Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Lewis, a prisoner at HMP Norwich, on 9 August 2022

A report by the Prisons and Probation Ombudsman

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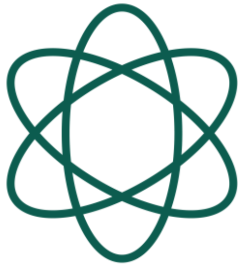
Our vision

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

OGL

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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 Robert Lewis died from the exacerbation of chronic obstructive pulmonary disease (COPD, a lung disease) on 9 August 2022 while a prisoner at HMP Norwich. He also had cardiovascular disease (a reduction in the blood flow around the body), Parkinson's disease (a progressive disorder that affects the nervous system and the parts of the body controlled by the nerves) and was very frail and old. These factors contributed to but did not cause Mr Lewis' death. He was 83 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care that Mr Lewis received at Norwich was of a good standard and equivalent to that which he could have expected to receive in the community. However, she identified that there were no healthcare records from around the time of Mr Lewis' death. This lack of information meant that we could not determine what interaction healthcare staff had with Mr Lewis before he died.

5. The clinical reviewer was concerned that Mr Lewis' end-of-life care plan did not outline his full wishes, other than that he wanted to die in prison.

6. We are concerned about the prison's approach to early compassionate release for Mr Lewis. We do not consider that compassionate release was appropriate in the circumstances because he wanted to die in prison and did not meet the criteria for early release.

Recommendations

- **The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.**

- **The Head of Healthcare should consider the 'Dying Well in Custody Charter' and ensure that all aspects of end-of-life care are discussed and documented.**

- **The Governor should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses:**

  - **are assessed on a case-by-case basis; and**

  - **are in line with the fundamental principles underlying the approach to early release within the Early Release on Compassionate Grounds (ECRG) Policy Framework.**

The Investigation Process

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

8. The PPO investigator investigated the non-clinical issues relating to Mr Lewis' care, including his location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. The PPO family liaison officer wrote to Mr Lewis' next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Previous deaths at HMP Norwich

11. Mr Lewis was the tenth prisoner to die at Norwich since August 2020. There has been one death since. Of the previous deaths, six were from natural causes and three were self-inflicted.

12. We have previously made recommendations about the prison's handling of early release applications. Following our recommendations, Norwich agreed in January and July 2022 that they would hold a monthly multidisciplinary meeting about the ongoing management and care of terminally ill prisoners and those with social care needs. They agreed to progress appropriate applications under compassionate grounds following the recommendations made in the previous cases.

Key Events

13. On 27 September 2019, Mr Robert Lewis was remanded into custody for murder. He was later sentenced to life in prison, with a minimum 16-year term.

14. On 9 April 2020, Mr Lewis said he did not want anyone to resuscitate him if his heart or breathing stopped and he signed an order to that effect.

15. On 30 April 2021, Mr Lewis was transferred to Norwich and went to L Wing, a 15-bed healthcare unit for elderly patients, many receiving palliative care.

16. Before arriving at Norwich, Mr Lewis had been diagnosed with several significant medical conditions. These included hypertension (high blood pressure), acute coronary syndrome (heart problems) and chronic obstructive pulmonary disease (COPD, a lung disease). He was considered frail and had a history of falls.

17. On 13 July, a Custodial Manager was assigned as the Family Liaison Officer (FLO) for Mr Lewis as he had been admitted to hospital for suspected pneumonia.

18. Mr Lewis was diagnosed with Parkinson's disease during this hospital admission. He returned to Norwich on 6 August.

19. On 11 August, Mr Lewis was referred for a palliative care assessment because his health was deteriorating.

20. On 20 August, a nurse discussed an end-of-life care plan with Mr Lewis who said that he did not want to be admitted to hospital if he became acutely unwell. She noted that he said that he wanted to die on L Wing and that he did not want to apply for early release on compassionate grounds (ERCG).

21. On 22 August, the Head of Suicide and Self-Harm Prevention, recorded that the nurse had informed him that Mr Lewis did not want to be moved from L Wing and did not want early release.

22. On 8 December, the Head of Suicide and Self-Harm Prevention recorded that an application for early compassionate release would not be considered because Mr Lewis wanted to stay on L Wing.

23. On 27 January 2022, Norwich held a multidisciplinary meeting to discuss prisoners with social care needs and those with a terminal diagnosis. The Head of Suicide and Self-Harm Prevention recorded that Mr Lewis was terminally ill and early release paperwork would be completed and submitted for consideration. Prison records note that the team felt it would be unlikely to be agreed. They also noted that an application would be made as the PPO had recently made a recommendation and criticised the prison for not submitting applications and making decisions at a local level.

24. On 29 January, the FLO telephoned Mr Lewis' daughter and told her about the application for early release. He explained that despite her father saying he did not want to be considered for early release, the prison had to start the application following criticism from the PPO.

25. On 31 January, the Head of Suicide and Self-Harm Prevention, saw Mr Lewis to discuss the early release application. He told him that previous PPO recommendations had criticised the prison for not seeking early release for other prisoners and that he wanted to confirm that Mr Lewis did not want to apply. The Head of Suicide and Self-Harm Prevention noted that Mr Lewis said he wanted to stay on L Wing but that they 'may as well' seek an application.

26. On 12 April, an application for Mr Lewis' early release on compassionate grounds was submitted to the Public Protection Casework Section (PPCS) of HM Prison and Probation Service (HMPPS). The application was refused on the grounds that there was no clear clinical evidence that Mr Lewis' life expectancy was three months or less, he was not physically incapacitated, there was no suitable release plan in place and his risk of re-offending was not considered to be in the past.

27. On 28 April, a prison GP documented that Mr Lewis had a life expectancy of three to six months and that he would continue to be treated in prison in line with his agreed care plan.

28. At 4.45am on 2 June, a nurse saw Mr Lewis because he was 'wheezy'. She completed his physical observations and calculated a National Early Warning Score (NEWS2) of 7. (NEWS2 is a tool to detect and respond to clinical deterioration. A score above 7 indicates the need for an emergency response.) She requested an ambulance but Mr Lewis refused to go to hospital and said that he wanted to die in prison.

29. On 4 August, a prison GP assessed Mr Lewis as part of the ward round. She noted that he was receiving end-of-life care and that oral medication should stop.

30. On 8 August, a nurse saw Mr Lewis to carry out end-of-life care. She noted that he remained nursed in bed and was weak and frail. He also had slow irregular breathing.

31. At around 4.30am on 9 August, a Health Care Assistant (HCA) attended to Mr Lewis' personal care.

32. At 5.14am, a nurse noted that she had tended to Mr Lewis' personal care needs and repositioned him every two hours.

33. At 7.00am, a nurse started work. He reported that a roll check had been carried out and that Mr Lewis was still alive.

34. At 8.55am, an entry in the wing observation book noted that Mr Lewis had passed away.

35. At 9.08am, the prison GP confirmed that Mr Lewis had died.

36. At 12.30pm on 9 August, the Governor held a meeting to discuss Mr Lewis' death and offer staff support. At that meeting, an HCA said that she had checked on Mr Lewis at 8.45am. She reported that at 8.50am she was made aware by another patient that Mr Lewis did not appear to be breathing and that she went in to check on him and believed that he had passed away. This was not recorded in the medical records.

Post-mortem report

37. The Coroner accepted the cause of death provided by the prison doctor and no post-mortem examination was carried out. A prison doctor concluded that Mr Lewis died from an exacerbation of COPD. He also noted that he had cardiovascular disease and Parkinson's disease. These factors, together with his old age and that he was very frail, contributed to but did not cause his death.

Inquest into Mr Lewis' Death

38. The inquest into Mr Lewis' death was held on 26 June 2023 and a verdict of natural causes was recorded. The coroner concluded that Mr Lewis' death was due to exacerbation of COPD.

Clinical Findings

39. The clinical reviewer found that the care that Mr Lewis received at Norwich had been of a good standard overall and equivalent to that which he would have received in the wider community. She identified that Mr Lewis had complex health needs and prison healthcare staff responded promptly and proactively to his needs.

40. The clinical reviewer was concerned that there were no healthcare records at the time of Mr Lewis' death and that this was not in line with the Nursing and Midwifery Council (NMC) record keeping and the code of conduct. Although she acknowledged that healthcare staff had discussed palliative care options with Mr Lewis, she was concerned that his full end-of-life wishes were not clear.

41. The clinical reviewer made two recommendations to Norwich which did not directly relate to Mr Lewis' death but which the Head of Healthcare will need to address.

Record keeping

42. The last entry in the medical records on the morning of Mr Lewis' death was at 5.14am when a nurse repositioned him in bed. During a meeting held after Mr Lewis' death, the HCA reported that she had been told of his death by another prisoner and that she believed he was dead after she went to check on him. This is not recorded in the medical records.

43. There is an entry about Mr Lewis' death in the wing observation book but it does not provide any detail.

44. We asked Norwich for statements from staff who responded to Mr Lewis when he died. However, they were only able to provide a statement from two nurses. We were not provided with statements from any other officers attending the scene which meant that we could not establish who was there.

45. A nurse said in his statement that it was clear that Mr Lewis was still alive during a roll check after 7.00am. However, he did not say who carried out the roll check, who saw Mr Lewis, and it is not recorded in any other documentation provided to the investigator. The second statement was from a nurse who said that she had been asked to attend L Wing after Mr Lewis's death. She said that when she arrived, there were other healthcare and prison staff there and she was no longer required. However, this is not recorded in any other documentation.

46. We asked Norwich if we could interview a nurse and the HCA. Norwich told us that neither were available for interview. This meant that we were not able to establish the full events leading up to Mr Lewis' death. We make the following recommendation:

    The Head of Healthcare should ensure that all staff are aware of the requirement to maintain full and contemporaneous healthcare records.

End-of-life care planning

47. The Dying Well in Custody Charter states that each individual is offered the opportunity to be involved in the planning of their care which is regularly reviewed and shared appropriately with health and care professionals and those important to the individual, where requested.

48. A nurse saw Mr Lewis in August 2021. They discussed his advance care plan and documented that he did not want to be admitted to hospital again but wanted his care to focus on symptom control and management.

49. It is clear that that healthcare staff regularly reviewed Mr Lewis' palliative care options, including his wish to die in prison. However, it is not clear if he had any other wishes for the end of his life. The clinical reviewer was concerned that no one had asked Mr Lewis if he wanted anyone with him when he died. We know that Mr Lewis was repositioned every two hours overnight but we were not able to determine whether anyone was with him at the end of his life. We make the following recommendation:

    The Head of Healthcare should consider the 'Dying Well in Custody Charter' and ensure that all aspects of end-of-life care are discussed and documented.

Non-Clinical Findings

Compassionate release

50. 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 are set out in the Early Release on Compassionate Grounds (ERCG) Policy Framework. Among the criteria is that the risk of reoffending 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 (PPCS) of HM Prison and Probation Service (HMPPS).

51. Mr Lewis had clearly stated that he wanted to die in prison on L Wing, where he lived. He had expressed this view to multiple members of prison staff and there were no concerns raised about his mental capacity to make this decision.

52. Whilst the ERCG policy framework allows the prison to make an application in cases where the prisoner has expressed a wish to stay in prison, it should only be made if it is in the best interests of the prisoner. There were no arrangements in place for Mr Lewis’ care outside prison and no evidence that an application for early release would have benefitted him.

53. During a multidisciplinary meeting in January 2022, prison staff noted that it was unlikely that Mr Lewis’ application would be approved, and it was clear that Mr Lewis was unlikely to meet the eligibility criteria for ERCG.

54. Following two previous deaths at Norwich in June and July 2021, the PPO found that the process for compassionate release was not managed appropriately and that no prison manager took effective control of the process.

55. Norwich therefore agreed, in January 2022 and July 2022, that they would hold a monthly multidisciplinary meeting about the ongoing management and care of terminally ill prisoners and those with social care needs. They agreed to progress appropriate applications under compassionate grounds following the recommendations made in the previous cases. While we are content that that a multidisciplinary meeting was held, we are concerned that the prison did not consider Mr Lewis’ case in line with the ERCG Policy framework. Each individual’s circumstances should be considered against the framework eligibility on their own merits.

56. We are also concerned with the narrative expressed to Mr Lewis and his family about the ‘criticism from the PPO’ being the driver for making an application. This is a misrepresentation of the feedback and recommendations we made after the previous deaths. We consider that Norwich should revisit the recommendations and action plans in those cases, and we make the additional following recommendation:

The Governor should ensure that applications for early release on compassionate grounds for prisoners with terminal illnesses:

- **are assessed on a case-by-case basis; and**
- **are in line with the fundamental principles underlying the approach to early release within the ECRG Policy Framework.**

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