INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP WYMOTT ON 26 OCTOBER 2004

REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND AND WALES

JANUARY 2005

This is the report of an investigation into the death of a man who was in the custody of HMP Wymott when he died due to natural causes on 26 October 2004.

My office investigates the deaths of all prisoners in custody, including those due to natural causes. In this case the investigation was carried out by one of my team leaders. She also commissioned an independent clinical review from Chorley and South Ribble Primary Care Trust, whose assistance is much appreciated.

The man died at the Royal Preston Hospital following weeks of treatment there and at Chorley District General Hospital. He was serving a six year sentence at the time and would have been due for consideration for parole in January 2005.

My condolences are extended to the man's sister for the sad loss of her brother, and to those in Wymott touched by his death.

I would like to thank Wymott's Governor and his colleague for their assistance during the investigation. I would also like to draw attention to the endeavours of the healthcare manager, to find appropriate accommodation for the man, and to the actions of bedwatch staff. As the man became increasingly frail, the prison could not meet his needs and he returned to hospital on more than one occasion.

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January 2005

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SUMMARY

1. The man was born on 7 June 1929 and was 75 years old when he died due to natural causes on 26 October 2004. He had been successfully treated for Hodgkin's disease but developed a lung abscess and bowel ischaemia, and his coronary arteries were also diseased. At the time of his death, he was serving a six year sentence at HMP Wymott and had been admitted to the Royal Preston Hospital for treatment.

2. The man experienced some months of ill health and increasing frailty, in which time he was relocated to the prison's wing for older prisoners and had three lengthy inpatient stays in hospital. As his health deteriorated and the prison could not meet his personal care needs, mainstream and healthcare staff made extensive efforts to secure better arrangements for him. Notwithstanding these efforts and at least three multi-disciplinary assessments, for more than a week just before his death the man was dependent on the assistance of fellow prisoners for many of his personal needs. The author of the clinical review I commissioned was also concerned at the serious difficulties faced by staff that resulted at least once in the man being discharged from hospital to Wymott, only to be promptly re-admitted to hospital.

3. As well as endeavouring to secure an alternative location for the man, wing and healthcare staff were all committed to looking after him as well as possible within the limitations of the prison environment and staff resources. The most recent report from HM Chief Inspector of Prisons says that personal officers on I wing provide extremely high levels of care to the elderly and infirm prisoners held there. My investigator concurs with this, having been impressed with their dedication to their duties.

4. The man was convicted of sex offences and would have been required to sign the Sex Offenders Register had he reached the stage of being released on parole. The prison did not consider releasing him on temporary licence, even when he was immobile and reaching the end of his life, and he remained in custody until his death at the Royal Preston Hospital.

5. He had no contact with any family during his sentence and his sister, who was his next of kin, was apparently unaware of his conviction. The prison recognised his isolation from his family and the chaplain visited him in hospital to discuss making contact. The man agreed that, if he felt he needed his family he would ask officers to inform the chaplain. He had not done so by the time of his death.

6. The investigation report makes two recommendations to the Governor regarding arrangements for terminally ill prisoners. The first is in respect of assistance being provided by other prisoners. The second is regarding formal consideration of release on temporary licence. A further recommendation is to commend the actions of staff on bedwatch duty.

BACKGROUND

7. The man was convicted of six offences of indecent assault in 2002 and was sentenced to six years imprisonment. This was his first time in prison and his first convictions. He was subject to Multi Agency Public Protection Arrangements and was registered indefinitely as a sex offender. He would first have been eligible for parole in January 2005, some three months after he died.

8. The early part of the man's sentence was served at Stafford prison and he was transferred to Wymott in May 2002. He requested protection because of the nature of his offences and was placed in the Segregation Unit until a place was available on the Vulnerable Prisoners wing. He moved to I unit for frail and elderly prisoners when it opened in May 2003. His personal records describe him as a quiet and reserved man who talked to his friends and worked in the weaver's workshop. Throughout his sentence the man denied his offences and refused to attend Offending Behaviour courses for that reason.

9. The man's sister was his next of kin but he had no contact with her during his sentence. Indeed, she told my office's Family Liaison Officer that she had previously been unaware of her brother's conviction, and so was especially shocked to be informed by police of his death.

HMP WYMOTT

10. HMP Wymott is a category C training prison for adult male prisoners. Over half of its population are vulnerable prisoners, many of these being sex offenders. The certified normal accommodation is 1021.

11. The prison is located on the outskirts of Leyland in Lancashire and has an industrial base, which emphasises production and manufacturing. The prison is geographically split into two, which allows the category C and vulnerable prisoners to be held separately. Vulnerable prisoners are located in units A, B, J and I, the latter being designated specifically for elderly and infirm prisoners. It was there that the man served the last months of his sentence. More frequent changes of bedding and clothing are available to I unit prisoners.

12. I wing is described by staff and prisoners alike as being a safe environment, where prisoners keep a watchful eye and give help to others. Examples of neighbourly support between prisoners are collecting meals, listening out for orders, helping mobility and making drinks. Despite its designation as a specialist wing for older and disabled prisoners, its accommodation is generally not adapted to suit their needs. Cells are small and the bath is a conventional one without a lifting hoist. However, in the last few months the showers have been adapted and now have seats and rails. The wing has two floors and meals are served on the ground floor with association on the first. Applications are only heard on the first floor and so prisoners who cannot climb the stairs cannot make applications in person. The only personal care provided by the prison is an auxiliary nurse who assists with bathing twice a week.

13. The most recent inspection of Wymott by HM Chief Inspector of Prisons took place in December 2003 and found that overall it was a safe prison. A recommendation was made to the governor to make sure that the accommodation and facilities on I unit were fit for purpose, and to provide a separate treatment room.

14. Wymott has a healthcare centre providing primary healthcare. Since the time of the man's death, the centre has been able to extend its service to the night time as well as day time. However, it does not have inpatient facilities and access by nurses to cells during the night depends on the availability of prison officers to accompany them.

15. Wymott received a green rating for its healthcare centre in its 'traffic lights' audit report. HM Chief Inspector's report said that the healthcare needs of elderly prisoners were well met and there was a lead nurse for them. Inspectors also said that there was good communication between I unit and the healthcare centre, and prisoners were cared for in a holistic manner. Prisoners requiring treatment at outside hospitals benefited from good relationships between the prison and hospital.

16. The prison healthcare centre implemented its palliative care policy in December 2003. Its aims are twofold:
    - to provide a level of palliative care and symptom control for the terminally ill in prison that is equivalent to that available in the NHS;
    - to deliver the best possible quality of life whilst in the prison in an environment conducive to a dignified and pain free death.

    The policy also refers to temporary release on compassionate grounds or care at an in-patient facility within the Prison Service as alternative locations for prisoners who are terminally ill. It states that in all cases patients will be afforded appropriate dignity, with full attendance to their pastoral needs.

17. Another development since the man's death is the introduction of a policy to respond to prisoners who fail to collect their own medication. This was introduced on the initiative of the healthcare manager who identified it as a learning point from her own review of his care.

CONDUCT OF THE INVESTIGATION

18. The investigator visited the prison shortly after the man's death and was given access to his records, including his medical records. She spoke informally to Governor, the Duty Governor on the day of the death, and to the healthcare manager. The Independent Monitoring Board and the Prison Officers' Association were informed of the visit but neither took up the offer of a meeting.

19. No formal interviews with staff were conducted. The relevant documentation was reviewed, as was the prison's palliative care policy.

20. Three prisoners who provided personal care for the man were interviewed and the cell where he lived was visited.

21. Chorley and South Ribble Primary Care Trust carried out a clinical review of the man's care on behalf of the Ombudsman.

22. The Ombudsman's Family Liaison Officer made telephone contact with the man's sister, who had appreciated the support and information from Governor. It was, however, unfortunate that she was informed of her brother's death – and indeed of his conviction and sentence – by a visit from the police in the early hours of the morning. She is an elderly woman who lives alone and the timing of the police visit caused her unnecessary alarm. In the circumstances, it would seem reasonable had the visit been delayed until daylight.

KEY FINDINGS

23. The first indication that the man's health was deteriorating was in February 2002 when he was at HMP Stafford. The man complained of dizziness, and staff said that he was confused and disorientated and had no control of his bowels. He was admitted to the healthcare centre for observation and for tests to be carried out.

24. The man was seen on 18 May 2002 at reception to Wymott and described as fit and well for allocation to work. In January 2003, he collapsed and was prescribed medication by the medical officer. The man was relocated to I wing from its opening in May 2003 as its regime was designed for frail and elderly prisoners. The following month he saw healthcare and it was suspected that he was confused about whether to take his medication, saying that he was unsure whether it was to be continued. Similarly, in July he saw the medical officer and said that he was not taking his medication. This time it was stopped, with a review to take place in a month. In August, the man developed a chest infection and was prescribed paracetamol and fluids, with observations to be made by night staff.

25. In March 2004, the man's personal record refers to an episode of incontinence but that he wanted to carry on working as he enjoyed the walk to work and the company. A month later, the man fell during the night against the pipes in his cell. The I wing observation book said that he had been incontinent and was in a confused state. Two other prisoners assisted and he was cleaned up, the records stating that their help eased a difficult situation. It was suspected that he had had a stroke and he was admitted to Chorley Hospital for assessment. He was discharged four days later, and the diagnosis of a stroke was confirmed.

26. On 27 April, he attended healthcare for dressings to the burns sustained prior to his hospital admission.

27. On 14 May, a healthcare assessment was carried out as other prisoners said he was not eating properly, and was vomiting. Wing staff described him as looking weary and jaundiced. Other prisoners had previously made requests on his behalf to healthcare and the man was described as someone who did not like to make any trouble for anyone. He was adamant that he was well but arrangements were made for him to see the medical officer the following day and blood tests were requested.

28. The man was seen by healthcare staff on the wing on 18 May and said he felt unwell and had abdominal pain. The results of the blood tests were abnormal and he returned to hospital the next day.

29. During his stay in hospital the prison made frequent checks on his progress, both via bedwatch officers and by telephone contact from healthcare staff. The prison recognised that the man had no visits from his

family and so the chaplain went to the hospital to discuss contact with his next of kin. The man's view was that he did not want his sister informed but agreed that if he had a change of heart he would ask the chaplain to get in touch with her. He remained in hospital on this occasion until 28 July. He was diagnosed as having Hodgkin's lymphoma, chronic diarrhoea and jaundice and was waiting for an oncology appointment.

30. On returning to the prison, staff were immediately concerned that they could not meet the man's needs. He was described as unsteady on his feet and needing his meals to be brought to him by another prisoner. He went back to hospital the following day, 29 July, being dehydrated due to malabsorption secondary to the jaundice.

31. When the man returned to Wymott on 28 August, staff again reported that he was not in the right environment as he was not able to look after himself and needed help to dress and undress. The prisoners interviewed had also recognised the man's vulnerability and had informally arranged a day and night rota to keep an eye on him. They described this as having someone sit with him at all times to make sure that he did not fall, and to help him to the toilet. After four days, the arrangement was formalised by staff and a named prisoner was asked to assist during the night as the man had fallen again. He was assessed on 1 September by a clinical nurse specialist who stated that the man should not be left overnight without professional support.

32. The Governor and the Healthcare Manager made extensive efforts to find either prisons with 24 hour healthcare or a nursing home. They were unable to find a prison with a cell suitable for lifting equipment or for the disposal of human waste. A Community Palliative Care Specialist assessed the man and discussed his care needs at the end of his life.

33. Within the limitations of their resources the prison arranged for the man to be looked after as well as possible, albeit by using the goodwill of other prisoners. One of the prisoners interviewed described how he thought the man felt about these arrangements. He said that he thought the man felt the arrangements robbed him of his self worth and dignity. He said the man felt dumped because the system did not care, and he thought he should have been somewhere else with a better bed and better attention. During the night, Listeners stayed with him to provide for his hygiene and other needs, and the showers were left open. A Listener was requested to help in this way because they have all had first aid training, but it is not their usual role. They were told to call for staff if the man fell and not to lift him themselves.

34. On 3 September, the man was left alone overnight as the Listener felt unable to stay again because of lack of sleep. He fell in the early hours of the morning and two prisoners were needed to get him back into bed. One of them, referred to as a carer, assisted with basic hygiene, and clean clothing and bedding was issued. A further assessment by the NHS

Continuing Care Co-ordinator and Occupational Therapist was subsequently carried out.

Although it is clearly a good thing if prisoners help one another, I recommend that the Governor ceases the practice of using other prisoners to provide voluntary assistance with personal care, such as bathing and dealing with incontinence.

35. After nine days, the man was transferred on 6 September to the medical unit at HMP Preston, before admittance to the Royal Preston Hospital two days later. A discharge planning meeting took place at the hospital on 13 October at which it was decided that 24 hour nursing care was required. HMP Garth offered a bed but the man remained at the hospital until his death on 26 October.

36. Bedwatch risk assessments were made for each of the man's stays in hospital. In May, he was described as immobile and of good behaviour. The assessment recommended that two officers supervise him, remaining outside the door of his side room and making four checks per hour. The assessment in July reduced the supervision to one officer, without restraints, but on 26 August it was said that the man's mobility had improved and so the bedwatch was increased to two officers. On 7 September, the supervision was reduced again to one officer but with handcuffs at all times. On 9 September, supervision decreased to one officer again.

37. No consideration was given to releasing the man on temporary licence, even at the end of his life, and this was explained as being because of the nature of his offences. Release on compassionate grounds may be granted on medical grounds when death is likely to occur within three months, provided that the Home Secretary can be satisfied that there is no longer any risk of re-offending and that adequate arrangements are in place for care and treatment outside prison. There was no evidence of a formal decision being made or recorded, or that the proximity of the man's parole date was taken into account.

The Governor should remind senior staff to consider release on temporary licence for all terminally ill prisoners and to make a record of the decision made.

38. Bedwatch officers did, however, make numerous improvements to the quality of the man's life as it drew to an end. It was these staff who alerted the prison when, in their view, premature discharge plans were under consideration. They also helped the man to eat and drink. They spent time chatting to him and ensured that he was not alone when he died.

The Governor should issue a letter of commendation to bedwatch staff for their actions.

RECOMMENDATIONS

1. **Although it is clearly a good thing if prisoners help one another, I recommend that the Governor ceases the practice of using other prisoners to provide voluntary assistance with personal care, such as bathing and dealing with incontinence.**

2. **The Governor should remind senior staff to consider release on temporary licence for all terminally ill prisoners and to make a record of the decision made.**

3. **The Governor should issue a letter of commendation to bedwatch staff for their actions.**