Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Glazebrook, a prisoner at HMP/YOI Norwich, on 9 July 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 Peter Glazebrook died of respiratory failure and bronchopneumonia while a prisoner at HMP Norwich, on 9 July 2021. This was caused by severe chronic obstructive pulmonary disease (COPD, a lung disease) and fibrosis (scarred lung tissue). He was 79 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Glazebrook received at HMP Norwich was of a consistently good standard and was equivalent to that which he could have expected to receive in the community. She found good practice in the palliative care support and end-of-life care he received and noted that healthcare staff provided compassionate care.

5. However, we found that even though healthcare staff said that they carried out observations on Mr Glazebrook on the afternoon before his death, these were not recorded in his medical records.

6. We had a number of non-clinical concerns. Mr Glazebrook's wife was not consistently updated about the deterioration of his health, specifically in the final two months of his life when his prognosis worsened.

7. On 3 April, when Mr Glazebrook went to hospital, he was restrained, even though a prison manager did not authorise restraints.

8. On 17 June, prison staff did not restrain Mr Glazebrook when he went to hospital despite a prison manager authorising restraints on this occasion. He was however restrained on his return to Norwich after his appointment. There is no evidence that prison staff considered his age, poor mobility and deteriorating health when deciding if he should be restrained.

9. Prison staff did not complete an application for early compassionate release. Prison staff told the investigator that Mr Glazebrook was not terminally ill and therefore compassionate release was not appropriate. This is in clear contrast to the medical records and email evidence which indicate that discussions about compassionate release started in March.

Recommendations

- **The Head of Healthcare should ensure that staff understand their professional requirement to make accurate, timely and contemporaneous notes in prisoners' medical records, in line with the Nursing and Midwifery Council's guidance.**

- **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 a 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 review the adequacy of the risk assessment process at HMP Norwich to ensure the inconsistencies in the use of restraints on 3 April 2021 and 17 June 2021 have been addressed.**
- **The Governor should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay, keeping a record of action taken.**
- **The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.**

The Investigation Process

10. NHS England commissioned an independent clinical reviewer, to review Mr Glazebrook's clinical care at HMP Norwich. The clinical reviewer's report is annexed to this report.

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

12. The PPO family liaison officer wrote to Mr Glazebrook's wife to explain the investigation. She asked the following about the care Mr Glazebrook received at Norwich:

    - Why it took so long to certify his death;
    - Whether regular, bank or agency staff were on duty and if they knew how seriously ill he was;
    - Whether he was locked in his cell;
    - What time he was checked before being found;
    - Whether he had bronchopneumonia symptoms (a high temperature and struggling to breath), and whether he received treatment for them;
    - Whether he had asked not to be treated; and
    - Whether a doctor had seen him.

13. Mr Glazebrook's wife also said that the family could not fault the regular staff for Mr Glazebrook's care and their kindness. A separate comment about an issue not relating to his death has been passed to the prison to address. Mr Glazebrook's wife's concerns have been addressed in our report and in the clinical review.

14. Mr Glazebrook's wife received a copy of the draft report. She made some comments relating to the findings which do not impact on the factual accuracy of the report and have been addressed through separate correspondence.

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

Previous deaths at HMP Norwich

16. Mr Glazebrook was the tenth prisoner to die at Norwich since July 2019. Of the previous deaths, eight were from natural causes and one was a self-inflicted death. Since Mr Glazebrook's death, there have been two self-inflicted deaths at Norwich. There are similarities between our findings in this investigation and our investigation findings for the previous deaths.

17. In December 2019, Norwich agreed to train the healthcare team to ensure they were actively involved in the escort risk assessment process. They said that they would regularly monitor and quality assure the risk assessment process. We are

concerned that we have again identified deficiencies with the escort risk assessment process.

Key Events

18. On 15 September 2017, Mr Glazebrook was convicted of sex offences and sentenced to 15 years in prison. On 3 June 2019, he was transferred to HMP Bure.

19. On 9 July 2019, Mr Glazebrook signed an order to say that he did not want anyone to resuscitate him if his heart or breathing stopped.

20. In November 2019, Mr Glazebrook was diagnosed with pulmonary fibrosis (a type of lung disease).

2020

21. On 27 January 2020, a nurse sent Mr Glazebrook to hospital because he had been breathless, coughing and had a National Early Warning Score (NEWS2, a tool to detect and respond to clinical deterioration) of 8 which required an emergency response.

22. He stayed in hospital until 20 February when he was transferred to HMP Norwich because he needed 24-hour healthcare which could not be provided at Bure. Mr Glazebrook lived on L Wing, a 15-bed healthcare unit for elderly patients.

23. On 21 February, a nurse carried out an initial health screen for Mr Glazebrook and noted that he had COPD and was not able to carry out daily activities without assistance. He needed 24-hour oxygen therapy and he used a wheelchair.

24. On 29 February, a nurse saw Mr Glazebrook and completed advanced care planning documents for him. She noted that he was extremely frail and in poor health but was stable and did not need to be considered for early compassionate release. She referred him for palliative care services.

2021

25. On 12 January 2021, Mr Glazebrook tested positive for COVID-19.

26. On 13 January, the Head of Suicide and Self-Harm Prevention at Norwich, appointed a Custodial Manager (CM) as Mr Glazebrook's family liaison officer (FLO). The FLO telephoned Mr Glazebrook's wife and told her that he was unwell.

27. On 15 February, Mr Glazebrook went to hospital for a CT scan, unrestrained.

28. On 2 March, a prison GP reviewed Mr Glazebrook and noted that his lung fibrosis had got worse.

29. On 4 March, a nurse discussed Mr Glazebrook's life expectancy with a prison GP who said it had worsened and that he may have a prognosis of less than 6 months. The prison GP said that Mr Glazebrook's family were happy to care for him at home if an application for compassionate release was successful. The nurse spoke to Mr Glazebrook who told her that he was aware that he had been at a palliative stage of life since he arrived at Norwich.

30. On 3 April, a nurse saw Mr Glazebrook as he was short of breath and needed more oxygen. He sent Mr Glazebrook to hospital and completed palliative support and

older person care plans, noting that Mr Glazebrook needed help to move his wheelchair.

31. On 3 April, before Mr Glazebrook went to hospital, prison staff completed an escort risk assessment. A nurse who completed the medical section, did not object to the use of restraints but noted that he used a walking aid. The Head of Segregation and Key Work did not authorise the use of restraints.

32. However, at 6.30pm, Mr Glazebrook left Norwich for hospital, restrained with a single handcuff 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). A CM incorrectly named him on the escort paperwork as "Gary". A Supervising Officer (SO) signed to confirm that he had identified Mr Glazebrook despite the incorrect name and an officer completed the record of events throughout the evening, incorrectly identifying him as Gary.

33. At 7.40am on 4 April, officers removed the restraints. On 8 April, Mr Glazebrook went back to Norwich.

34. On 23 April, Mr Glazebrook was sent back to hospital, unrestrained, because he had low oxygen saturation and a NEWS score of 8.

35. On 23 April, Mr Glazebrook told a hospital consultant, that he did not want to be resuscitated or be admitted to intensive care for invasive treatments. Hospital staff diagnosed Mr Glazebrook with end-stage respiratory failure. On 30 April, he went back to Norwich.

36. On 26 April, the Assurance Lead, telephoned Mr Glazebrook's wife because healthcare staff were concerned that Mr Glazebrook's health was worsening in hospital. The next day, the FLO telephoned Mr Glazebrook's wife to update her about Mr Glazebrook's condition.

37. On 28 April, after Mr Glazebrook's wife spoke to a hospital doctor, she telephoned the FLO to discuss compassionate release. He told her that he would speak to the Head of Suicide and Self-Harm Prevention.

38. Throughout April, a prison GP and a nurse noted in Mr Glazebrook's medical records that he should be considered for compassionate release. The nurse repeatedly noted that she had asked the hospital respiratory team to confirm his prognosis. Mr Glazebrook's hospital discharge summary on 30 April confirmed a prognosis of less than 6 months and that he had been discharged with palliative care medication.

39. On 2 May, Mr Glazebrook fell over and staff moved him to a cell next to the nursing office.

40. On 4 May, a prison GP noted that Mr Glazebrook had weeks and not months to live and that early compassionate release should be considered. That day, the Head of Suicide and Self-Harm Prevention emailed a nurse to say that compassionate release would presumably be difficult because Mr Glazebrook needed social care and there was still no clear prognosis. The nurse told him that she had a hospital letter, confirming that Mr Glazebrook had been given less than six months to live and that he had end-stage emphysema. The nurse said that he needed a full care

package for compassionate release and in the prison GP's and her opinion, Mr Glazebrook had weeks to live.

41. On 5 May, Mr Glazebrook's wife and son visited him in prison.

42. On 10 May, Mr Glazebrook went to hospital for a respiratory appointment, unrestrained. Hospital staff told Mr Glazebrook that he had a short prognosis.

43. On 15 June, a prison GP reviewed Mr Glazebrook and noted that he should be released early on compassionate grounds, that his condition was irreversible and that he had days or weeks to live.

44. On 17 June, Mr Glazebrook went to hospital for a CT scan, unrestrained. Before he left Norwich, prison staff completed an escort risk assessment. A nurse completed the medical section and did not object to the use of restraints. She noted that Mr Glazebrook had a medical condition which restricted his ability to escape unaided and that restraints should be removed for his CT scan. A member of staff authorised that Mr Glazebrook should be restrained with a single cuff and an escort chain for social distancing. However, Mr Glazebrook was not restrained as the escorting officer said that the Head of Projects, had authorised this decision. There is no record of this in the escort risk assessment. After the CT scan, officers restrained Mr Glazebrook with a single handcuff and an escort chain.

45. On 19 June, Mr Glazebrook went to hospital, unrestrained.

46. In the early hours of 8 July, a nurse and Healthcare Assistant (HCA) went to Mr Glazebrook's cell after he shouted for help. She asked officers to open his cell door. Mr Glazebrook's oxygen tubes had come away from his nose and his oxygen saturation levels were very low. Mr Glazebrook said that he was breathless and unwell. At 7.15am, The nurse reviewed him and noted that he had a NEWS score of 7. A score of 5-7 was regarded as in the normal range for Mr Glazebrook in view of his advanced lung disease.

47. On the morning of 8 July, a prison GP reviewed Mr Glazebrook with a nurse. The prison GP noted that Mr Glazebrook had had a bad night, was anxious and coughing but did not have a fever, diarrhoea, vomiting or chest pains. The prison GP noted that he had a very subtle chest crackle, with a wheeze, and told Mr Glazebrook that he should go to hospital. He declined to do so. A prison manager authorised an open-door policy (a cell door to be open 24-hours a day). The nurse noted that he had a low NEWS score of 4 which was below the acceptable range for Mr Glazebrook and therefore did require an emergency response.

48. At about 12.35pm, the nurse found Mr Glazebrook falling in his bathroom. An HCA and the Managing Chaplain supported him. At 12.44pm, an ambulance was called and at 12.57pm, ambulance paramedics were at his side. He still declined to go to hospital.

49. The HCA carried out observations throughout the afternoon and checked on Mr Glazebrook every half an hour. These checks were not recorded in the medical records.

50. At approximately 7.35pm, a nurse and the HCA were in the healthcare office and heard a rumbling sound from Mr Glazebrook's cell. They went into his cell and found him unresponsive on the bathroom floor, with his eyes open. They found no

signs of life. They did not start cardiopulmonary resuscitation (CPR). At 2.04am on 9 July, an out-of-hours GP, pronounced that Mr Glazebrook had died.

Post-mortem report

51. A post-mortem examination established that Mr Glazebrook died from respiratory failure (a lack of oxygen in the blood) and bronchopneumonia (lung infection), caused by severe chronic obstructive pulmonary disease (COPD, a lung disease) and fibrosis (scarred lung tissue).

Clinical Findings

Record keeping

52. Three healthcare staff reported interacting with Mr Glazebrook on 8 July but none of these interactions were recorded in the medical records. A nurse said that he gave Mr Glazebrook his medication at around 4.00pm. A nurse said that she visited Mr Glazebrook in his cell shortly after this, returning past his cell and observing him later on. An HCA said that she carried out observations on Mr Glazebrook every half an hour throughout the afternoon. She did not record her observations in the medical records so there is no evidence that healthcare staff saw Mr Glazebrook after 12.35pm when the ambulance crew attended to him.

53. Good record keeping is vital for continuity and shared understanding of decisions. While we acknowledge that an open-door policy was put in place to monitor Mr Glazebrook after paramedics attended, we are disappointed that there was no plan to record those observations. We make the following recommendation:

The Head of Healthcare should ensure that staff understand their professional requirement to make accurate, timely and contemporaneous notes in prisoners' medical records, in line with the Nursing and Midwifery Council's guidance.

Non-Clinical Findings

Restraints, security and escorts

54. 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.

55. 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 was found that using handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

56. Authorising officers did not authorise restraints to be used on Mr Glazebrook for the escorts and hospital admissions on 15 February, 3 April, 23 April, 10 May, or 19 June. The authorising officer did however authorise restraints to be used for the escort of 17 June.

57. There were clear breakdowns in the escorting process on 3 April. Staff signed to say that they had confirmed the identity of Mr Glazebrook while the escort paperwork had an incorrect name on it. This was not corrected until after the officers moved to bedwatch paperwork. Mr Glazebrook was then restrained against the authorising officer's decision on the escort risk assessment.

58. There was a further breakdown in the escorting process on 17 June. Although Mr Glazebrook was ultimately not restrained on his way to hospital and we recognise that a nurse noted that his ability to escape was restricted and that restraints would need to be removed for the CT scan, we are concerned that she did not object to the use of restraints and that the authorising officer subsequently decided to restrain him.

59. There was no record of the Head of Projects decision not to restrain Mr Glazebrook and no accompanying risk assessment to evidence his decision-making process. Mr Glazebrook was then restrained for his return journey to Norwich.

60. Mr Glazebrook was a Category C prisoner. His health had deteriorated, he was wheelchair bound, required oxygen 24-hours a day, had chronic lung disease and was predicted to have only weeks left to live. It is clear that the authorising officer did not take these factors into account when she authorised that Mr Glazebrook should be restrained. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances.

61. The Head of Suicide and Self-Harm Prevention told the investigator that Norwich had previously decided that prisoners on L Wing should not be routinely restrained unless there was a specific change to their risk status.

62. Medical input into the risk assessments for Mr Glazebrook's escorts was inconsistent and there is no evidence to justify why there was no objection to the use of restraints on 15 February, 3 April, 10 May and 17 June, given that Mr Glazebrook had extremely limited mobility, terminal medical conditions and resided on L Wing.

63. We understand that Norwich has not trained healthcare staff on completing escort risk assessments. This is very disappointing given that they agreed to do so by 31 December 2019 in response to a previous PPO recommendation following a death in June 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. We make 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.**

The Governor and Head of Healthcare should review the adequacy of the risk assessment process at HMP Norwich to ensure the inconsistencies in the use of restraints on 3 April 2021 and 17 June 2021 have been addressed.

Compassionate release

64. 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. Prison Service Order (PSO) 6000 states that the criteria for early release includes that the risk of re-offending should 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 (PPCS) of the Her Majesty's Prisons and Probation Service (HMPPS).

65. The Head of Suicide and Self-Harm Prevention told the investigator that when Mr Glazebrook was transferred to Norwich in February 2021, he was not terminally ill, and was expected to make a full recovery. He also said that after Mr Glazebrook's health deteriorated, he was still never deemed to be terminally ill, that he could have made a full recovery and therefore compassionate release was never supported or sought. This is in clear contrast to the medical records and email evidence that show discussions about compassionate release started in March and continued through April and May.

66. Mr Glazebrook's family were prepared to look after him at home, and the GP made clear statements that Mr Glazebrook had deteriorated to a position of having weeks rather than months left to live. Discussions between the Head of Suicide and Self-

Harm Prevention, the FLO and healthcare staff at the end of April and beginning of May appeared to end when a nurse responded to the Head of Suicide and Self-Harm Prevention, explaining that she had a letter to confirm Mr Glazebrook's life expectancy and that he would require a full package of care.

67. The Head of Suicide and Self-Harm Prevention later told the investigator that following these emails, the decision was made not to continue with Mr Glazebrook's compassionate release application 'due to social care requirements for release, current concerns around hospital in-patient and life expectancy'. Norwich provided no evidence about this decision-making process.

68. While we recognise that there might have been obstacles to overcome relating to the care required for Mr Glazebrook at home with his family, and in obtaining a clear prognosis, we are concerned that the compassionate release process was not managed efficiently. This meant that Mr Glazebrook was denied the opportunity to apply to die at home with his family around him. 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 recommendations:

The Governor should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses are prioritised and completed without delay, keeping a record of action taken.

The Governor and Head of Healthcare should ensure that a copy of this report is shared with all staff named in this report and that a senior manager discusses the Ombudsman's findings with them.

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