

**Investigation into the circumstances surrounding the
death of a man at HMP Norwich
in September 2007**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

April 2008

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Norwich. The man was found dead by nursing staff in his cell during the evening. He was 68 years old.

The man was already an elderly man and in poor health when he was sentenced to three and a half years imprisonment in January 2007. He moved between Bedford and Littlehey prisons a number of times, before being transferred to the Older Prisoner Unit at HMP Norwich on 23 August 2007. The man then spent three weeks in an outside hospital. He returned to Norwich on 18 September where he received end of life care.

The loss of any family member is distressing, but especially so whilst they are in prison (and in the man's case, in prison for the first time). I offer my sincere condolences to his family and friends.

The investigation was undertaken by one of my colleagues. We would like to extend our thanks to the then Governor of Norwich and his staff for their cooperation during the investigation. Particular thanks go to the prison's liaison officer for gathering all the relevant documentation and ensuring it was made available.

A medical practitioner representing Norfolk Primary Care Trust, carried out a clinical review into the care and treatment the man received whilst at Norwich, Littlehey and Bedford. I am most grateful to her for completing the review. I have relied heavily on her findings for this report. The other main focus of this investigation has been Norwich's management of the man's stay in hospital and his return to the Older Prisoner Unit.

Four prisons currently provide specific accommodation for elderly prisoners, but Norwich is the only one with a dedicated unit that is Prison Service-led. I have praised the work of the Older Prisoners Unit in several of my reports, and I am pleased to record here that the man's last days were made as comfortable as the circumstances allowed. In the privacy of his own room, the man received a high standard of 24 hour palliative care. His family was also fully consulted over his care plan and able to visit him on the day he died.

However, the man's transfer to an outside hospital has highlighted the importance of maintaining family contact when prisoners are too ill to communicate effectively themselves. My investigation has also revealed the difficult balance to be struck between protecting the public and managing a prisoner compassionately and with dignity whilst in hospital.

My report makes six recommendations, includes two commendations and highlights one area of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman

April 2008

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SUMMARY

When the 67 year old man was sentenced to three and a half years imprisonment in January 2007, he went straight to HMP Bedford. In reception, he was identified with a number of complaints including heart problems, arthritis, hypertension and alcohol dependency. He was seen by a doctor and referred for alcohol detoxification and regular blood pressure monitoring.

The man stayed at Bedford for 11 days before being transferred to HMP Littlehey. On arrival he was given another full reception health screen, and was seen by a doctor the following day. For the next two months, his physical health began to deteriorate and he appeared confused. Healthcare staff were concerned about his loss of memory and the difficulty he had looking after himself. He became concerned about his eyesight and problems he had with his teeth.

In March, he was seen by a doctor on four occasions. Blood tests were taken, and he was referred to a diabetes nurse following diagnosis of Type II Diabetes. The man was also seen by an optician and given a prescription for reading glasses. Along with his confusion, he developed cellulitis in his legs and was treated with antibiotics. The following month, he presented with a fungal nail infection, and a referral was made for him to see the visiting chiropodist. He got an appointment at the Podiatry Clinic within a week, but it clashed with a visit from his family and he did not attend.

On 25 June, one of the prison doctors referred him to the local hospital's consultant neurologist for tests and scans. This followed symptoms of continued confusion, tremors in his arms, abnormal reflexes and incontinence of urine.

A week later, the man was admitted as an emergency to the hospital's Accident and Emergency Department. His outpatient appointments were cancelled.

The man stayed in hospital for four days and was diagnosed as having suffered a cerebral vascular accident (a stroke). When he returned to Littlehey, another prisoner was allocated to help him with his hygiene needs and a full care plan was drawn up. He transferred back to Bedford on 25 July in order to receive 24 hour healthcare. He saw a dentist prior to his transfer and requested an appointment with a podiatrist when he got to Bedford. He stayed in healthcare for two weeks and was relocated in the induction wing (C1).

After around three weeks at Bedford, the man returned to Littlehey. He deteriorated again and a request was made for him to be transferred to a prison with 24 hour healthcare facilities. On 22 August, the Head of Healthcare at HMP Norwich accepted the request and the man transferred the following day.

Soon after his arrival on 23 August, the man was transferred to the local hospital. He stayed there for just over three weeks and underwent a number of medical examinations and assessments. Sadly, he developed breathing, swallowing and mobility difficulties and was fed by tube. He remained attached to an escort officer until 13 September, a few days before he returned to Norwich for end of life care. The man received palliative care in the Older Prisoner Unit for the last two days of his life.

THE INVESTIGATION PROCESS

1. On 26 September 2007, the investigation was opened at HMP Norwich by one of my investigators. She was briefed about the circumstances leading up to the man's death, and requested all prison and medical files. The investigator began the process of identifying the key issues and the staff who had interacted with the man during his time at Norwich. Unfortunately, some documents from HMP Bedford and HMP Littlehey, including the man's wing histories, were not located and gaps remain in his story. The investigator made attempts to find the missing documents and contacted the Governor's secretary at Littlehey. Following a search of relevant departments, the Governor's secretary confirmed that all paperwork held at Littlehey had been sent to Norwich.
2. The investigator carried out informal telephone interviews on 16 and 17 January 2008 with a number of prison staff and the Head of Healthcare.
3. A medical practitioner representing Norfolk Primary Care Trust (PCT) was asked to conduct a review of the clinical care the man received whilst at Norwich. She agreed to speak with the hospital consultant, and the Heads of Healthcare at both Littlehey and Norwich. A panel review took place on 10 January. The clinical review was completed and sent to my office on 25 January.
4. The Coroner was informed of the Ombudsman's investigation. The post mortem report concluded that the man's cause of death was as follows:
 - 1a Cerebrovascular Accident
 - 1b Cerebral Infarction

The inquest date has been set. The Coroner will receive a copy of this report when it is completed to assist with his enquiries.

5. One of my family liaison officers (FLOs) contacted the man's next of kin shortly after the investigation was opened. The FLO explained her role and that of my office, and provided information about the investigation process. She also offered the family the opportunity to meet her and the investigator to discuss any issues or concerns. The FLO and the investigator subsequently met the man's family at their home. During the visit, the family raised several concerns about the man's healthcare, in particular:
 - The man had swollen legs and was in pain during family visits to Littlehey. Did the prison fail to care for him properly?
 - The man was discharged from the first hospital after his stroke and sent back to Littlehey. Was his discharge premature? The family believe that he might still be alive if he had stayed in hospital.

The family also raised concerns about the use of restraints whilst he was in hospital and were distressed to learn that he would spend his last few

days in prison. The family visited him several times in Bedford and Littlehey and told my FLO that they were shocked at his appearance. They also visited him in the Older Prisoner Unit at Norwich, and found this distressing.

A draft copy of this report was sent to the man's family and the prison service. His family made the following comments on the draft:

- Both of his legs were swollen whilst he was in custody.
- His sister was shocked to learn of the non-resuscitation policy at Norwich and wanted further information about how healthcare decides which prisoners this should apply to. His sister further added that she hoped it was not an age-related decision.
- It was a relief to learn that the man was medicated, in accordance with a palliative care plan, to help ease his passing on the evening he died.

I address the issue of the non-resuscitation policy in the appropriate sections of this report and will send the man's family a copy of this report. The prison service accepted the recommendations and commendations and their response can be found on page 28 of this report.

HMP NORWICH

6. HMP Norwich is a multi-functional local and training prison, holding both adult men and young offenders. It also has a remand unit, resettlement unit and is one of the few prisons in England and Wales with a dedicated Older Prisoners Unit. Norwich serves the east of England and accepts both convicted and unconvicted prisoners. It has an operational capacity of 824.
7. Between 1996 and 2004, Norwich underwent substantial reorganisation of its wings, some of which were converted into dedicated units. As a result, the resettlement unit, young offender units and the Older Prisoner Unit (on the ground floor of the healthcare centre) are all located outside the main prison.
8. Her Majesty's Chief Inspector of Prisons has inspected Norwich twice in the last three years. Her inspection in March 2005 described Norwich as "an over-complex prison" unable to fulfil its purpose properly. The unannounced full follow-up inspection in November 2006 focussed on how well the prison had addressed the problems highlighted and was able to carry out its multiple roles. Overall, Norwich was doing this with some success, but HMCIP said the attempts made to fully function as a community prison were hindered by the high number of prisoners passing through its gate.

Healthcare

9. As noted, the healthcare centre is located separately to the main prison. It covers two floors, is well staffed and has an appropriate skills mix. HMCIP said in her 2005 report that the healthcare centre was underperforming. However, since Norfolk PCT took over responsibility, the standard of services had improved. The healthcare centre is managed by the Head of Healthcare (I Grade nurse), and is supported by a deputy. The centre currently has a mix of registered general and registered mental health nurses, senior healthcare officers, healthcare assistants and prison officers.
10. In her follow up inspection in 2006, HMCIP said that, since Norfolk PCT had taken over commissioning responsibility for healthcare services, Norwich had good links to palliative and Macmillan nurse teams. The palliative care delivered by healthcare staff is taken from the Liverpool Care Pathway for the dying, which is a gold standard award guide.
11. The SystemOne clinical information system has replaced hand written medical records at Norwich. It is only compatible with the same system in other prisons, but where two prisons use the same IT staff at the receiving prison are able to look at a patient's medical history and provide a continuous care record. The SystemOne has been fully embraced by healthcare staff, so much so that HMCIP commended the

healthcare centre for the way it had been fully incorporated into their prisoner care services.

Nelson Unit (Older Prisoners Unit)

12. Nelson Unit was introduced to address the specific needs of Norwich's ageing prison population. The unit holds 15 prisoners, all in single rooms. It is located on the ground floor of the healthcare centre and is staffed by prison officers, nurses and healthcare officers. The Chief Inspector of Prisons found that the unit operated an unlock policy during the day (staff permitting) and the standard of clinical care was good. However, Nelson Unit prioritised operational duties over clinical ones and this left some prisoners unduly waiting for nursing care. If a prison officer was not available, prisoners were not unlocked irrespective of how many nursing staff reported for duty.

Elderly Prisoners

13. Prisons are not principally designed for the elderly, and it is difficult for an individual establishment to accommodate an aged population. A thematic review by HM Chief Inspector of Prisons in 2003 found that, although older prisoners (60 years and over) make up a small percentage of the overall prison population, the number of elderly prisoners had trebled between 1992 and 2002 and was continuing to grow. The study also said that there was no overall strategy throughout the prison estate for assessing and delivering a regime that addressed the needs of older prisoners.
14. Since the review, the elderly male prisoner population has seen a year on year increase. The most recent figures, taken from the Ministry of Justice, Offender Management Caseload Statistics, show that in the last four years (2002-2006), the population has increased by another 26 per cent from 1,365 to 1,725.
15. The Chief Inspector's thematic review concluded that some elderly prisoners would inevitably spend the rest of their lives in prison. Early release from prison on medical grounds for severely or terminally ill prisoners is subject to restrictive criteria, and the thematic review stressed that the prison environment must be geared towards meeting the specific needs of its ageing population.
16. A report, *Growing Old in Prison*, published by the Prison Reform Trust in 2003 quoted a Department of Health study that also focussed on older prisoners. The study said that out of 203 prisoners aged 60 and over, 85 per cent had one or more major illnesses reported in their medical records. The most common illnesses were psychiatric, cardiovascular, musculoskeletal and respiratory.

KEY FINDINGS

The man's time at HMP Bedford and HMP Littlehey

17. When the man arrived at HMP Bedford in mid-January 2007, he was already taking a substantial amount of medication. As part of the reception process, his first reception health screen also listed a number of medical complaints including alcohol problems, high blood pressure, Chronic Obstructive Pulmonary Disease (COPD), arthritis and an irregular heart beat.
18. Eleven days later, on 30 January, the man was transferred to HMP Littlehey. In February, he presented healthcare staff with symptoms of confusion, low mood and incontinence. In the absence of a 24 hour healthcare facility, he was managed on the wing and his medication continued.
19. The following month, the man was diagnosed with cellulitis (of the legs) and type II diabetes mellitus. His diabetes was discovered after a series of blood tests and the prison doctor prescribed metformin, an oral anti-diabetic drug. The man's cellulitis was treated with a course of antibiotics but his skin problems continued.
20. In June, following further periods of confusion and incontinence, the man was referred to hospital for a CT scan. Whilst awaiting this referral, he deteriorated and was escorted to the hospital's Accident and Emergency Department, and from there, to a suitable ward. The man had a CT scan shortly after he arrived and this revealed a right frontal lobe infarct. In short, the man had suffered a stroke.
21. The man was discharged back to Littlehey after four days and was prescribed additional medication. A care plan was drawn up to help him with his daily routine. As part of the plan, another prisoner agreed to help him with his personal hygiene needs. The clinical review panel pointed out that National Institute for Health and Clinical Excellence (NICE) guidelines were not in circulation at the time of the man's diagnosis, and as such there was no best practice for the treatment of strokes. These guidelines are due for publication in July 2008.

The man's transfer from HMP Littlehey to HMP Norwich

22. The head of healthcare at Norwich, told my investigator that on 22 August she received a telephone call from her equivalent at Littlehey. The conversation centred around a possible move for the man to Norwich's Older Prisoner Unit and 24 hour healthcare facility. The head of healthcare at Norwich said that her counterpart provided her with a brief overview of the man's condition, and asked whether she would accept him as a patient. She initially refused to take the man and explained to my investigator, as she had to her counterpart, that Littlehey

was outside Norwich's catchment area and the man should go to Bedford.

23. Her conversation with the head of healthcare at Littlehey continued and he explained that it might not be in the man's best interest to return to Bedford. On hearing this, the healthcare manager at Norwich told my investigator that she agreed to take the man as an inpatient. Both prisons then made their respective arrangements to transfer him to Norwich.
24. The following day, a healthcare officer (HCO) from Littlehey escorted the man to Norwich by car. His risk assessment for the transfer described the man as "... a confused elderly man with poor hygiene". The man was attached to the HCO using single cuffs. He arrived at Norwich just after lunchtime, bypassed the normal reception process, and went straight to the healthcare centre. Shortly after his arrival, he was assessed by nursing staff in much the same way as a patient arriving at an Accident and Emergency Department. His observations were taken and he was made comfortable.
25. Later that evening, the man's confusion and mobility worsened, and a nurse asked the head of healthcare to assess him. She did so, and quickly made the decision to send him out to hospital. The head of healthcare booked an ambulance between 8.00pm and 9.00pm and liaised with the duty governor and the senior officer (SO) on duty to arrange an escort to take him to hospital. A risk assessment put together by the wing SO set out the security arrangements required to take to the man to hospital.
26. By the time the man was ready to be escorted, the prison had gone from day duty to night patrol state. This affected staffing levels and, in order to secure two officers to escort him, the prison rang one of the officers at home. The first wing officer, together with his colleague, the wing second officer, made their way to Norwich to begin what the first wing officer thought was bedwatch duty. The officer told my investigator he was surprised to see that the man had not left for the hospital, and that it had turned into an escort and bedwatch duty. The ambulance left Norwich at approximately 10.15pm. The man was attached to the first wing officer using double cuffs and an escort chain.

The man's stay in hospital from 23 August – 18 September

27. On arrival at the hospital, approximately ten minutes later, the man bypassed the Accident and Emergency Department (A&E) and went straight to the Medical Admissions Unit (MAU). The head of healthcare told my investigator that she telephoned the Medical House Officer at the hospital in advance of the man's admission. Between them, they arranged for him to bypass A&E to speed up the process. He went straight to a ward.

28. In the ward, the man was made as comfortable as possible and a nurse came round to see him within half an hour. The nurse carried out some basic observations. The first wing officer told my investigator that he got more involved in the man's care than usual for a bedwatch, and helped the nurses to undress him. The officer said that this was because the restraints used were obstructing the nurse's ability to do this alone. At approximately 11.45pm, a doctor took a blood sample. Within the hour, the same doctor returned and carried out further checks on his condition. From memory, the officer said that the man remained in double cuffs and an escort chain throughout these initial interventions.
29. At 1.10am, the man was taken for an x-ray by both officers. The bedwatch log said that he was compliant with the procedure but appeared to be "confused and very tired". There was no record of whether the man remained in full restraints for the x-ray. My investigator discussed the x-ray procedure with the first wing officer, and he confirmed that the radiographer asked him to remove the double cuffs. The officer did so after a brief consultation with his colleague, the second wing officer. This officer explained that there seemed little point in notifying the duty governor in order to obtain authorisation, as the procedure was to take approximately five minutes. The man was still attached to the first wing officer (who was wearing a hospital issue protective apron) via an escort chain, whilst the second wing officer stood behind the screen. The officer said this was normal procedure.
30. The first wing officer said that the double cuffs were reapplied after the man's x-ray, and he was taken back to the MAU. At 3.30am, he was transferred to the hospital, a stroke ward which is open plan in design. The man slept for a short time before nursing staff came round at regular hourly intervals to monitor his blood sugar, blood pressure and temperature.
31. The principal officer (PO) and the wing SO relieved the bedwatch officers at approximately 8.30am. The first wing officer told my investigator that during the handover the PO questioned why the man was still in full restraints. The officer said that he was following the instructions in the risk assessment which said "double cuffs and an escort chain". In response, the PO explained that this related to the escort to hospital procedure only, and once the man was admitted he should have been attached to the first wing officer using an escort chain. When my investigator spoke to the PO, he could not remember the conversation or whether the man was attached using double cuffs.
32. Later that morning, the hospital consultant asked the officers to remove the man's restraints in order for mobility and response tests to be carried out. The PO contacted the head of security, and obtained authorisation. The tests began at 10.45am and took approximately 20 minutes. The PO made an entry in the bedwatch log which said that both he and the wing SO remained in close proximity during the tests and had re-applied the restraints at 11.05am.

33. After the tests, the consultant told the PO that the man would need a number of other examinations including a CT scan. He also said that it was likely that the man would be in hospital until the following Tuesday (28 August).
34. Throughout the rest of the day, the man underwent a physiotherapy assessment and was seen by a speech therapist. The therapists assessed the man's ability to walk and swallow. The PO recorded in the log that the man was still unable to walk when moved from his chair to his bed, and that it appeared he could not swallow.
35. The man's next two days in hospital were peaceful. Bedwatch officers continued to keep a log and did not record any change in his condition. The man remained attached to one officer using an escort chain. A review of his risk assessment on 26 August carried out by the duty governor also recorded no change in his security level. The same morning, the man was taken to the radiography department for another chest x-ray. The PO noted on his return to the ward that restraints were not removed for the procedure.
36. Over the next few days, the man's alertness fluctuated. The officers on bedwatch duty described him as agitated and then sleepy and poorly. A nurse attending to the man on the evening of 27 August told one of the officers that she was concerned that he was not responding well to the treatment. Later that evening, one of the escort officers told a nurse that the man's toenails looked too long. At 11.00pm, the man tried to get out of bed and was restless. His airway was cleared using suction but he remained agitated throughout the night.
37. Following his speech therapy assessment, the man was designated as unsuitable to take food or drink through his mouth, and was being tube fed. This information was passed between outgoing and incoming officers using the handover checklist document. After the man's restless night, the checklist also said that the left side of his body was weakening and that he was trying to get out of bed. The wing SO took over bedwatch duty at 7.30am on 28 August. His first entry in the log said that the man was much more active, very confused, and still trying to get out of bed.
38. The man had another CT scan at approximately 3.00pm. The escort officer, who was also on duty, knew about the procedure in advance and contacted the duty governor to obtain permission to remove the escort chain. The duty governor authorised this in accordance with the risk assessment provision. The man's CT scan took around 15 minutes. He was reattached to the wing SO immediately after the scan. The SO telephoned Norwich to let communications staff know that the security level had been restored. The wing SO also recorded that the man had a tendency to 'grab' at nurses during treatment. An unsigned log entry by

either the duty governor or a principal officer that day reflected that the man had been quite difficult and was in a confused state.

39. At 6.50pm on 29 August, the man was moved from an open ward to a side room. Here he seemed more settled and slept for long periods. The following day, after being made more comfortable by the nurse, he sat up in his chair. Shortly after 5.00pm, he had his evening meal and spoke to the officers on duty. The escort officer, who had been on duty all day, made an entry in the log which said that the man appeared to be getting better. An hour later, the man was put back into bed in preparation for an x-ray. He was also told several times that he should not try to get out of bed. The bedwatch log did not record whether he had an x-ray that day.
40. The man's second week in hospital mirrored the first and officers continued to log his condition as restful, confused or agitated. The man remained immobile and struggled to eat on occasion. Risk assessment reviews were carried out on a regular basis by the appropriate members of staff, and his security level remained unchanged. The reviews did not give an indication of the factors considered in keeping his security level the same.
41. During the afternoon of 1 September, one of the nurses attending to the man's personal hygiene asked an officer if Norwich had the facilities to cope with his physical health needs. The escort officer, on duty that day, told the nurse that she would have to speak to the head of healthcare, to discuss this further.
42. For the next few days, the man found it increasingly hard to speak. This was due to the difficulty he had in swallowing. On 4 September, a member of the physiotherapy team came to see him and made him more comfortable in bed. The escort officer on duty made an entry in the log which said the man had been given liquid paracetamol during the day. The officer also said that the man was lethargic and that there seemed to be little sign of improvement to his health.
43. The morning of 6 September began as most of the man's days in hospital did. He was given a wash and attempts were made to give him some breakfast. At lunchtime, two physiotherapists lifted him from his bed to a chair and he sat for about half an hour. One of the hospital's nutritionists then attempted to feed him some yoghurt. The man gained some movement during the afternoon and was seen by a doctor at 4.25pm. The doctor decided he should not take food and fluid orally. The officer on bedwatch duty, passed on the head of healthcare contact telephone number to a member of staff in order for the hospital to discuss the man's previous medical history with her.
44. The next day, the man was washed and dressed as normal before being assessed by the speech therapist. At 12.50pm, he had another CT scan and was escorted back to the ward. The bedwatch log gave no

indication of the security arrangements for the scan. In the afternoon, the man was fitted with a cannula to the nose cavity to help him breathe. At around 5.15pm, nurses experienced some difficulty in finding a suitable vein to take a blood sample. Approximately 45 minutes later, the man had another chest x-ray and then slept on his return to the ward. The head of security carried out a management check at 6.40pm before the man settled for the evening. He had a peaceful night.

45. The man's third week in hospital saw a further deterioration in his health. However, a positive development was the number of visits by his family. For the first 15 days of the man's stay in hospital, his family thought he was still at Littlehey and had been in contact with staff there to arrange visiting orders so that they could see him. At some point during this third week, the man's sister received a telephone call from the PO to say that her brother was now in hospital. Bedwatch officers were also updated. The second page of the bedwatch handover checklist for 7 September was completed by an escort officer. This informed the incoming duty officer that the man's brother and sister had been given authorisation to visit him in hospital.
46. At 3.15pm on 8 September, the man's family visited his bedside. This was the first time they had seen him since his transfer from Littlehey. The man's family stayed until approximately 5.00pm and the escort officer on duty that afternoon, recorded in the log that he had responded well. Shortly after his family left the hospital, the duty governor, arrived and completed a management check. In the bedwatch pack said that the risk assessment would remain unchanged, but that the man's security level might be reduced at a later stage.
47. The next day, the man became emotional and was seen crying. The officer on duty thought he was in pain and made a record of this. At 10.30pm, a nurse started a tube feed for him and changed his bedding. The feed finished at 3.30am the next morning.
48. The man's risk assessment was reviewed by the head of security at around 7.20pm on 9 September. Further reviews took place on 10, 11 and 12 September by three different members of staff. The man's security level stayed the same as the day he was admitted to hospital. The documentation gave no indication of what factors were considered when carrying out reviews.
49. On 12 September, the man's sister arrived shortly after 2.00pm and found him unresponsive. She then spoke to nursing staff about his condition. The second wing officer made an entry in the log which said that the man's family had requested a Roman Catholic priest. His sister and a priest returned to the ward at 3.10pm. Approximately 20 minutes later, the sister was told by the consultant that he was not likely to live beyond another week. The duty governor carried out a management check at 4.50pm and recorded no issues with the escort arrangements.

50. The man was given the last rites by the chaplain at 7.00pm that evening. The escort officer witnessed this before handing over to the night duty officers. The man's sleep pattern throughout the night was described as restless by one of the officers. At 9.00am on 13 September, an escort officer noted that he sometimes struggled to breathe. The officer made another entry in the log, 20 minutes later, which said he was breathing heavily but settled.
51. At 10.25am, the duty governor telephoned the escort officer and ordered the removal of the escort chain. The officer contacted the communications staff at Norwich to confirm that the man was no longer attached to an officer and recorded the change in security level appropriately. A revised risk assessment was completed by the second PO. Under the section 'Medical Information', the head of healthcare wrote the following:
- "The man is extremely ill and is unlikely to be able to get out of bed. Medically, he [is] unlikely to live for much longer."
52. The duty governor provided overall authorisation for the reduction in security. In agreement with the Governing Governor, he confirmed that due to the nature of the man's illness restraints would not be used, but that two escort officers would remain on bedwatch duty in a supportive role. Another governor made an extensive entry in the log to instruct bedwatch officers following the change in circumstances. Officers were reminded to preserve all paperwork and personal belongings and to contact the duty governor if the man died. The governor also reminded officers that the man was not to be left unescorted at any time.
53. The prison chaplain visited the man at 3.45pm that afternoon and offered prayers. The sister telephoned the ward shortly afterwards to notify staff that, unless he deteriorated, she planned to visit him the next day.
54. The man did deteriorate. Aside from two family visits on 14 and 15 September, he continued to sleep, had difficulty breathing and was continuously monitored by nursing staff. During the early hours of 17 September, his breathing worsened due to a build up of fluid in his throat. One of the bedwatch officers called a nurse and he was made more comfortable. The nurse confirmed that the man was 'getting worse'.
55. At lunchtime on 17 September, the sister came to see him again. He had not been awake during the morning and continued to sleep. At 3.30pm, the head of healthcare arrived and spoke to the man's sister. She explained that the man would be more comfortable if he transferred back to Norwich and that his family could visit him there. She reassured her that he would have 24 hour care, privacy and would not be supervised by prison officers. The head of healthcare also discussed the 'no resuscitation' policy at Norwich with his family. Before the sister

left the hospital, she recalled that the man squeezed her hand and she knew he knew she had been at his bedside.

56. The man slept all evening and throughout the early hours of the 18 September. His transfer back to Norwich was arranged by both the head of healthcare and operational staff at the prison. At 2.50pm, the man left the hospital by ambulance, and made the short journey back to HMP Norwich. He arrived at approximately 3.15pm and was moved straight to a single occupancy cell in Nelson Unit.
57. In preparation for the man's return to Norwich's care, a number of provisions were put in place. A feeding pump, and the feeds he required to ensure his nutritional needs, were provided. The Liverpool Care Pathway, adapted for Norwich prison, was commenced by the multidisciplinary team, and a care plan, tailored to the man's specific needs was commenced. Part of the plan stipulated that the man was not for resuscitation, in accordance with Norfolk PCT's policy on resuscitation. At the draft stage of this report, the head of healthcare confirmed to my investigator that the reasons given for 'do not resuscitate' were documented as:
1. The patient's condition indicates that effective CPR is not likely to be successful;
 4. Successful CPR is likely to be followed by a length and quality of life which would not be in the best interests of the patient to sustain.

The head of healthcare also recorded on the care plan that the man's sister could be contacted at any time in the event of an emergency.

58. The senior staff nurse also wrote an extensive note for the attention of healthcare staff and placed it in the man's medical records. The note acted as an admittance plan to Nelson Unit. Staff were told that the man would have a fixed nasogastric tube fitted to assist with feeding and medication, a pump and feed. The plan prompted staff to arrange 24 hour open cell access authorisation, and reiterated the no resuscitation arrangements. The senior staff nurse also confirmed that a palliative care nurse from the community would visit Norwich on 19 September.
59. In addition, the head of healthcare and the duty governor drafted a management plan. This gave authorisation for the door to the man's cell to remain open during patrol states (when, ordinarily, cell doors would be locked). The plan explained that the man had suffered multiple strokes and was receiving end of life care. The open door provision gave nursing staff on Nelson Unit easy 24 hour access to the man. The management plan stipulated that he was at risk of choking and needed frequent assistance with mouth care and pressure sores. The plan also said the following:

"It is not necessary that an officer is present at the times the man receives his care."

60. The man was made as comfortable as possible overnight. His care plan was followed meticulously and he received mouth care at regular 20 minute intervals. He was continuously monitored and nursing staff recorded his laboured breathing and 'bubbly chest'.
61. The prison chaplain visited him on 19 and 20 September and prayed at his bedside. At around 2.30pm on 20 September, the man's brother and sister arrived and were escorted to Nelson Unit to see him. They sat with him privately until approximately 4.00pm. The man remained unconscious.
62. Shortly after his family left, the man deteriorated significantly. The senior staff nurse contacted the palliative care nurse and following his advice a syringe driver was commenced. The first wing nurse and the second wing nurse started the syringe driver at 5.30pm.
63. At around 6.30pm, the second wing nurse was approached by another member of staff who asked about the man. The nurse went straight to his cell and on checking him, thought that he had died. The nurse contacted the head of healthcare at approximately 6.40pm. She checked for signs of life, and verified that the man had died at 6.45pm.
64. The head of healthcare contacted the duty governor and other relevant prison staff who commenced the death in custody contingency plans. She then telephoned the man's sister, as arranged, and told her that her brother had died. The sister expressed her gratitude for the care he received at Norwich and for the opportunity to visit him there.

Events following the man's death

65. The Safer Custody Manager at Norwich, is also a trained family liaison officer (FLO). She kept a log of the contact she had with the man's sister from the moment he died up to the last contact she made.
66. In accordance with Prison Service Order 2710, Follow up to a Death in Custody, the FLO spoke to the man's sister about funeral arrangements and explained how Norwich could help with costs and organising the service. The sister confirmed that her family would arrange the funeral, and appreciated the offer of financial help. The FLO also spoke to the sister to arrange the return of the man's valuables and personal belongings. His personal effects were then returned by post.
67. The funeral took place and at the request of his family, the prison did not send a representative to the funeral.

ISSUES CONSIDERED IN THE INVESTIGATION

68. As I mention in my introduction to this report, the main focus of my investigation has been on Norwich's management of the man's stay in hospital and his return to the Older Prisoners Unit. The deceased was an elderly man who came into prison already in poor health. In the eight months that he was in custody, he moved between Bedford, Littlehey, and Norwich. He was admitted to hospital on two occasions. Without his prison wing history records from Bedford and Littlehey, it has been difficult to give a full account of his time in custody apart from the healthcare he received. However, it is clear that his poor health prevented him from fully participating in prison life and any purposeful regime.
69. I have also mentioned the exceptional work of the Older Prisoners Unit at Norwich, and I am pleased to record that the man's last 48 hours in the unit were peaceful and comfortable. The care he received, which closely followed the Liverpool Care Pathway for the dying, was compassionate, professional and dignified. In addition, the man's family was consulted in drawing up his care plan and had access to the unit whenever they wished to visit. This holistic approach to an elderly and dying man is something that Norwich has excelled at.
70. I agreed with the clinical reviewer that there was some relevance in focussing on the healthcare the man received prior to his arrival at Norwich. I believe the benefits have been two fold. First, it has enhanced the man's story. Secondly, the extended focus has addressed the issues the man's family raised with my office. It will be necessary for copies of this report to be shared with the Governors of Bedford and Littlehey so that they are able to read the clinical review panel's findings.
71. Not for the first time, it has been a pleasure to write so warmly about the actions of staff at HMP Norwich. However, the man's transfer to an outside hospital, coupled with his long term stay in hospital, has highlighted where clarity in instructions to staff could improve Norwich's performance still further. I deal with these and the issues raised by the clinical reviewer below.

Clinical care

72. When the man arrived at Bedford, he underwent an alcohol detoxification course. The clinical reviewer could not find any evidence that this was followed up with investigations into possible liver damage. Whilst this is not directly linked to the deterioration in the man's health, and would not have changed the outcome for him, the clinical review panel made a recommendation (which I have reworded as follows):

Bedford's healthcare staff should ensure that interventions such as alcohol detoxification programmes are fully documented and that a follow up with appropriate diagnostic testing is carried out.

73. Whilst at Littlehey, the man was referred to a diabetes nurse and the infection in his leg was treated with a course of antibiotics. The clinical review panel commented that, whilst a referral was made, there was no documented evidence that a follow up took place. On speaking to staff at Littlehey, the clinical reviewer was told that diabetes records were kept separately from medical records and were not available. The panel made the following recommendation.

Littlehey's healthcare staff should ensure that documentation reflects the care and evaluation of care given.

74. When he transferred back to Bedford in July, the man's legs appeared to be an ongoing problem and he was prescribed cream to treat them. His infection continued to cause him discomfort in the weeks leading up to his death, and he was referred to a dermatologist whilst an inpatient at the local hospital.
75. Following the diagnosis of a stroke at the hospital, he was prescribed a large quantity of medication and sent back to Littlehey. From this point on, he could not look after himself and a care plan was designed to assist with his care. The clinical review panel noted that this included calling upon the assistance of another prisoner to help the man with his daily personal hygiene. Whilst this helped him in the interim, the clinical review panel did not feel this was a sustainable arrangement and made the following recommendation. Again, I have reworded it slightly:

The Head of Healthcare at Littlehey should review how social care is provided to prisoners who clearly demonstrate an inability to carry out basic care needs such as washing and dressing for themselves.

76. Continuous medical records should accompany a prisoner when he or she transfers between prisons. This enables healthcare staff to see a recent medical history and to pick up any outstanding appointments. When the man arrived at Norwich, his medical record accompanied him. However, it is not clear whether this was the case when he transferred between Littlehey and Bedford. The man was waiting for podiatry and dentistry care during the early part of his imprisonment. The clinical review panel said that he missed two appointments because they coincided with visits, but his appointment with the dentist at Littlehey fell when he was transferred to Bedford and was not rescheduled either there or when he returned to Littlehey. The panel felt that this was not satisfactory and stressed the importance of continuity of care. I agree that the man's appointment with the dentist should have been rescheduled.
77. The clinical review panel also identified the lack of full follow up care for the man, after he suffered his stroke. When he was discharged from hospital to Littlehey, there was no evidence in his medical record that he

was referred to a physiotherapist or occupational therapist. When transferred to Bedford, he was assessed by the nursing staff but there was no evidence of referral to a multidisciplinary team for post-stroke care. When he returned to Littlehey from Bedford on 17 August, staff told the clinical reviewer that they only 'found out by chance' that the man had returned. The panel stressed the following expected outcome for someone who suffers a stroke:

"Following a stroke, patients should be cared for by a specialist stroke team and participate in a multidisciplinary programme of secondary prevention and rehabilitation."

78. It is clear that, once the man was transferred to the local hospital, he received multidisciplinary care. The clinical review panel noted that at present there are no National Institute for Health and Clinical Excellence (NICE) guidelines on the treatment of stroke patients. These are due for publication in July 2008. That said, there is existing guidance in NHS National Service Frameworks. Prison should not be a barrier to the care someone receives. The review panel recommended the following which I endorse.

Bedfordshire and Cambridgeshire PCTs should be aware of the recommendations in the National Service Framework for Older People following strokes. Appropriate multidisciplinary rehabilitation should also be provided.

During the draft stage of this report, Norfolk PCT's clinical review panel did not feel that the above recommendation, which I edited, fully reflected the concerns highlighted in the clinical review. In a letter to my office, received on 7 April 2008, the panel said:

"...we do not feel that this [recommendation] addresses with clarity the particular issues identified in this review. These were that prisons should have systems in place to ensure clinical assessments are undertaken prior to discharge as part of a wider discharge planning programme, and that staff undertaking these assessments need to have received training and be appropriately qualified"

Maintaining family contact

79. When the man was transferred to Norwich and then hospital on 23 August 2007, it was two weeks before his family knew where he was. When previously transferred between Littlehey, Bedford and the hospital, his sister was kept informed of his whereabouts, albeit not necessarily on the days he moved. The sister told my FLO that she went on holiday in August at around the time that the man was transferred to Norwich. She had sent in a visiting order to Littlehey prior to going on holiday, and when she telephoned the prison on her return to query the VO she was told a message would be passed to the man's wing. Sadly, the man had already moved on.

80. It is unfortunate that the man's sister did not have the opportunity to visit him in hospital until 11 September. Learning from the PO that her brother had been in a local hospital for two weeks must have been distressing. That said, as soon as the PO received a telephone call from the VO booking clerk at Littlehey, he contacted the man's sister immediately and made the necessary security arrangements so that his family could visit.
81. Transfers between prisons for non-healthcare reasons are frequent. Healthcare to healthcare transfers are less frequent but still relatively common. The man was transferred outside of his immediate area to Norwich. This presented his family with a greater distance to travel to visit him.
82. Maintaining family ties has obvious benefits for the prisoner and his or her family. The man's family had visited him regularly at Littlehey. When the PO did speak to the man's sister, their family links were re-established. From then on, staff at Norwich (in particular, the head of healthcare) kept in regular contact. The man's family telephoned the hospital and was able to visit. Once plans were made to return him to Nelson Unit, the head of healthcare reassured the man's sister that her family could visit him in his cell, in private, whenever they wanted to.
83. There is no mandatory requirement placed on prisons to contact families when a prisoner is transferred. The PO told my investigator that the Prison Service did not inform families over impending transfers for security reasons. However, where a prisoner is too ill to make contact himself, and a prison has next of kin details on record, I consider it good practice for a prison to make contact with a prisoner's next of kin on his or her behalf.
84. I make no formal recommendation. However, the Prison Service may wish to consider if there is further advice that could be offered to Governors to ensure that families are kept informed when a prisoner is in hospital, and thus have the opportunity to maintain contact with their loved ones at the earliest opportunity.

Use of restraints

85. The man was a category C prisoner when he transferred to Norwich, and as such would normally be escorted using an escort chain. He came by car and was escorted by a healthcare officer. His risk assessment clearly indicated the type of restraint used (a single cuff). Hours later, after the head of healthcare arranged for him to be transferred to hospital, the man was 'double cuffed' and attached to an officer using an escort chain. The use of a double cuff is more in line with the security used for a category B prisoner. When informally interviewed, the PO confirmed the different levels of security normally applied to different

categories of prisoner. A category C prisoner, like the man, should have been escorted with a single cuff and an escort chain.

86. The man's risk assessment for the hospital escort confirmed that officers were to use the level of restraints normally applied to category B prisoners. The SO who completed the risk assessment told my investigator that it was necessary to treat the man as a category B prisoner because he was transferred at night. However, there remains some confusion over why he was subject to a higher level of restraint when he went to hospital.
87. Unfortunately, the man may have remained in double cuffs for longer than was intended. The first wing officer followed the risk assessment to the letter as he should, but wrongly assumed double cuffs were to remain once the man was admitted to hospital. Once the mistake was noticed by the PO on the morning of 24 August, my investigator was told that it was quickly rectified. That said, the mistake was not recorded and the PO could not remember anything specific when questioned.
88. The first wing officer contacted my investigator on 11 April to discuss amendments to his statement, dated 17 January 2008. The officer said that following a discussion with colleagues, the man was double cuffed for the entirety of his bedwatch duty, which was one 12 hour period, save for undertaking an x-ray procedure where the double cuffs were removed and an escort chain used. However, he was not double cuffed and attached to an officer using an escort chain, as was originally indicated. The officer confirmed that this was his first bedwatch duty as an officer. The officer also confirmed he would be amending his original statement to reflect the level of restraints used.
89. My investigator fed the issue of restraints back to the current Governor of Norwich. The Governor confirmed that, if the man was left in inappropriate restraints, this must have been due to a breakdown in communication as he was not aware of an occasion where a prisoner on bedwatch would require double cuffs. I make no formal recommendation but urge the Governor to remind security and bedwatch staff of the need for clarity in relation to risk assessment instructions.
90. The man was then attached to an officer using an escort chain until 13 September, approximately three weeks after he was first admitted to hospital. The bedwatch documentation indicated on occasion when the escort chain was removed for treatment. This was usually at the request of medical staff. However, the temporary removal of restraints was not always recorded, and I must assume that the man's escort chain did come off when he was taken for CT scans. It would be both physically impossible and potentially dangerous for staff to remain attached otherwise.

The Governor of Norwich should remind bedwatch officers of the importance of recording the temporary removal and re-application of restraints in bedwatch logs.

91. What is also clear is that the man underwent x-ray procedures whilst attached to one officer. During an informal interview with the first wing officer and the wing SO, my investigator learnt of the routine officers follow when escorting a prisoner to the x-ray department. The officers explained that a protective apron, issued by the hospital, is worn by officers to protect them against radiation. This was standard procedure and something the SO, in particular, had experienced many times. None of the bedwatch staff my investigator spoke to felt that the level of restraints used was disproportionate to the risk the man posed in an open ward.
92. My investigator raised the issue with the Deputy Governor. She confirmed that she was not aware of the routine arrangements for x-ray and had not experienced this herself.
93. The clinical review panel has recorded that, when the reviewer visited the hospital, medical staff questioned the use of an escort chain for the man. The man's family also raised the issue with my FLO, and stressed that it was distressing to see him 'shackled' and under the constant supervision of prison officers.
94. I have considered the same two questions as Norwich did in preparing the man for hospital, and in reviewing his security level once admitted. One is whether the man posed a significant risk to the public, and continued to pose a risk. The other is whether the level of restraints hindered his medical treatment.
95. The man was unknown to staff at Norwich when he arrived. He was escorted to hospital and remained on a prolonged bedwatch with officers who also did not know him. However, having suffered a stroke, the man was in poor health and could not walk unaided, feed himself, or communicate effectively, whilst in hospital. On the surface, it is difficult to understand why he was restrained for so long.
96. The man's bedwatch logs also paint a picture of declining health, but it was not until the hospital consultant spoke to his sister and to the head of healthcare on 12 September that his restraints were authorised for permanent removal the following day. I am pleased to see that once the duty governor became aware that the man was dying, the escort chain was removed and the process of transferring him back to Nelson Unit began.
97. The balance between public protection and the compassionate management of seriously ill or dying prisoners is a difficult one to strike and one that I frequently address in my reports. In three recent reports on deaths of prisoners from HMP Birmingham, HMP Gartree and HMP

Maidstone, I have been critical of the lack of flexibility in local policy on bedwatches. There are, of course, many factors to consider when arranging a bedwatch, particularly a prolonged bedwatch as in the man's case. I also appreciate they involve discretionary judgements. Moreover, in the man's case the management checks and risk assessment reviews were carried out frequently, and in accordance with the National Security Framework (NSF) guidelines.

98. That said, the NSF does not give explicit instructions on how to deal with gravely ill or dying prisoners in outside clinical environments. My report regarding the death of a prisoner in Maidstone's care in 2007 stressed that consideration should be given to building this into the Security Framework so that local practice may become more widespread. In this case, the restraints were removed once prison staff were told the man was dying and, as I have already said, the care he received on his return to Norwich made his last days as comfortable as they would have been in the community. However, I repeat the thrust of the recommendation I made in the 2007 Maidstone report:

The Prison Service should ensure that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds when their risk to the public is much reduced.

99. The clinical review panel made one commendation and highlighted one area of good practice evident in the man's care. I echo their findings below. (Once more, I have re-written the text slightly.)

The healthcare team at Norwich should be commended on the standard of care given to the man. Documentation was detailed and provided evidence of good collaborative working alongside members of the Specialist Palliative Care Team and staff at the hospital. As a result, the man's care needs were met and he was allowed to die peacefully and with dignity.

Arrangements had been put in place to ensure that the healthcare staff at Norwich had open access to the man's cell during the terminal stage of his life. This allowed him to receive appropriate 24 hour care.

100. I am personally aware that the head of healthcare is the author of the open door access policy in Nelson Unit. I am also aware that she ensured that the man's family were authorised to visit him in prison. These healthcare-led local policies will undoubtedly benefit prisoners and their families who find themselves in similar situations in future.

I commend the head of healthcare for her vision in ensuring her staff can provide additional, compassionate end of life care to

elderly prisoners. She should also be commended for opening up the prison gates to families of dying relatives. The man's family was able to maintain important links up to the day he died.

RECOMMENDATIONS

To the Primary Care Trusts

Bedford's healthcare staff should ensure that interventions such as alcohol detoxification programmes are fully documented and that a follow up with appropriate diagnostic testing is carried out.

The recommendation was accepted. In response, the prison service area included the following and set the target completion date for September 2008.

All HMP Bedford's detoxification programmes are now fully documented, although due to staff shortages, follow up diagnostic testing is not carried out in all cases. However, funding has now been secured to enable the recruitment of an additional two Detoxification nurses. Once the additional resources are in place, follow up diagnostic testing will be carried out in all cases.

Littlehey's healthcare staff should ensure that documentation reflects the care and evaluation of care given.

The recommendation was accepted and has been completed. In response, the prison service area said the following:

The quality of record keeping has been re - emphasised to staff and management checks put in place.

The head of healthcare at Littlehey should review how social care is provided to prisoners who clearly demonstrate an inability to carry out basic care needs such as washing and dressing for themselves.

The recommendation was accepted. In response, the prison service area included the following and set the target completion date for July 2008.

To be discussed at the PCT partnership Board in order to review and facilitate required need.

Bedfordshire and Cambridgeshire PCTs should be aware of the recommendations in the National Service Framework for Older People following strokes. Appropriate multidisciplinary rehabilitation should also be provided.

The recommendation was accepted. In response, the prison service area included the following and set the target completion date for July 2008.

To be discussed at the PCT partnership Board with a view to identifying resource implications.

To the Prison Service

The Governor of Norwich should remind bedwatch officers of the importance of recording the temporary removal and re-application of restraints in bedwatch logs.

The recommendation was accepted. In response, the prison service area included the following and set the target completion date for May 2008.

Instruction will be issued to staff conducting bedwatches reinforcing the procedure and their responsibilities.

The Prison Service should ensure that a review of the escorts, restraints and bedwatch sections of the National Security Framework takes place with a view to providing advice to staff on the removal of restraints from gravely ill or dying prisoners on compassionate grounds, when their risk to the public is much reduced.

The recommendation was accepted. In response, the prison service area said the following:

The Prison Service is undertaking an urgent review of the existing procedures in relation to hospital escorts and bedwatch risk assessments in the light of the 'Graham' judgement.

Commendations and good practice

The healthcare team at Norwich should be commended on the standard of care given to the man. Documentation was detailed and provided evidence of good collaborative working alongside members of the Specialist Palliative Care Team and staff at the hospital. As a result, the man's care needs were met and he was allowed to die peacefully and with dignity.

In response, the prison service said the following and set a target date for completion on 1 June 2008:

Commendations will be passed onto the staff involved and some form of formal recognition of the work done will be arranged.

Arrangements had been put in place to ensure that the healthcare staff at Norwich had open access to the man's cell during the terminal stage of his life. This allowed him to receive appropriate 24 hour care.

In response, the prison service said the following:

This system will be maintained for future use.

I commend the Head of Healthcare for her vision in ensuring her staff can providing additional, compassionate end of life care to elderly

prisoners. She should also be commended for opening up the prison gates to families of dying relatives. The man's family was able to maintain important links up to the day he died.

In response, the prison service said the following and set a target date for completion on 1 June 2008:

Commendations will be passed onto to the Head of Healthcare and some form of formal recognition of the work done will be arranged.