date about the deterioration of his health when he was last sent to hospital.

7. Mr Kadri was restrained when he went to hospital in February and May 2021, even though he had poor mobility and many serious medical conditions. We were also concerned that Norwich did not provide the investigator with all the documentation about the use of restraints when Mr Kadri went to hospital, which meant that we could not determine whether the decision-making process on those occasions was appropriate. Norwich had previously agreed to train staff on completing escort risk assessments and we were disappointed to find this had not happened.

Recommendations

- **The Head of Healthcare should ensure that key staff, particularly clinical staff, are aware of all prisoners with an active order not to be resuscitated and understand that they should not be resuscitated during an emergency response.**

- **The Governor and Head of Healthcare should ensure that:**

    - **control room staff who telephone the ambulance service provide them with contact details for the prison and as much information as possible before transferring the call; and**

- **when there is a medical emergency, staff at the scene remain in contact with staff on the call to the ambulance service and provide timely updates about the prisoner's condition.**

- **The Governor and Head of Healthcare should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with Prison Service Instruction (PSI) 64/2011.**

- **The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that in all cases:**

  - **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**

  - **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

- **The Governor and Head of Healthcare should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised, and that a record is kept of action taken.**

- **The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.**

The Investigation Process

8. NHS England commissioned a clinical reviewer to review Mr Kadri's clinical care at HMP Norwich. The clinical reviewer's report is annexed to this report.

9. The PPO investigator has investigated the non-clinical issues including Mr Kadri's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

10. The PPO family liaison officer, wrote to Mr Kadri's nominated next of kin, a friend, to explain the investigation. She did not respond.

11. We shared the initial report with the prison service. There were no factual inaccuracies and the action plan has been appended to this report.

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

Previous deaths at HMP Norwich

13. There were eight deaths from natural causes and two self-inflicted deaths at Norwich in the two years before Mr Kadri's death. There has been one death from natural causes and one self-inflicted death since Mr Kadri's death.

14. Following the recommendations we made, Norwich agreed in December 2019 to train the healthcare team to ensure they were actively involved in the risk assessment process for hospital escorts. They also agreed to a number of actions relating to the regular monitoring and quality assurance of the risk assessment process.

15. Norwich also agreed in May 2020, to implement actions ensuring that staff administered CPR in line with best practice and that in an emergency, staff provide information about the prisoner's condition to the communication room, including whether the patient had in place an order not to be resuscitated.

Key Events

16. On 26 October 2017, Mr Anthony Kadri was convicted of sex offences and sent to prison for seven years.

17. In November 2020, while a prisoner at HMP Bure, Mr Kadri was diagnosed with pneumonia and heart failure. A hospital care plan noted that the focus for Mr Kadri should be on symptom control rather than life sustaining treatment and CPR should not be attempted.

18. On 25 December, Mr Kadri was transferred from hospital to HMP Norwich, and went to L Wing, a 15-bed healthcare unit for elderly patients, many receiving palliative care. A nurse carried out his initial health screen. She noted that he had early cognitive impairment (trouble remembering and learning), diabetes, that he had had a colostomy (a bowel operation which leaves an opening in the abdomen called a stoma to collect urine and faeces into a bag) and that he had poor mobility and was at risk of falls.

2021

19. On 5 January 2021, a nurse saw Mr Kadri and noted that he had a National Early Warning Score (NEWS2) of 9. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above 7 indicates the need for an emergency response.) The nurse asked a second nurse to review Mr Kadri. The second nurse saw that Mr Kadri's stoma had stopped working and that his urine output was minimal. He sent Mr Kadri to hospital with a suspected chest infection and possible sepsis (a severe infection). Mr Kadri tested positive for COVID-19 in hospital.

20. We cannot say if Mr Kadri was restrained during the escort to the hospital as Norwich did not provide these records. However, Mr Kadri was not restrained during his stay in hospital. On 19 January, he went back to Norwich.

21. On 13 January, the Head of Suicide and Self-Harm Prevention appointed a Custodial Manager (CM) as the family liaison officer (FLO). The FLO contacted Mr Kadri's next of kin, his friend, to inform her of his condition and that he was returning to Norwich on 19 January.

22. On 11 February, a nurse reviewed Mr Kadri and recorded that his NEWS2 was 10. He called 111 (the NHS Helpline) as Mr Kadri was struggling to breathe. Ambulance paramedics took Mr Kadri to hospital, where hospital staff treated him for pneumonia.

23. Mr Kadri was restrained using single handcuffs and 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). At 4.00pm the next day, the Head of Business Assurance reviewed the level of restraints and authorised their removal. Norwich did not provide us with a copy of the risk assessment.

24. On 11 February, the FLO tried to contact Mr Kadri's friend. He told her on 13 February that Mr Kadri had been sent to hospital and spoke to her again on 18 February to update her about his condition. On 2 March, Mr Kadri went back to Norwich, bedbound.

25. On 4 March, a nurse created a palliative care plan for Mr Kadri. She noted that she had told prison staff that they needed to start a compassionate release application.

26. Before Mr Kadri attended a chest x-ray at the hospital on 16 March, prison staff completed an escort risk assessment. A nurse completed the medical section and the Head of Operations, did not authorise restraints because Mr Kadri used a wheelchair and had poor mobility.

27. On 25 March, Mr Kadri told a prison GP and a nurse that he did not want to be resuscitated and signed an order to that effect.

28. At 10.50pm on 19 May, a nurse went to Mr Kadri's cell because a healthcare assistant (HCA) had found him unresponsive. She noted that his eyes were open but that he had a weak pulse and shallow breathing. She noted that his NEWS2 score was 9. She asked for an ambulance and ambulance paramedics took him to hospital.

29. Before Mr Kadri went to hospital, prison staff completed an escort risk assessment. The medical section was not completed. A CM noted that Mr Kadri's risk to the public and risk of escape was unknown. The Head of Residence and Safety authorised that two officers escort Mr Kadri to hospital and that Mr Kadri should be restrained with a single handcuff and/or an escort chain.

30. When he went to hospital, Mr Kadri remained restrained, including while hospital staff carried out examinations, bloods tests and an x-ray. At 11.05am, the Head of Reducing Reoffending, authorised that the restraints be removed.

31. On 20 May, while Mr Kadri was in hospital, two doctors completed a form about his emergency care and treatment. It noted that Mr Kadri did not want to be resuscitated due to his lung condition and the fact that he was bedbound.

32. On 25 May, prison staff updated Mr Kadri's escort risk assessment. A nurse completed the medical section and did not object to the use of restraints. She noted that his condition did not restrict his ability to escape but noted that he was on oxygen and had limited mobility. The Head of Offender Management Unit, noted that Mr Kadri should not be restrained, and that one officer should stay with him at the hospital. On 27 May, Mr Kadri went back to Norwich.

33. On 2 June, a nurse and a prison GP discussed Mr Kadri's care and noted his poor prognosis. A nurse referred Mr Kadri to community specialist palliative care.

3 June 2021

34. At about 4.00pm on 3 June, an HCA gave Mr Kadri his evening meal. After eating his meal, Mr Kadri became unresponsive. The HCA called for help. A nurse went into the cell and started CPR as he thought that Mr Kadri had a faint pulse.

35. An HCA radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing) and continued with CPR.

36. At 4.16pm, an officer in the control room telephoned the ambulance service but gave no details about the medical emergency. The officer transferred the telephone call to the wing office, and an HCA explained the emergency. The HCA did not give the prison's telephone number or Mr Kadri's age as she did not have his file ready. She was unable to answer all the call handler's questions as she said she was in the office and not at the scene. The HCA left the call on two occasions to find information and check on the scene in order to update the call handler.

37. An HCA, a nurse and a prison GP went to Mr Kadri's cell and carried out CPR.

38. The HCA told the ambulance operator that Mr Kadri had signed an order not to be resuscitated and the ambulance service operator asked her why they were continuing CPR. A male member of staff took over the call and told the call handler that CPR was ongoing, and that they were not using the defibrillator because of the order. Norwich did not confirm who this member of staff was.

39. Healthcare staff continued CPR until ambulance paramedics arrived at Mr Kadri's side at 4.22pm. The paramedics were shown the form about emergency care and treatment dated 20 May 2021 and told healthcare staff to stop CPR.

40. At 4.25pm, an ambulance paramedic pronounced that Mr Kadri had died.

Post-mortem report

41. A post-mortem examination established that Mr Kadri died from congestive cardiac failure (heart failure), caused by cor pulmonale (right-side heart failure).

Findings

Clinical findings

Mr Kadri's clinical care

42. The clinical reviewer found that the clinical care that Mr Kadri received at Norwich was at least equivalent to that which he could have expected to receive in the community. She was satisfied that appropriate care planning was in place for Mr Kadri's clinical conditions and noted that risk assessments and screening tools were used positively. The clinical reviewer found that the care delivered to Mr Kadri was safe, effective, compassionate, caring and responsive.

43. However, she was concerned that staff decided to try to resuscitate Mr Kadri despite noting that he had made an informed decision not to be resuscitated.

Order not to be resuscitated

44. Mr Kadri signed an order on 23 November 2020 to confirm that he did not want to be resuscitated if his heart or breathing stopped. On 25 March 2021, he signed a further notice to the same effect which remained in place until his death. A form about Mr Kadri's emergency care and treatment completed in hospital on 20 May included the same information.

45. However, when Mr Kadri became unresponsive on 3 June, healthcare staff started and continued CPR until paramedics arrived, despite knowing that he had an order in place not to be resuscitated. The clinical reviewer is concerned that healthcare staff decided to resuscitate Mr Kadri. She said that the wishes, choices and preferences of prisoners, as with other patients, about resuscitation are paramount and, although difficult to accept, must be applied on all occasions. We make the following recommendation:

    The Head of Healthcare should ensure that key staff, particularly clinical staff, are aware of all prisoners with an active order not to be resuscitated and understand that they should not be resuscitated during an emergency response.

Emergency response

46. Prison Service Instruction (PSI) 3/2013 on medical emergency response codes says that the member of staff using the medical emergency code must also provide relevant information about the condition of the prisoner to the control room staff, so that they can pass it on to the ambulance service for use so they can determine what priority to give their response.

47. Norwich's local policy on the protocol for healthcare emergency response codes states that Communications Room staff should call an ambulance and convey this information or put the ambulance service through to an extension nearest the emergency scene. The control room operator did not give any information to the ambulance service about the medical emergency, including basic information such as the location of the call, namely HMP Norwich. The control room operator immediately transferred the call to L Wing, where an HCA took the call. The

HCA was unable to give basic information about the location and prisoner and was also not in contact with the scene. As a result, the ambulance service was not immediately aware that Mr Kadri had difficulty breathing.

48. It is unlikely that the delays during the call changed the outcome for Mr Kadri, but they could make a significant difference in other emergencies and we make the following recommendations:

The Governor and Head of Healthcare should ensure that:

- **control room staff who telephone the ambulance service provide them with contact details for the prison and as much information as possible before transferring the call; and**
- **when there is a medical emergency, staff at the scene remain in contact with staff on the call to the ambulance service and provide timely updates about the prisoner's condition.**

Non-Clinical Findings

Liaison with Mr Kadri's next of kin

49. Norwich appointed a family liaison officer (FLO), in January 2021 who told Mr Kadri's next of kin, his friend, about his deteriorating health. He made contact again during Mr Kadri's stay in hospital in February. However, the FLO made no contact with Mr Kadri's friend from this date until after his death.

50. The FLO said that after Mr Kadri returned to Norwich in March, his health improved, and he was not thought to be at risk of dying so he made no further contact with Mr Kadri's friend. The medical records indicated that Mr Kadri returned from hospital bedbound, he needed palliative care and his health deteriorated until his death. While we recognise that Norwich appointed a family liaison officer who contacted Mr Kadri's friend in January and February, we would have expected him to update her when Mr Kadri's health deteriorated further, in line with PSI 64/2011. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff notify a prisoner's next of kin as soon as possible when they become seriously ill, in line with PSI 64/2011.

Restraints, security and escorts

51. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

52. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the

prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change. It found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

53. Although Mr Kadri was not restrained when he went to hospital on 16 March, he was restrained with an escort chain when he went to hospital on 19 May and remained restrained until 11.05am the following day. When he went to hospital, the medical section of the risk assessment was not completed despite Mr Kadri's deteriorating health. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances.

54. A nurse had access to Mr Kadri's medical records and should therefore have known about his health and medical conditions. There is no evidence to justify why there was no clinical objection to the use of restraints given that Mr Kadri was bedbound and had terminal medical conditions. Mr Kadri was restrained in hospital for nearly 12 hours before the restraint was removed and this was just two weeks before he died.

55. Mr Kadri was a Category C prisoner. His health had deteriorated, he was bedbound, he needed oxygen 24-hours a day, he had a personal emergency evacuation plan (PEEP) in place, a colostomy bag, chronic lung disease, severe arthritis in his hands, heart failure and difficulty swallowing. He had also been found unresponsive in his cell before being taken to hospital. It is clear that the authorising officer did not take these factors into account when he authorised that Mr Kadri should be restrained.

56. We understand that Norwich has not trained healthcare staff on completing escort risk assessments. This is very disappointing given they agreed to do so in response to a previous PPO recommendation following a death in June 2019 and said they would have done so by 31 December 2019 (that is, before the COVID-19 pandemic). We refer Norwich back to their action plan of December 2019 and ask that they implement the actions agreed at that time.

57. We repeat the following recommendations:

The Governor and the Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints and that, in all cases:

- **healthcare staff complete the medical information section of the escort risk assessment to say whether the prisoner's current medical condition affects their mobility and risk of escape; and**
- **authorising managers show that they have taken this information into account when assessing a prisoner's current level of risk.**

Compassionate release

58. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for

determinate sentenced prisoners are set out in Prison Service Order 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section of HM Prison and Probation Service.

59. The Head of Suicide and Self-Harm Prevention told the investigator that when Mr Kadri was transferred to Norwich at the end of December 2020, he was not terminally ill and was expected to make a full recovery.

60. On 4 March 2021, a nurse asked the Head of Suicide and Self-Harm Prevention to begin the compassionate release application. The Head of Suicide and Self-Harm Prevention said that he asked the nurse for a prison GP to complete a formal letter confirming the prognosis. The Head of Suicide and Self-Harm Prevention said that he did not receive this, and the nurse said that she did not receive the Head of Suicide and Self-Harm Prevention's request. A Prison Offender Manager told the Head of Suicide and Self-Harm Prevention that there were difficulties in finding a suitable address for Mr Kadri's release.

61. While this may have been the case, we are concerned that the compassionate release process was not managed efficiently. We have seen no evidence that the compassionate release application form was completed, and we are concerned that no prison manager took effective control of the process. We make the following recommendation:

The Governor and Head of Healthcare should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised, and that a record is kept of action taken.

Providing the PPO with relevant documents

PSI 58/2010 requires prisons to provide evidence to the Ombudsman's office for the purpose of our investigation. Norwich did not supply all the escort risk assessment documentation. This adversely affected our investigation and meant that we could not determine whether the decision-making process when Mr Kadri was escorted to hospital in January and February 2021 was appropriate. We make the following recommendation:

The Governor should ensure that all evidence about a death in custody, including electronic evidence, is retained and promptly made available to the Prisons and Probation Ombudsman, in line with PSI 58/2010.

Sue McAllister, CB
Prisons and Probation Ombudsman **January 2022**

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