Investigation into the circumstances surrounding the death of a man at HMP Norwich in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

September 2008

This is a report of an investigation into the death of a man at HMP Norwich in March 2008. The man who died had a history of poor health including diabetes and in November 2007 was diagnosed with cardiac failure.

The man's medical care and support was carried out by a multi-disciplinary team of health professionals including prison healthcare staff, diabetic specialists and, in the latter stages of his life, palliative care specialists. My colleagues and I would like to extend our condolences to his family.

This investigation was carried out on my behalf by one of my investigators. A review of the clinical care was carried out by an Assistant Director of Nursing at a University Hospital NHS Foundation Trust, on behalf of Norfolk Primary Care Trust (PCT), and I am grateful to the Assistant Director for her assistance.

The Assistant Director was asked to review the man's clinical care in prison and ensure that it was comparable to that which he might have received in the community. Both the Assistant Director and I are satisfied that the man received a good standard of care. I have commented in previous investigations of deaths at Norwich on the standard of care delivered by the healthcare team and I am pleased to report again on the level of decency and dignity terminally ill patients receive under their care.

I make one recommendation jointly to HMP Norwich and HMP Birmingham. I have also reiterated previously identified areas of good practice at HMP Norwich.

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Deputy Prisons and Probation Ombudsman **September 2008**

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SUMMARY

The man was 69 years old when he died at HMP Norwich following a terminal illness. The man had spent 40 years in and out of custodial establishments. His final period of custody began in 2002 when he was sentenced to seven years imprisonment. He was already in poor health at this time. In 2006, the man was released on licence to a Probation Approved Premises (AP), where the Social Services Department assisted him with his personal hygiene and daily activities. Six months later, he was recalled to prison because he would not comply with several of the rules of his licence and those of the AP.

As a result of the recall, the man was taken to HMP Birmingham in December 2006. He was admitted as an inpatient into their healthcare unit where he remained whilst at Birmingham. The man did not comply with his diabetic diet and his diabetes was controlled with medication. He was seen regularly by diabetic specialist nurses. From July 2007, the man was noted to have increased swelling in his legs and his diuretic medication was reviewed and increased. Between July and December 2007, the man was admitted to hospital on several occasions due to an increase and spreading of swelling and variable blood pressure. He was unhappy that he could not smoke in hospital and always discharged himself.

During a hospital admission in November 2007, the man was diagnosed with heart failure (biventricular failure) but again discharged himself before further investigations could take place. There were several more self discharges and the consequences of refusing treatment were explained to the man. He accepted that he might die. A psychiatric assessment was carried out to determine the man's capacity to refuse medical treatment, and he was judged to have capacity.

Following an appointment with a consultant cardiologist which the man attended in December 2007, end stage heart failure was confirmed. It was considered that his condition would continue to deteriorate and that he only had a few months to live.

In March, the man was transferred to the Nelson Unit at HMP Norwich to receive palliative care. The man received care from the healthcare staff and specialist palliative care nurses, as well as specialist diabetes nurses, whist at Norwich. His condition continued to deteriorate and, four days before he died, terminal congestive cardiac failure was noted and all oral medication stopped. The man was kept comfortable and pain free until he passed away. As per his wishes, his family were not informed of his deteriorating condition and resuscitation was not attempted.

THE INVESTIGATION PROCESS

1. My investigator requested all the relevant documentation including medical records and core prison records. She visited HMP Norwich during the course of the investigation.

2. Notices to staff and prisoners were displayed by the prison. These invited anybody with information to talk to my investigator. In this instance, no-one raised any matters of concern.

3. Norfolk Primary Care Trust (PCT) was asked to carry out a clinical review. The review was carried out by an Assistant Director of Nursing at a University Hospital NHS Foundation Trust on their behalf. Due to the man's lengthy periods in custody, it was agreed that the clinical review would concentrate on the man's healthcare from the point of his recall to prison in December 2006.

4. The HM Coroner for the district was informed of my investigation. He will receive a copy of this report.

5. The man's sisters are recorded as his next of kin. One of my Family Liaison Officers wrote to them to offer the opportunity of involvement in the investigation. The Family Liason Officer spoke to one of the sisters who confirmed that they had both received her letters. During the conversation, the man's sister said that they did not have any questions or concerns for the investigation and added that the contact and assistance received from the prison was good and helpful. The family have asked to receive a copy of my report.

HMP NORWICH

6. Norwich is a city centre prison, predominantly serving the courts of East Anglia. It has an operational capacity (maximum crowded capacity) of 557, holding remand and sentenced adult men and young offenders. The prison is divided into two sections. One area accommodates young offenders and the healthcare centre and the other is for all other prisoners.

7. The healthcare centre provides 24 hour healthcare cover and has space for a maximum of 23 in-patients. On the ground floor of the centre is a specialist elderly patients unit, Nelson Unit. This unit has been designed and equipped to enable older and less able prisoners to be supported and cared for within the confines of the prison environment.

8. In previous reports into deaths at Norwich I have highlighted areas of good practice. Given the function of the Nelson Unit at the prison, the staff are experienced at providing care for the elderly and for those who are terminally ill. I have mentioned the following good practice in previous reports and reiterate them regarding the care of the man who died:

    - The cell doors for prisoners at the end of their lives remain unlocked, allowing quick, easy and regular access to nursing staff.
    - There are good links between the prison's healthcare staff and the community palliative care services (as well as other specialist services) which provide good continuity and a multi disciplinary approach to the treatment of terminally ill prisoners.

9. Her Majesty's Chief Inspector of Prisons (HMCIP) last inspected HMP Norwich in November 2006. HMCIP recognised the good links with palliative care teams and good use of the Liverpool Care Pathway.

Liverpool Care Pathway

10. The Liverpool Care Pathway (LCP) is a key recommendation in the National Institute for Health and Clinical Excellence (NICE) guidelines for supportive and palliative care. It is a continuous quality improvement programme for care for a dying patient. It has been developed to transfer the hospice model of care into other settings.

11. There is a multi-disciplinary document which provides an evidence-based framework for end-of-life care. The LCP provides guidance on the different aspects of care required, including comfort measures, anticipatory prescribing of medicines and discontinuation of inappropriate interventions. Additionally, psychological and spiritual care and family support can be included.

Release on licence

12. Prisoners released on licence are supervised by the Probation Service. There are standard conditions for all licences, which include:

- Keeping in touch with the probation officer in accordance with any instructions that may be given.
- Residing at an address approved by the supervising officer.
- Being well behaved, not committing any offence and not doing anything that could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

13. Further conditions can be added by the Secretary of State if they are deemed necessary to manage a person’s risk.

PROBATION APPROVED PREMISES

14. Approved Premises were formally known as Probation and Bail Hostels. They are approved by the Secretary of State within section 9 of the Criminal Justice Act 2000. Approved Premises provide a supportive, structured environment in the community for high risk and difficult to manage offenders. The management of those accommodated in Approved Premises is governed by the National Standards for Supervision of Offenders and the guidance contained in the National Approved Premises Handbook.

15. The purpose of Approved Premises is to provide an enhanced level of supervision for some of the potentially most difficult and high-risk offenders in the community. They are not principally an accommodation resource.

KEY FINDINGS

16. The man was remanded into custody in May 2002. He was sentenced in June 2002 to seven years' imprisonment with three years' extended licence. During sentencing the judge alluded to the man's poor health. He was released in June 2006 on licence and had to reside at a Probation Approved Premises (AP) and, because of his ill health, enquiries were being made for more suitable accommodation. Whilst at the AP, the man had regular contact from the Social Services Department with regards his personal hygiene and activities.

17. Six months later however, in December 2006, the man was recalled to prison. He had not been complying with the AP rules and some rules of his licence regarding offending behaviour treatment programmes. His place at the AP was withdrawn and he was recalled to prison and taken to HMP Birmingham.

18. The man arrived at Birmingham on December 2006. His medical history noted that he had diabetes, diabetic retinopathy (damage to the retina) and heart failure. He did not comply with a diabetic diet and needed medication to help control his diabetes. The man was reviewed by the specialist diabetic team at the prison regularly.

19. Whilst at Birmingham, the man stayed in the healthcare unit. His mobility had deteriorated and he walked with the aid of a Zimmer frame. He was also taking medication for heart failure and smoked heavily. Through 2007, the medical records show that the man received various treatment for his diabetes. From July 2007, he was noted to have increased swelling to his legs. His medication was varied accordingly.

20. In early November 2007, an urgent cardiac referral was made after the man was found to have further swelling up to his midriff. Four days later, before an appointment was scheduled, his blood pressure had dropped and he still had swelling. The man was taken to the Accident and Emergency department at the local hospital for further investigations. A diagnosis of biventricular failure (heart failure) was made and the man was treated with intravenous diuretics. However, he discharged himself from hospital a day later, because he had not had tobacco since he was admitted. As a result no further medical investigations could be undertaken.

21. In November, the man agreed to a hospital admission, but again discharged himself the next day. A consultant had advised him of the treatment he needed and that he should see a heart failure specialist, but the man reportedly refused. He was made aware that his heart was very weak and he could die without treatment, but he did not change his mind. Initially he agreed to let the prison contact his next of kin but later changed his mind about this too.

22. A psychiatric review took place in November, to form an opinion on whether or not the man had the mental capacity to refuse medical treatment and it was judged that he did. The man agreed to be admitted to hospital again but as

before, discharged himself the next day. He continued to refuse treatment, not attending an outpatient appointment early December, although he did attend a further appointment five days later. At the second appointment he was seen by a consultant cardiologist and had an echocardiogram (test which gives information about the heart). His medication was subsequently reviewed and altered. By the beginning of January 2008, it was noted that the man's swelling had improved.

23. A letter was received by the prison from the cardiologist early January. The cardiologist confirmed end stage heart failure. The man was also noted to have poor lung function. Palliative care was the only further care available and the man's life expectancy was short.

24. Over the next week staff spoke to the man about compassionate release and also with the Social Services Department to arrange a care assessment should he be released. The man agreed to compassionate release, but later said that he wished to die in prison. Due to his accommodation needs and risk of offending, finding a suitable placement would not have been easy nor necessarily granted. No arrangements for his release were in place before he died.

25. In the middle of January, the man collapsed, but recovered. Two days later he collapsed again and was admitted to hospital. He discharged himself five days later but was readmitted the following day because he had low blood pressure. The man remained in hospital for two nights before discharging himself.

26. In February, a Community Health Care Coordinator (CHCC) and Social Worker visited the man to assess his health and care needs. The assessment found the man's needs to be complex in nature and recommended that he had 24 hour access to registered general nurses for a variety of care including palliative care.

27. The man transferred from Birmingham to HMP Norwich's Nelson Unit in March 2008 to receive palliative care. Birmingham produced a transfer summary detailing the man's medical history as well as a current medication list, personal hygiene needs, care plans and dietary needs. The man's initial healthcare screen at Norwich noted his diabetes, foot ulcers and possible gangrene. He had poor mobility and a specialist bed was ordered to relieve pressure sores. He was also noted to have congestive heart failure and chronic obstructive pulmonary disease (COPD).

28. The following day he was seen by a Senior Staff Nurse, who noted that the palliative care treatment needed to start once he was reviewed by the doctor. The doctor saw the man later that morning and also noted that palliative care should commence.

29. Later that evening, the doctor, head of healthcare and the senior staff nurse discussed the man's deteriorating cardiac condition with him. They talked about his wishes for resuscitation in the event of a cardiac arrest. Together it

was decided that the man would not be resuscitated in the event of cardiac arrest based on the fact that he had been diagnosed with end stage bilateral ventricular (cardiac) failure and chances of successful resuscitation would be low or leave him with a poor quality of life. He would however, continue to be treated for reversible or treatable conditions and to increase his comfort.

30. Over the next five days, the man received personal hygiene care, dressing for his ulcers, checks for pressure sores, advice about smoking cessation and general medical observations. He was taking fluids but not eating much solid food. He had been vomiting so the doctor had been called and the man was given relevant medication. During the five days, some of his tablets had been found on the floor and between his sheets. It was also thought that the man was tending to suck the tablets rather than swallow them. This was noted in his medical record so that staff could assist him taking his medication. At approximately 11.20pm on 26 March, the night nurse was checking the man. She found some more tablets on the floor and asked him about it. The man told the night nurse that he did not think the medication was doing him any good and generally did not want any. The night nurse said she would speak to the day staff about it.

31. The first staff nurse made an entry in the medical record at 2.52pm on 27 March to say that the man had been very sleepy all day. He had eaten little lunch but had drunk fluids. The record shows that the man did not want his medication, but had been kept comfortable through the day and turned every two hours to prevent pressure sores.

32. The Head of Healthcare reviewed the man later in the evening. She had noted that his condition had significantly deteriorated over the past 24 hours and that he was in the terminal stage of his disease. The man did not want his family to be informed of his deterioration, nor did he wish to see the chaplaincy. At this point, as is common practice for terminal patients in Norwich, the man's cell door was left open at all times so that his end-of-life and healthcare needs could be met.

33. Through the night, the man continued to be checked by healthcare staff. At 4.00am (28 March), he appeared to have been vomiting secretions. Staff helped to clean him and make him comfortable. Once he was comfortable he requested a cigarette. Later that morning he was noted to have an "increase in respiratory secretions" but had become weaker when trying to cough.

34. The man had a palliative care review at approximately 11.20am that morning. Terminal congestive cardiac failure was noted and all oral medication was stopped. The man was kept comfortable in accordance with Liverpool Care Pathway. Through the rest of the day he became increasingly restless and confused. He was still coughing and vomiting. Norwich healthcare staff discussed this with the palliative care team who advised that the man be given a syringe driver (used to continuously administer medication).

35. Over the next two days, the man continued to receive medication through the syringe driver. He was given personal care such as washing, dressing and shaving and remained pain free.

36. A Healthcare Assistant checked on the man at approximately 2.40pm on 31 March. The man appeared peaceful and pain free. The Staff Nurse went to see him at 3.00pm and found that he had passed away. The Head of Healthcare was called and, as an authorised person, pronounced the man's death at 3.05pm.

37. The news of the man's death was reported to other prisoners on the unit individually. Staff were reminded of the PCT Occupational Health Service which healthcare officers are also able to access, as well as the peer support available. A memorial service was held, led by the chaplaincy for any staff and prisoners to pay their respects.

ISSUES

Transfer between prisons

38. The clinical reviewer questioned the appropriateness of the man's transfer to Norwich shortly before his death. My investigator spoke to the Deputy Ward Manager at Birmingham who confirmed that the facilities for a prisoner in the dead man's condition were better at Norwich than those available at Birmingham. With compassionate release an unlikely option, it was believed appropriate to transfer the man. Although in the end stages of his life, the exact timescale would not have been known.

39. The clinical reviewer has also commented that there are no clear documents for the referral process and subsequent transfer arrangements. My investigator has however, found a transfer summary outlining the man's needs and medical history. The transfer was arranged between the two prisons and I am satisfied that Norwich is an appropriate prison for prisoners with terminal conditions, particularly if compassionate release is not an option.

Chronic Disease Management

40. In both prisons, the man was seen by diabetes specialist teams for his diabetes and resultant foot ulcers. There are documented records of interactions with these specialists and care from the prison healthcare teams. However, the clinical reviewer has found that although there was chronic disease management logged in terms of dietary advice and retinal screening, there was less recorded evidence of peripheral neuropathy[1] testing. Haemoglobin tests (HbA1c) are also not evidenced to have been carried out on a regular basis. The clinical reviewer does comment that this may have been due to the rapid deterioration in the man's condition. These tests give clinicians an indication of the patients' management of their diabetes and staff were already aware that the man did not control his diabetes adequately. The tests would not have affected the outcome of the man's death.

    Healthcare staff within both prisons need to ensure that chronic disease management is comprehensive and any action is clearly documented.

Medication

41. There are several records of the man's refusal of his prescribed medication which healthcare staff were told to monitor. He also apparently sucked tablets rather than swallow them and staff were asked to assist. The medical records do not log any monitoring of medication, although it should be noted that it was the man's right to refuse treatment. On 26 and 27 March he told healthcare staff that he did not want some of the medication he was prescribed.

[1] Peripheral neuropathy involves damage to the peripheral nervous system (PNS). Infection, injury, nutritional deficiency and disorders such as diabetes can cause peripheral neuropathy. (explanation taken from the BBC health website)

42. On 28 March, all oral medication was stopped because he had reached the terminal phase of his illness. I am satisfied that the man received medication administered by a syringe driver, which was the most effective means of keeping him comfortable and pain free during his last days.

Clinical care

43. The man was transferred to Norwich for palliative care. As part of this, senior members of the healthcare team discussed resuscitation options with him. The staff explained that, given his condition, if his heart was to stop beating, the chances of successful resuscitation were poor. The quality of his life should resuscitation be successful was also discussed and the likelihood was that he would have a poor quality of life. It was agreed with the man that he would not be resuscitated in the event of cardiac arrest, but he would be treated for treatable conditions and for comfort and symptom management.

44. In line with the Liverpool Care Pathway, there were good links between the healthcare staff at Norwich and the palliative care services as well as the diabetes specialist team. This ensured that specialist advice, care and medication were provided to the man during the final phase of his illness.

45. The clinical review found that the man's condition deteriorated over the last six to nine months of his life. He understood his condition and prognosis but frequently refused medical treatment, particularly with regards to hospital admissions where he was not allowed to smoke. The clinical reviewer felt that this would have made the man a difficult patient to manage.

46. This said, the clinical reviewer is of the opinion that prison healthcare staff at Birmingham and Norwich acted within the duty of care and in the man's best interests. Both prisons worked to the Liverpool Care Pathway and worked collaboratively with specialist care teams. The man, therefore, had all his care needs met and his wishes were respected. The man was able to die peacefully and with dignity.

RECOMMENDATIONS

1. Healthcare staff within both prisons should ensure that chronic disease management is comprehensive and any action is clearly documented.

   HMP Norwich and HMP Birmingham have accepted this recommendation.

GOOD PRACTICE

Open door

2. When the man reached the last stages of his illness, his cell door remained unlocked, allowing nursing staff quick, easy and regular access to attend to his needs.

Specialist links

3. There are good links between Norwich's healthcare staff and the palliative care services (as well as other specialist services). They provided the man with good continuity and a multi-disciplinary approach to his treatment, care and support.