Investigation into the circumstances surrounding the death of a man whilst in the custody of HMP Wellingborough in March 2010

Report by the Prisons and Probation Ombudsman for England and Wales

May 2011

This is the report of an investigation into the death from natural causes of a man, who was a prisoner at HMP Wellingborough, who died in hospital in March 2010. He was 74 years old. He came into custody in 1985.

I offer my sympathy to all those touched by the man's death. I apologise for any further distress caused by the delay in the production of this report.

The investigation was carried out on my behalf by my colleague. An independent review of the man's medical care in prison was conducted by a clinical reviewer on behalf of the local Primary Care Trust. I am most grateful to him for his assistance.

He concludes that the man's clinical care at Wellingborough was at least to the standard he would have received in the community and that he was treated with compassion and care. I agree. Unusually I also highlight the decision not to apply for compassionate release towards the end of his life. I have in the past criticised decisions not to apply for compassionate release. On this occasion he wanted to stay in prison and the decision was made wholly in his interests, despite the demands it placed on the prison. The compassion shown towards him was, I believe, an example of good practice.

This report recognises the good quality care which all staff provided to him. I would be grateful if the Governor would share this report with staff and pass on my thanks for their actions. I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Jane Webb
Acting Prisons and Probation Ombudsman **May 2011**

CONTENTS

SUMMARY

The man had an unsettled childhood, and lived in a number of different children's homes. He committed his first offence at 18 years of age, for which he received a term of imprisonment. This was followed by a number of further periods in prison. In 1985 he was convicted of the murder of his long term partner.

In 1999, he was admitted to hospital having experienced severe chest pains. He was diagnosed as having suffered a heart attack. He refused to have surgery until he suffered a further bout of severe chest pain in 2001. He was placed on the waiting list for a heart bypass, which he had in 2002.

His health remained generally settled until mid 2008 when he suffered a severe attack of angina (spasmodic intense chest pain) and was diagnosed with an irregular heart rhythm. In September 2008, he was fitted with a heart pacemaker. Two months later, he was found to have excess fluid in the abdomen and disease of the liver. He delayed having treatment until December 2008 when he had an operation to drain the excess fluid.

He remained stable until 4 March 2010, when he was admitted to hospital suffering from a swollen abdomen, chest pains and difficulty breathing. He discharged himself the same day, but was readmitted the following day. Excess fluid was drained from his abdomen and he was found to be suffering from multi organ failure including kidney failure.

On 12 March, the consultant treating him told staff that he was not responding to treatment and was terminally ill. The consultant instructed that, in the event of heart failure, he was not to be resuscitated. He said that he should not be moved from hospital and should spend his last days there. The end of life pathway procedure was commenced on 13 March (designed to give a high quality of care for people approaching the end of life). Over the next days prison healthcare staff and a representative of the chaplaincy visited. He died several days later. The coroner's office told the prison that he had died of natural causes.

The clinical reviewer said that he had been given a standard of care at least equivalent to that he would have received in the community. I too do not have any concerns.

I have been struck particularly by the way the Governor and staff at Wellingborough gave timely consideration to issues such as the compassionate release and ensuring that appropriate end of life and palliative care was in place. The consultant spoke compassionately about his relationship with him and a number of staff visited him in hospital. In particular, I believe that the decision not to grant compassionate release solely in order that he would have company during his final days was an example of good practice.

THE INVESTIGATION PROCESS

1. This investigation was undertaken by one of the investigators from this office. He first visited HMP Wellingborough on 23 March 2010 when he met the Governor and family liaison officer. He was given access to the man's prison records and to all the relevant staff. Notices were issued inviting staff and prisoners to contribute to this investigation. In the event, no one came forward with any further information.

2. The local Primary Care Trust (PCT) was commissioned to review his clinical care and treatment at Wellingborough. The PCT appointed a clinical reviewer.

3. The clinical reviewer was asked by my investigator to establish the circumstances surrounding the man's death and to comment on the care provided to him. The doctor made two visits to Wellingborough. The initial visit was to establish the facts and to familiarise himself with the medical environment. The clinical reviewer examined the medical records, including those on the computerised system. He also reviewed the notes made by the hospital and correspondence between the hospital and Wellingborough relating to his out-patient appointments. On his second visit he was accompanied by my investigator and, together, they interviewed a number of staff.

4. The man had declined to give Wellingborough any details of his next of kin and instructed that they should not be contacted whilst he was alive. Despite exhaustive attempts by the prison's family liaison officer to trace his next of kin she has been unable to locate any family members to inform them of his death. I too have no contact details for any members of his family. A copy of this report will be retained by my office should any of his relatives make contact in the future.

HMP WELLINGBOROUGH

5. HMP Wellingborough currently holds 635 adult male offenders. It first opened in 1963 as a borstal and held young offenders until 1990. Following a temporary closure whilst essential repairs were carried out, Wellingborough re-opened as a category C training prison for adult men. (Category C prisoners are seen as presenting a medium risk of offending and escape. Training prisons provide courses to help prisoners address their offending behaviour.)

6. Commissioning healthcare in the prison is the responsibility of the local Primary Care Trust, which in turn, commissions Care UK to provide primary care services. The healthcare centre employs a part-time doctor and operates an out of hours GP service. There are a number of out-patient clinics on site, including dentist, optician and psychiatrist. There are no in-patient beds.

HM Chief Inspector of Prisons' report

7. The most recent full inspection of Wellingborough by the then Chief Inspector of Prisons dated December 2008, describes Wellingborough's healthcare as largely satisfactory. The Chief Inspector said that it was insufficiently integrated into the rest of the prison, and did not have a lead person who was responsible for older prisoners. I note that the clinical reviewer reports that there is now a lead nurse for older patients, who coordinates care and is the nursing link for medication. He says that "[the nurse] had lots of input into the care of the man over the time he was at Wellingborough and particularly in the build up to his hospital admissions".

Independent Monitoring Board

8. Every prison in England and Wales has an Independent Monitoring Board (IMB). IMB members are volunteers who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The Board's report for the year from 2008 to 2009 does not contain any issue that should be considered here.

9. Since my office took over responsibility in 2004 for investigating all deaths in prison custody, there have been two deaths attributed to natural causes at Wellingborough, including the man's death. No issues arising from the other case are directly relevant to the circumstances surrounding his death.

KEY EVENTS

10. The man was born in April 1935. He was the youngest of three children having one brother and one sister. His father died during the Second World War and he spent his formative years in several children's homes. After leaving school, he did National Service before taking a variety of jobs. He had spent a number of periods in custody before committing the offence of murder in 1984.

11. On conviction on 12 September 1985, he was sent to HMP Wormwood Scrubs. He moved to a number of prisons before moving to HMP Wellingborough on 1 June 2005.

12. In 1999, he was taken to hospital suffering from acute chest pain. He was found to have a posterior myocardial infarct (heart attack) but he refused to have surgery. He went to hospital again in 2001 suffering from chest pains. He was referred to a consultant cardiac surgeon who diagnosed triple artery disease (blocking of the arteries that supply the heart with oxygen rich blood) and moderate ventricular function (irregular heart beat). He required coronary artery bypass graft surgery (heart bypass) and his name was placed on the waiting list for an operation which took place in June 2002. Following discharge from hospital, he chose not to go to follow up appointments with a consultant cardiologist. In February 2003, the consultant decided to discharge him from hospital care.

13. On arrival at Wellingborough in June 2005, he had established hypertension (high blood pressure), hypercholesterolemia (high levels of cholesterol – one of the body's fats – in the blood), and mild renal impairment (which means that the kidneys do not function properly). The clinical reviewer concluded that all these medical conditions "appear to have been managed appropriately".

14. On 2 June 2008, he told Nurse A at Wellingborough that he was experiencing an ache in his left arm and shortness of breath when walking. He was examined by Prison Doctor A, who noted that he had "significant pitting oedema (retention of fluid) in his legs up to mid calf level". The doctor prescribed an increase of furosemide (a drug used to treat excessive fluid) which the man had been prescribed for a number of years. He examined him again on 6 and 13 June, and on each occasion noted an improvement in the oedema.

15. When he went to collect his medication from healthcare on 18 June, he told one of the community health service staff that he felt unwell. She offered to speak to the doctor and an appointment was made for him to see him on 20 June. He did not go to the appointment. When he did not go to another appointment made for 25 June, the doctor went to the wing and examined him there. The doctor noted that his oedema had become slightly worse and prescribed a further increase in furosemide.

16. He was examined by Prison Doctor B on 14 July. The doctor noted that the oedema had spread to the knees and there was a small amount in the tissues of his lower abdomen wall and thighs. He prescribed an increase in captopril, a medication which had been prescribed for a number of years. (Captopril is used to treat a number of medical conditions including hypertension, congestive heart failure and kidney malfunction.)

17. Nurse A saw him on the wing on 21 July and noted that his legs remained swollen but his arms were "no longer" swollen. (There is no earlier mention in the clinical record of him suffering from swollen arms.) He was not in pain. She discussed the case with an unnamed doctor who advised that medication should continue as prescribed and an appointment made for him to have blood tests. He failed to go to a number of appointments with healthcare staff and doctors including those for 23 and 28 July and 1, 4 and 8 August.

18. On 9 August, he was seen by Nurse A, who was concerned because he looked unwell. He had a sudden onset of swelling to hands and was short of breath. She contacted the out of hours doctor service who advised that he should be admitted to hospital by ambulance. He was admitted to the Accident and Emergency Unit at hospital.

19. The nurse visited him in hospital on 11 August. She was told by a hospital nurse that he had suffered a severe angina attack the previous day and should remain in hospital for monitoring. The clinical record noted that :

> "He stated that he has contacted his sister although it is too far [for] her to visit. He was unwilling to give prison staff any numbers for her, which was respected."

20. He was subsequently moved from that hospital to another, where, on 19 September, he had an operation to fit a biventricular inplantable cardioverter defibrillator implant (heart pacemaker). He was discharged from hospital on 26 September.

21. On 2 November, Nurse B went to his cell to give him a flu vaccine. She thought that his physical health had deteriorated. She noted he had a "large swollen abdomen and mild swelling to the ankles". Staff on the wing told her that he was no longer taking any exercise but he told her that he felt fine.

22. He refused to keep an appointment that had been made for him to attend hospital on 3 November for a review of his pacemaker and signed a disclaimer to that effect. The clinical record gives the reason for his refusal that he "cited that he does not want to be handcuffed and that is the only reason why he won't go".

23. There is a further entry in the clinical record for 3 November, by the Healthcare Practice Manager, which states "seen by Prison Doctor A – referred to A+E for further investigation (Patient informed)". It is not clear from the clinical record when he went to hospital as the next reference to hospital is on 6 November, which states "rang hospital, he is having a scan at 3pm". However, there is a letter in his medical papers from the hospital to Wellingborough's medical officer dated 5 November which states that he went to Accident and Emergency on 5 November at 3.09pm where he was seen by a doctor and admitted to hospital.

24. He discharged himself from hospital on 10 November, before an ultra sound scan could confirm a diagnosis. The initial diagnosis was that he had developed ascites (excess fluid in the abdomen) and cirrhosis (deterioration of the liver). He told Nurse C that he had been fed up with waiting for "things" to be done in hospital. She noted that she "stressed to him that he was extremely unwell and that the hospital could provide the best possible care for him at this time".

25. On his return from hospital, staff discussed whether to open the Assessment, Care in Custody and Teamwork procedures. (The ACCT procedures are used to monitor and support prisoners considered to be at risk of suicide or self harm. Once placed on an ACCT, the prisoner is subject to regular reviews that decide the level of observations and conversations to be carried out at intervals determined by the perceived level of risk to the prisoner.) Staff decided not to open the ACCT procedures and instead opened a care plan, which set out what support was in place for him, and who would provide the support. The care plan required wing staff to check on him every time his cell was locked or unlocked and twice throughout the night. He was made aware of the plan. He was asked whether he would like his next of kin contacted, but declined.

26. He refused to accept any treatment on 11 November and told Nurse C and the community health service staff, that he "couldn't be bothered and just wanted to be left alone". Nurse C had another discussion with several staff about opening the ACCT procedures and they decided that they should be opened as the existing care plan was not an official Prison Service document.

27. Nurse D tried to assess his mental state on 13 November but he refused to cooperate. He told her that he was unhappy about being monitored by the ACCT procedures which meant that he was being woken by officers asking him if he was alright. He told her that he did not want to go to hospital. She noted on that clinical review that he showed "[n]o evidence of any mental health issues".

28. Following a review, the ACCT procedures were closed on 13 November, as he was not considered at risk of harming himself. Healthcare staff continued to see him at least daily and wing staff observed him each

time his cell was unlocked and were told to contact healthcare if they had any concerns. Healthcare staff continued to visit him at least daily, although he told Nurse B on 18 November that he considered that staff were wasting their time by doing so.

29. My investigator asked the Healthcare Practice Manager further questions about opening the ACCT monitoring. He explained, in an e-mail of 3 November 2010, that

> "an ACCT was opened on 11 November 2008 following discussions between healthcare and residential staff … in order to observe his well being. … The ACCT was subsequently closed on 13 November as it was clear he wasn't at risk of direct self harm."

30. On 2 December, he refused to go to a pre-operation appointment at the infirmary "... and that it is very doubtful that his [he] would attend the actual procedure on 12 Dec[ember]". Both appointments were cancelled and he signed a disclaimer. There is no reference as to the purpose of the operation. He told two nurses that he refused to go to hospital because he did not want to die in handcuffs in hospital. (Prisoners who are taken out of the prison for any reason, including hospital, are risk assessed and restrained by hand cuffs or an escort chain as well as being escorted by two or more staff.)

31. Prison Doctor A saw him on 10 December, when he continued to refuse to go to hospital and said that he understood that the decision could have grave consequences. On 11 December, he went to healthcare as he felt unwell. He told staff that he had had trouble breathing in the night and his abdomen was swollen. He was taken by ambulance to Accident and Emergency at hospital, where he was seen by a consultant. The doctor noted that he was suffering from abdominal pain. However, he refused treatment and discharged himself.

32. The following day, prison medical staff and the Heart Failure Nurse Specialist at the hospital talked to him about the options for further treatment. As a result he agreed to return to hospital for treatment. He also agreed to consider a transfer to HMP Norwich. (Norwich has a specialist elderly patients unit, the Nelson Unit. The 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.)

33. He was taken back to hospital on 12 December and had an operation to drain the excess fluid from his abdomen. On 21 December, he discharged himself against medical advice and signed another disclaimer. Nurse A saw him on the wing on 22 December and he told her that he felt fine and would contact healthcare if needed. A nurse wrote to the Healthcare Practice Manager on 29 December including a management plan for him.

34. The clinical record shows that throughout 2009 he was regularly reviewed by healthcare staff and his heart condition was monitored. The Healthcare Practice Manager wrote to Norwich on 23 January 2009, proposing that he should transfer there. On 9 February, Nurse C told him that Wellingborough "were no longer able to give him the care which he required and that his needs would be met in a more appropriate manner at Norwich". When Nurse E spoke to the Head of Healthcare at Norwich on 26 February she was told that the referral papers had not been received. Prison Doctor A wrote to the Head of Healthcare at Norwich on 13 March saying that the man "would benefit greatly from a transfer to Norwich as the holistic care we are able to give him here [Wellingborough] is not ideal". The medical record for 16 March by the Healthcare Practice Manager states:

> "Have been repeatedly following up on referral process for Norwich elderly lifer unit – additional information faxed and further e-mails sent including referral letter from Prison Doctor A and the hospital discharge information. Will need to explore community palliative care options as there continues to be a general deterioration in health and ability to self care."

35. There are no further references in the clinical record to the proposal for the man to transfer to Norwich. My investigator asked Prison Doctor A why he had decided he should not be transferred. He said that, after taking some advice, he concluded that it would be better for him to remain at Wellingborough. The doctor confirmed that he had discussed the matter with him who had told him that "he wasn't particularly keen to be transferred" and was happy at Wellingborough.

36. The Parole Board had last considered his case on 2 October 2009 but he did not cooperate with the process or attend the hearing. The Board is responsible for releasing prisoners serving a life sentence. A case cannot be referred to the Board until a prisoner has served the minimum term. The Board is empowered to direct release if it is satisfied that it is no longer necessary for the protection of the public that the individual should remain in prison. On this occasion the Board decided not to direct his release because they had no evidence that his risk of re-offending was manageable in open conditions or on release. The risks remained unaddressed because he refused to participate in rehabilitative work.

37. In December 2009, he was examined by Prison Doctor A and found to have a low haemoglobin (Hb) level (below average concentration of the oxygen-carrying proteins in the blood). The doctor discussed this with the hospital's Medical Registrar, who agreed that he should be referred to hospital. He was taken to hospital on 4 December, but discharged himself despite the advice of both hospital nurses and the prison officers who were escorting him.

38. The following day, he told the officers on his wing that he again felt unwell. The officers asked Staff F to visit him and he told her that he wanted to go to hospital. Arrangements were made for him to be taken to the hospital's Accident and Emergency by ambulance. He had a blood transfusion before being discharged on 8 December.

39. The entries in his clinical record covering the next few months show that he continued to receive regular care and medication. On 5 February 2010, an appointment was made at the pacemaker department at hospital in May, although concerns were raised that he would refuse to go.

40. On 4 March, Officer A asked Nurse B to come to his cell on the wing. He told the nurse that he had been experiencing chest pains and shortness of breath. She noticed he had a swollen abdomen and arranged for him to be admitted to Accident and Emergency at hospital. He was examined by one of the hospital doctors but discharged himself before the tests could be completed. The Case Note History completed by Officer B, his personal officer, records that he "discharged himself against medical advice". (Every prisoner is assigned a personal officer. Their role is to meet prisoners regularly to discuss any issues or concerns the prisoner may have.) On return to Wellingborough, he told Nurse B that he had discharged himself "because they were faffing about".

41. The next day, Prison Doctor A examined him and found that he continued to experience chest pains and difficulty breathing. He also noted widespread oedema. He readily agreed to the doctor's advice that he should go to hospital. The Governor decided that he need not be handcuffed for the journey to hospital as a defibrillator was in place. The machine uses electricity to re-establish a normal heart rhythm.

42. Later on 5 March, Nurse C received a telephone call from Oscar 1 that he was refusing medical intervention and intending to discharge himself from hospital. (Oscar 1 is the senior officer on duty who responds to any emergency situations. The record does not show how he became aware of his intentions, but it is likely that one of the escort staff would have reported their concern to Oscar 1.) She passed on the information to the Governor and also contacted the palliative care team at the hospital.

43. In the event, he did not discharge himself and remained at hospital. The Hospital Watch Occurrence Log for 5 March records "Full briefing received from day staff. He is uncuffed and very poorly." (When a prisoner is admitted to an outside hospital the escort staff maintain a daily occurrence log recording all events that occur whilst the prisoner is out of the prison.) The Governor also asked staff to see if they could find another prison with 24 hour healthcare which would be prepared to take him. Their attempts were unsuccessful.

44. Nurse E contacted a member of the hospital ward staff on 7 March and was told that he was suffering from a kidney infection which meant that they did not work properly. Fluid had been drained from his abdomen. A member of Wellingborough's chaplaincy team visited him at the hospital.

45. On 8 March, a Macmillan nurse from the hospital's palliative care team, contacted Nurse C. She confirmed that, while she was content to assess him, the request would have to be made by a member of the hospital staff. (Macmillan Nurses provide advice and support for people who are thought to be near to the end of their lives.) Nurse C contacted a nurse at the hospital to ask her to make the necessary referral to the Macmillan nurse.

46. The Bedwatch Log for 8 March states he is "demanding to go back to prison. We have tried to reassure him that the hospital is the best place for him at this time". It also records that he was asked twice whether he would like the prison staff to contact his sister but was "adamant that we are not to contact his next of kin or give us a number for them". Officer B was on bedwatch duty and noted in the Case Note History:

> "Myself and an officer tried on several occasions to convince him that contacting his next of kin, his sister, was a thing he should consider. He became agitated and said 'I will contact her in my own time'."

47. On 9 March, Nurse C visited him in hospital and also spoke to a ward doctor and hospital nurse. They told her that he was making steady progress and was not considered to require palliative care. They also informed her that no discussion was necessary at that time as to whether he would wish to be resuscitated in the event of his heart failing. She left papers relating to the compassionate release of prisoners with the doctor and the hospital nurse. (In certain circumstances a prisoner will be allowed to leave prison on a temporary licence for, amongst other reasons, compassionate grounds. In the case of the man, who was already outside the prison, the practical applications of granting compassionate release could include the withdrawal of the bedwatch staff and resettlement into accommodation in the community such as a nursing home or hospice.)

48. Also on 9 March, a multidisciplinary meeting took place at Wellingborough. Among those present were the Governor and two members of staff who had visited him earlier in the day. The minutes of the meeting record that he continued to refuse to provide any details of his sister's whereabouts but efforts would continue to trace her. In accordance with his wishes, if the staff did trace her, she would not be contacted until after his death. Compassionate release (possibly to a hospice) would also be pursued. The meeting also made arrangements to support the welfare of the staff assigned to bedwatch duty.

49. Another multidisciplinary meeting took place the following day. Nurse C reported that she had been told by a consultant the previous day that his condition had improved. Contingency plans were considered for the possibility of his discharge from hospital and also if remained and died in hospital. The meeting was told that bedwatch staff had talked with him about his will, funeral arrangements and making contact with his sister.

50. On 11 March, the Consultant Gastroenterologist (a specialist in diseases of the digestive system), told the staff who were on bedwatch that he was suffering from multi organ failure and could not be moved from hospital. One of the officers on bedwatch updated the Senior Officer.

51. The following day, the Consultant told the bedwatch staff that he was not responding to treatment and, if that remained the position for the next 24 hours, treatment would be stopped. The bedwatch log completed by one of the officers states:

> "[i]nstructions have been given by the Consultant that if his [the man's] heart fails he should not be resuscitated. ... I have discussed compassionate release with the consultant and he would be content for him to be released to the hospital". (The decision not to resuscitate means that, should the patient go into heart failure, no attempt would be made to restart the heart.)
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> The bedwatch log notes confirm that the Consultant had completed the application for compassionate release. The record also noted that no restraints (handcuffs) were in use.

52. A further multidisciplinary meeting was held on 12 March attended by, among others, three members of staff who had visited him earlier in the day. They reported that the Consultant advised that he had a terminal illness. All treatment was to be withdrawn and he would be made as comfortable as possible. The meeting discussed compassionate release and the Governor decided that the application should not be pursued. The minutes of the meeting record that "removal of staff from the bedwatch would not be beneficial to him and that it was more decent for staff to remain with him during his last days". The Governor asked that, when he died, a governor should go to the hospital to ensure that the bedwatch staff were supported.

53. The clinical record states that after the meeting of 12 March, Nurse C went to the hospital and spent some time with him. She noted that

> "… he was comfortable in bed, unable to maintain a conversation but occasionally able to answer yes when I asked him if he was comfortable. He is being nursed in a side room."

54. On 13 March, Nurse B noted that the hospital doctor had withdrawn all treatment except paracetamol. The bedwatch log for 13 March states "Nurse states he is on palliative care and will give him medication to

manage his pain if required". The Liverpool end of life pathway was put in place. It ensures that high quality care is given to people approaching the end of life.

55. The Bedwatch Log records that over the next few days he continued to receive regular visits from doctors and nursing staff. The bedwatch staff reported every four hours to healthcare. On 15 March, Nurse C was told in a telephone conversation by a hospital staff nurse that he remained comfortable. The following day, she visited him. She recorded that "[he] remains comfortable in bed, receiving regular analgesia (used to relieve pain) so he is pain free and comfortable".

56. Officer C confirmed to my investigator that he was on bedwatch duty on the evening of 16 March. He and a colleague had taken over from the day staff at approximately 7.45pm. The day staff had briefed them that there was no change in the man's condition. The officer said that:

> "The man slept throughout the night with the occasional coughing and groaning similar to the day of 14 March when I was also on duty. The nurses attended him at regular intervals to adjust his pain medication and his bedding with the last occasion at approximately 6.55am [on 17 March] when his medication was checked and his arms were placed under the covers."

57. The officer confirmed that he was relieved of duties by day staff at approximately 7.25am on 17 March.

58. Officer D was the second officer on duty on the night of 16 March. He told my investigator that the man did not wake up during the night and he was checked throughout the night by nursing staff.

59. At approximately 7.35am on 17 March, whilst the officer was handing over the bedwatch duty to Officer E, a nurse came into the room to check on the man. The nurse told the officers that she thought he had died. The nurse went to get a second nurse who confirmed that he was dead.

60. When interviewed, Officer E told my investigator that, shortly after he came on duty, a hospital staff nurse told him that she believed that the man had died. At 7.52am, the officer contacted a Senior Officer at Wellingborough to inform him of the death.

61. A meeting took place in the deputy governor's office at 11.30am on 17 March. After being debriefed, the relevant staff were offered appropriate support, including being allowed to go home for which transport was provided.

62. The Consultant's assistant wrote to the Coroner's office on 17 March to report that the man had died that day. In his letter he gave the cause of death as follows: "1. a) Decompensated chronic liver disease, b) biliary

tract infection and 2. Congestive heart failure, ischaemic heart disease and chronic disease". The death certificate identified that death was caused by biliary tract infection (the biliary tract transports bile from the liver to the duodenum to aid digestion). Contributing causes were congestive cardiac failure (heart failure), ischaemic heart disease and chronic kidney disease.

63. HMP Wellingborough arranged and met the full costs of the funeral. The man was buried with a Quaker service led by a member of the chaplaincy at Wellingborough and was attended by the Governor.

ISSUES

The length of time the man served in prison

64. The man was sentenced in September 1985 and given a life sentence with a 12 year tariff. The term to be served was reached on 1 December 1996. After that date he was eligible to have his case considered by the Parole Board.

65. Shortly after being sentenced, he told the prison chaplain at HMP Wormwood Scrubs that he was innocent of the offence and would rather serve "natural life" than face society as a murderer released on licence for an offence he did not commit. He continued to deny the offence throughout his time in prison. He did not attend any hearings of the Parole Board or have any involvement in the sentence planning process, which is designed to help towards rehabilitation on release.

66. The Parole Board last looked at his case (in his absence) in October 2009. The Board considered a number of reports including one of 21 July 2009, prepared by his probation officer which states:

> "... unless he receives a Free Pardon, he is quite content to remain at Wellingborough. He otherwise does not expect to be released; moreover, in the past he has voiced a preference to remain in prison rather than face having to support himself in the community in poor health in his latter years."

67. The Parole Board decided that it was not safe to direct his release from prison or to recommend transfer to an open prison (Wellingborough is a closed prison). The ground for their decision was that they considered that his risk of re-offending remained unaddressed as he had not completed any offending behaviour work.

Clinical care and refusal of medical treatment

68. Prison Doctor A, and healthcare staff, referred him to hospital for medical treatment on seven separate occasions between November 2008 and his death in March 2010. On five of those occasions, he discharged himself from hospital, and on one occasion he declined to go to an appointment that had been made for him. The clinical record shows that healthcare staff warned him of the consequences of refusing treatment. He signed a disclaimer on four occasions to confirm that he understood the implications of refusing treatment. He said that he disliked being handcuffed to prison officers, and having to wait for treatment.

69. In the same period, the clinical record shows that on a number of occasions he refused to see the prison doctor and did not keep appointments with staff in the healthcare centre.

70. The doctor told my investigator that he was:

> "… not a man who sought medical help in lots of ways really: refused admission to hospital, then often discharged himself once he'd been sent to hospital. Not because he was in any way aggressive or whatever, he was a nice man, but he was almost resigned to his fate."

71. The clinical reviewer comments on his attitude to accepting treatment:

> "His [the man's] medical care throughout has been compromised by his intermittent lack of co-operation with treatment, however, there is nothing contributory either in his actions or in anyone else's to his ultimate deterioration and death.
>
> "I have found the medical care to at least be of a standard he would have received in the community and where he was treated with compassion and care and his difficult medical conditions managed to the very best of their ability. This is an excellent example where the use of appropriate computerised medical records, organised chronic disease management programmes and a well staffed and trained medical, nursing and pharmacy team have provided good quality care. I do not feel that there are any specific recommendations for improvement within the service that was provided for him."

72. Given that he was undoubtedly a patient who frequently refused to co-operate with medical staff, I am satisfied that staff at Wellingborough made every effort to persuade him to accept treatment. Indeed, on those occasions when he discharged himself and was almost immediately taken ill again, staff invariably managed to convince him to return to hospital the next day. I believe that the care given to him was appropriate and empathetic to someone in his position, and I agree with the clinical reviewer's comments. I am particularly impressed with the multi disciplinary meetings which meant that healthcare and discipline staff worked together to plan the best arrangements for him.

Transfer to HMP Norwich

73. In December 2008 and early 2009, Prison Doctor A and healthcare staff at Wellingborough actively considered his transfer to the specialist unit for elderly patients at HMP Norwich. He was refusing medical intervention at that time and Wellingborough staff thought that Norwich would be better equipped to provide the care that he required. He was receptive to the move and an application for his transfer was made in January 2009.

74. The prison doctor decided not to pursue the application after taking advice. He told my investigator that the man was happy to remain at Wellingborough. It is unfortunate that the application seems to have

been lost. It is clear that, on reflection, the doctor considered it in his best interests that he should remain at Wellingborough. Also he spent his last weeks in hospital, rather than in prison, which was the right place for him.

Consideration of compassionate release

75. I note that timely consideration was given as to whether to release the man from prison on compassionate grounds. The Governor initially supported the move and had the support of the hospital consultant who was treating him.

76. However, it became apparent that he could not be moved from hospital (for example to be transferred to a hospice) as this would have been detrimental to his health. He had expressed his wish to return to prison if possible, and had not discussed any plans for resettlement. The Governor decided not to apply for compassionate release so that bedwatch staff would remain with him. He had no visitors and rejected the suggestion that his family should be told that he was dying. Retaining the bedwatch officers, despite the emotional cost on them and the demands on the prison's budget, meant that he was not alone at this time.

77. I often comment on cases where compassionate release has not been considered at all, or where a decision not to apply for such a release has been particularly risk averse. On this occasion, however, I applaud the compassion shown by the Governor and believe that this is an example of good practice. By keeping the bedwatch officers with him, which could only be done as he remained a prisoner in custody albeit one who was in hospital, the Governor ensured that he was well supported through the final days of his life. For a man who had no next of kin and who clearly saw the prison as his home, I think that this would have provided great comfort.

The decision not to release the man in order that bedwatch officers could remain with him was, on this occasion, an act of compassion and an example of good practice.

Use of restraints

78. There were two occasions when he refused to go to hospital because he did not want to be handcuffed and he said that he did not want to die in handcuffs. I have no reason to doubt that the risk assessment concluded that restraints (handcuffs) were necessary on those occasions. However, it is not evident whether the considerations were properly explained to him or if other options such as escorting him with more officers and without restraints were considered.

79. However, I am pleased to report that from when he was taken to hospital on 5 March until his death, he was not restrained in any way. This

common sense approach is welcomed and I am pleased that Wellingborough treated a terminally ill man so decently. In addition, my investigator found that the bedwatch notes were detailed with full and appropriate entries.

Contacting the man's next of kin

80. I have referred to the efforts made to trace his next of kin by Wellingborough's family liaison officer. It is evident from the clinical record that she tried several different routes and possible leads to track down his sister. She also contacted one of my family liaison officers for advice. My investigator noted from his prison record that he had told staff when he was remanded in custody in 1985 that he had lost contact with his brother and sister. Latterly, he received no visits or letters, and it was always going to be difficult to trace the whereabouts of his next of kin. I commend the efforts made by the family liaison officer.

CONCLUSION

81. The man was a prisoner who, because of his continual refusal to admit guilt or engage with offending behaviour programmes, remained in prison long after the length of his tariff. He seemed content to stay in prison and expressed his desire to remain there in preference to being in hospital.

82. When he became ill, he was given care to a standard that was at the very least equivalent to that he would have received in the community. The clinical reviewer cites the good standard of chronic disease management programmes and well trained staff across all parts of healthcare as key factors to achieving this outcome.

83. In addition, I am pleased to report that staff at Wellingborough ensured that the use of restraints were appropriate and that, in his final days, he had the companionship of the bedwatch staff. Releasing him would have meant that the staff could return to the prison to their other duties. Instead, the Governor decided that it was in his best interests to keep the bedwatch arrangements in place. I consider this to be a highly compassionate decision.

GOOD PRACTICE

The decision not to release the man from custody in order that bedwatch officers could remain with him was, on this occasion, an act of compassion and an example of good practice.

Response from the National Offender Management Service Safer Custody

> “As a general comment the prison are grateful that the Ombudsman acknowledges the good quality of care provided by all staff involved during the man’s time at HMP Wellingborough and in particular recognises the importance of the Governor's decision not to take forward an application for compassionate release. We are also pleased to note the Clinical Reviewer's very positive comments on the organisation and delivery of clinical care.”