

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr David Norton, a prisoner at HMP Dartmoor, on 9 March 2022

A report by the Prisons and Probation Ombudsman

OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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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 David Norton died from cardiac failure on 9 March 2022, while a prisoner at HMP Dartmoor. He was 86 years old. We offer our condolences to his family and friends.
4. Towards the end of his life, proper procedures were not in place to allow Mr Norton access to pain relief at night. The clinical reviewer found that this was not appropriate and not in line with the care Mr Norton could expect to receive in the community. She was also concerned that there was a lack of documentation in the medical records that described Mr Norton's death. We share these concerns. The clinical reviewer made five other recommendations which are not related to Mr Norton's death and which the Head of Healthcare will need to address.

Recommendations

- The Head of Healthcare should review the anticipatory medication process, with particular focus on access to medications for overnight pain relief.
- 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 Investigation Process

5. NHS England commissioned an independent clinical reviewer to review Mr Norton's clinical care at HMP Dartmoor.
6. The PPO investigator has investigated non-clinical issues, including Mr Norton's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
7. The PPO family liaison officer wrote to Mr Norton's next of kin, his brother, to explain the investigation. He did not respond to our letter.
8. Mr Norton's brother received a copy of the initial report. He raised several issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Previous deaths at HMP Dartmoor

10. Five prisoners died at HMP Dartmoor in the two years before Mr Norton's death, three of whom died from natural causes and two were self-inflicted deaths. Five prisoners have died at Dartmoor since. Four of those were due to natural causes.
11. Following recommendations we made, Dartmoor agreed in May 2022 to carry out record keeping training for healthcare staff to ensure that the medical records were completed accurately.

Key Events

12. On 29 March 2018, Mr David Norton was sentenced to seventeen and a half years in prison for sex offences. He was sent to HMP Nottingham.
13. On 3 July, Mr Norton was transferred to HMP Dartmoor. At the time of transfer, Mr Norton had a medical history of osteoarthritis (painful and stiff joints), heart attack, angina, high blood pressure and spinal stenosis and kyphosis (curving and narrowing of the spine). He had reduced mobility and walked with an aid.
14. Mr Norton's health and mobility deteriorated over the following months. He was provided with a prisoner buddy to support him with daily living skills, an electric bed, and he purchased an electric wheelchair. Mr Norton reported incontinence issues regularly.
15. On 16 July 2019, Mr Norton underwent a colonoscopy at a local hospital, which diagnosed diverticular disease (a bowel condition which can cause continence problems and pain).
16. On 21 January 2020, Mr Norton was diagnosed with dementia and depression.
17. On 23 April 2021, Mr Norton was taken to hospital by emergency ambulance after reporting chest pains to nursing staff. He was diagnosed as suffering from a heart attack, heart disease and heart failure. Mr Norton returned to Dartmoor on 28 April.
18. On 4 February 2022, a meeting with different professionals involved in Mr Norton's care was held. Mr Norton was reported to have mobility problems and pressure sores on his skin. A decision was made to make a referral for social care support for him.
19. The same day, a prison GP saw Mr Norton to assess him. She noted diagnoses of possible heart failure, general age-related deterioration and undisclosed diagnosis related to aging.
20. Between 5 and 17 February, Mr Norton received social care support with the aim of providing constant supervision during the day. Dartmoor agreed to have an open-door policy overnight (his cell door would not be locked in case he required assistance). The social care records did not cover every day but show that he received this care on 5, 9, 12, 15, 16 and 17 February.
21. On 11 February, Mr Norton told a prison GP that he did not want to be resuscitated and signed an order to that effect. He asked for treatment to continue if his condition deteriorated.
22. On 17 February, a nurse visited Mr Norton to complete a welfare check. She said that considering the frailty and decline in Mr Norton, she would consider him to be at the 'end of life' stage of care.
23. On 18 February, Dartmoor increased Mr Norton's social care package to 24 hours per day with two carers in place. One carer was to remain in his cell at all times.

24. On 19 February, overnight agency care began which covered the hours of 8.00pm to 8.00am.
25. On 22 February, a prison GP prescribed medication for pain and symptom control at the end of life for Mr Norton. These are described as 'just in case' or end of life medications as they are to be held on to safely until the time that Mr Norton would need them.
26. On 23 February, Mr Norton had been unable to access overnight pain relief due to the carers not being able to access any medication.
27. On 2 March, 24-hour social care support was put in place using Health Care Assistants (HCAs) from an agency. Mr Norton was granted two carers during the day and night due to not being able to have manual handling equipment in the cell.
28. The same day, a local hospice cancelled a visit to assess Mr Norton for end-of-life care planning.
29. On 8 March, a prison GP met with Mr Norton and made the decision to stop most of his medications due to a difficulty swallowing. She reassured him that pain relief and medication to control symptoms would be available to Mr Norton should he require it. Mr Norton said that, if required, he would like to go to hospital for treatment in line with his advanced care planning wishes.
30. During that afternoon, the HCAs looking after Mr Norton reported that he was agitated and restless. Throughout the late evening and overnight into the 9 March, Mr Norton called out for help and required assistance getting comfortable.
31. At approximately 12.40am on 9 March, one of the HCAs telephoned the out of hours doctor and spoke to a GP. She described Mr Norton as agitated with a "bubbly chest" and said that she had no access to the end-of-life medications (prescribed on 22 February) for Mr Norton. She said that the medication was locked away and the officers had no access to the keys or medication safes in healthcare. The HCA had been unable to contact the Head of Healthcare overnight and did not know who the on-call manager was.
32. Between 3.00am and 5.00am, the HCAs reported Mr Norton to be unsettled, agitated and asking for help, followed by Mr Norton appearing asleep from around 5.20am.
33. At 9.10am, the HCAs gave Mr Norton some water and recorded that he seemed agitated.
34. At around 9.35am, an officer radioed a nurse on the healthcare emergency response radio to ask her to attend Mr Norton's cell. Another officer heard the radio call and attended the cell. On arrival at the cell, the first officer Lee and the HCA were outside the cell and said that Mr Norton was passing away. The second officer called a medical emergency code blue. A nurse arrived a minute or so later.
35. The nurse reported that she entered the cell and found Mr Norton unresponsive and not breathing. She checked Mr Norton for signs of life and found none. She did not make an entry about Mr Norton's death into the medical records.

Post-mortem report

36. The post-mortem report concluded that Mr Norton died from cardiac failure (a condition that means the heart can't pump blood around the body as well as it should), caused by ischaemic heart disease (IHD, the narrowing of the blood vessels to the heart) with cardiomegaly (an enlarged heart).

Inquest Verdict

37. The inquest hearing into the death of Mr Norton was held on 12 October 2023. It confirmed that the medical cause of Mr Norton's death was cardiac failure caused by ischaemic heart disease with cardiomegaly. It concluded that Mr Norton died from natural causes.

Findings

Clinical care

38. The clinical reviewer found that the care that Mr Norton received at Dartmoor was of a reasonable standard and was equivalent to that which would have been received in the wider community in the areas of his daily activities of living. However, she considered his care in respect of his proposed pain relief not of the required standard and therefore not equivalent to that which would have been received in the wider community. She was also concerned healthcare staff did not document events at the time of Mr Norton's death correctly.
39. She made seven recommendations. Five of which were not related to Mr Norton's death and the head of healthcare will need to address separately.

Pain relief

40. On 23 February 2022, Mr Norton did not receive overnight pain relief due to the carers not being able to access the medication. On 8 March, a prison GP stopped most of Mr Norton's medications and reassured him that pain relief and medication to control symptoms would be available to him should he require it. On the night that Mr Norton died, he was unable to receive any medications for pain relief or symptom control because the overnight nurse could not access it.
41. The clinical reviewer was concerned that the issue of access to overnight medication had been raised in February but had remained unresolved. She was concerned that the HCA who was caring for Mr Norton on the night before he died was unable to access symptom management medication despite her attempts to access this.
42. Mr Norton was prescribed anticipatory medications, known as 'just in case' medication. These are medicines which are prescribed to a person should they need them in future. In this case, Mr Norton was reassured that he would be able to access pain medications when the time came that he would need it. We believe it is unacceptable that there was no access to pain relief for Mr Norton on the night of 8-9 March. During the night the agency staff clearly felt that he required pain relief. No provision had been made for the agency night staff to access the medication that he had been prescribed.
43. We make the following recommendation:

The Head of Healthcare should review the anticipatory medication process, with particular focus on access to medications for overnight pain relief.

Record keeping

44. There were no entries recorded in the medical records to describe the events surrounding Mr Norton's death. The records do not record how healthcare staff established that Mr Norton had died. The investigator requested a statement from

the nurse which provided further information. However, we are disappointed that this was not recorded within the medical records.

45. The nurse reported to the clinical reviewer that when she returned to the office after Mr Norton's death, she found that he had been removed from the medical records system. She said that she therefore could not record events in the records and wrote a statement instead. This statement is not signed or dated, and we are unable to confirm the timeline of completion. She also stated that she spoke to the Head of Healthcare a few days later, who informed her that she could have still opened the records and recorded the details of his death. She did not do so. Healthcare management did not ensure that the records were completed.
46. Good record keeping is vital for continuity and shared understanding of decisions. We are disappointed that there was no record of the events of Mr Norton's death.
47. Our report into a death in April 2021 found that medical records had not been completed appropriately. Following our recommendation, Dartmoor agreed to carry out record keeping training for healthcare staff by November 2021. We are therefore disappointed to see that this issue has been highlighted again within this report. We refer Dartmoor back to their action plan in that case and ask that they implement the actions agreed at that time.
48. 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.

Mark Judd

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