Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Webb a prisoner at HMP Preston on 19 January 2017

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Edward Webb died of sepsis (a widespread infection) on 19 January 2017, at HMP Preston. Mr Webb was 76 years old. I offer my condolences to Mr Webb's family and friends.

At both Wymott, Mr Webb's previous prison, and Preston, he received some well organised, effective and compassionate care despite frequently refusing help from healthcare and social care staff. However, the clinical reviewer concluded that the care Mr Webb received at Preston was not equivalent to that he could have expected to receive in the community. In particular, healthcare staff failed to replace catheters promptly or escalate changes in Mr Webb's National Early Warning score and physical appearance to senior healthcare staff, as they should have.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

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Summary

Events

1. On 22 October 1963, Mr Edward Webb was sentenced to life in prison for murder and assault. Mr Webb was a difficult prisoner who frequently refused treatment and medication. He had a record of poor health: he had chronic kidney disease, had had a stroke, high blood pressure, heart failure, leg ulcers due to poor circulation, urinary sepsis (infection) and obesity. Doctors prescribed a range of medications to manage his long-term conditions. He attended numerous hospital appointments and inpatient admissions. He was frequently treated for urinary and kidney infections.

2. On 20 November 2013, Mr Webb was transferred to HMP Wymott. He continued to refuse medical treatment and inconsistently took his medication. He had urinary incontinence. In August 2014, Mr Webb had swollen and infected legs, for which a prison GP prescribed antibiotics. Healthcare staff regularly monitored him.

3. On 27 October 2015, Mr Webb was transferred to the regional inpatient unit at HMP Preston because of his poor health.

4. On 14 February 2016, hospital doctors fitted a catheter when Mr Webb went to hospital with poor kidney function. A nurse created a care plan to manage his catheter. On 24 February, he returned to HMP Preston.

5. On 19 March, a prison GP gave Mr Webb antibiotics for a urinary tract infection.

6. On 28 April, a nurse reported that Mr Webb's catheter was blocked and removed it. On 29 April, a prison GP prescribed a replacement catheter which had not arrived 12 days later.

7. On 5 May, a prison GP admitted Mr Webb to hospital as he was dehydrated. He returned to Preston on 18 May. Hospital staff had fitted a new catheter.

8. On 29 August, a nurse saw Mr Webb, found his catheter blocked and removed it. He had not passed urine all night. The next afternoon, 24 hours later, a nurse fitted a new catheter, which drained a large amount of urine.

9. On 1 September, a healthcare worker saw Mr Webb. She said he had a National Early Warning (NEW) score (an assessment of acute illness) of 5. Deterioration in clinical condition is a score above 0. A score of 7 or more indicates a high clinical risk. A prison GP requested blood tests for urea and creatinine (kidney function tests). The results were abnormal and he told Mr Webb he needed to go to hospital. He refused to do so.

10. A nurse saw Mr Webb in the early hours of 1 November. She said his catheter was blocked and despite attempts to flush it, it did not drain, so she removed it. At 3.00pm that day, a nurse replaced it.

11. Healthcare support workers recorded Mr Webb's NEW score, frequently above normal, took his blood pressure and noted his physical condition. Prison GPs

and nurses accessed his medical records but did not comment on these vital signs.

12. On 9 January 2017, a nurse saw Mr Webb, who had a pain down the right side of his abdomen. The nurse offered to move him in his bed to reduce the pain. He said that he could not give pain relief as Mr Webb had recently taken his night time medication.

13. On 11 January, a nurse practitioner said Mr Webb should see the doctor as soon as he arrived. A prison GP reviewed him, diagnosed renal failure and admitted him to hospital. On 17 January, Mr Webb returned to HMP Preston to receive palliative care. A GP signed an order to say he did not want anyone to resuscitate him if his heart or breathing stopped.

14. On 19 January, Mr Webb died of sepsis (a widespread infection). This was caused by an accumulation of infected fluid between the diaphragm, liver and spleen.

Findings

15. There were areas at both Wymott and Preston of well organised, effective and compassionate care. Mr Webb refused help from healthcare and social care teams, resulting in his chronic conditions becoming worse and in him developing pressure sores and leg ulcers. The healthcare and social care teams worked hard to treat his chronic conditions despite his refusal to accept treatment. Healthcare staff created good care plans and regularly reviewed them.

16. Despite this, the care that Mr Webb received at Preston was not equivalent to that which he could have expected in the community.

17. There were no effective plans to deal with removing of the catheter when it became blocked. Mr Webb reverted to being incontinent of urine, which reduced the likelihood of his pressure sores healing and preventing new ones.

18. Healthcare staff at Preston used the NEW score to assess Mr Webb's acute illness. When his health had clearly deteriorated (according to the NEW score and his physical condition), healthcare support workers did not consistently escalate this to senior healthcare staff. There is no evidence that non-registered healthcare support workers who recorded the NEW score and his physical condition were supported by senior healthcare staff or that they alerted them about Mr Webb's health needs. We are concerned that senior healthcare staff accessed Mr Webb's records but did not take any action to respond to his urgent care needs.

Recommendations

- The Head of Healthcare should ensure that when catheters become blocked, replacements are made available and urgently changed to avoid the risk of infection.
- The Head of Healthcare at Preston should ensure that:

- Healthcare support workers escalate relevant information to senior healthcare staff when it is clear that a prisoner's health is deteriorating; and
- All healthcare staff act on information recorded so that prisoners receive appropriate and prompt care.

The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Preston informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

20. The investigator obtained copies of relevant extracts from Mr Webb's prison and medical records.

21. NHS England commissioned a clinical reviewer to review Mr Webb's clinical care at the prison.

22. The investigator interviewed with the clinical reviewer six members of staff at HMP Preston on 27 March.

23. We informed HM Coroner for Lancashire County Council of the investigation who gave us the results of the post mortem examination. We have sent the Coroner a copy of this report.

24. The investigation has assessed the main issues involved in Mr Webb's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

25. The initial report was shared with the Prison Service. The Prison Service pointed out eight factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Preston

26. HMP Preston is a local prison holding up to 811 adult men. Lancashire Care Foundation Trust provided healthcare services at the prison. On 1 April 2017, Spectrum CIC took over healthcare services. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HMP Wymott

1. HMP Wymott is a medium secure prison holding over 1,100 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. A private company provides GP services and out of hours medical cover. There are no inpatient beds, but there is 24-hour nursing cover.

HM Inspectorate of Prisons

2. The most recent inspection of HMP Preston was in April 2014. Inspectors reported that overall, healthcare provision was safe and decent. The inpatient unit supported patients with complex needs well but some aspects of the environment and regime needed to improve.

3. The most recent inspection of HMP Wymott was in October 2016. Inspectors reported that the wing for older prisoners and those with disabilities provided excellent care. The healthcare department gave good care, although medication issues undermined this. The relationship with local hospitals was good.

Independent Monitoring Board

4. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2016, the IMB reported that the primary care team at Preston provided a wide range of services and care. They said there had been a struggle to maintain an effective healthcare service as healthcare staff were less than 50% of the complement in the mental health team and just over 50% in the general healthcare team.

5. In its latest annual report for the year to May 2016, the IMB reported that there had been some improvement in health services at Wymott since 2015 but there were still serious problems with providing medication. This was exacerbated by staff shortages, although the report noted that staffing levels had also improved.

Previous deaths at HMP Preston

6. There have been no deaths from natural causes at Preston in the last 12 months.

Key Events

Background

7. On 22 October 1963, Mr Edward Webb was sentenced to life in prison for murder and assault.

8. Mr Webb had a record of poor health. He was a difficult prisoner who frequently refused treatment and medication. He had chronic kidney disease, had had a stroke, high blood pressure, heart failure, leg ulcers due to poor circulation, urinary sepsis (infection) and obesity. Doctors prescribed a range of medications for his chronic conditions. He attended numerous hospital appointments and inpatient admissions. He was frequently treated for urinary and kidney infections.

9. On 20 November 2013, Mr Webb was transferred to HMP Wymott. He continued to refuse medical treatment and inconsistently took his medication. He had urinary incontinence. A prison GP prescribed him medications for high blood pressure and fluid retention but he failed to collect his prescription. He later prescribed different blood pressure medication which he took inconsistently.

10. Mr Webb had swollen and infected legs for which a prison GP prescribed antibiotics. He frequently did not attend appointments for blood tests. Nurses created a care plan for Mr Webb's chronic kidney disease and obesity.

11. Mr Webb frequently went to hospital with infections, leg ulcers and deteriorating health. Healthcare staff at the hospital found pressure sores on his buttocks. A nurse created a care plan to manage the sores. A social worker saw Mr Webb in October 2015, and said he had a range of basic needs which he refused.

HMP Preston

12. On 27 October, Mr Webb was transferred to the regional bed inpatient unit at HMP Preston due to his poor health. He was still considered a Wymott prisoner. At his initial health screen, a nurse noted Mr Webb had pressure sores and oedematous (a build up of fluid) legs.

13. Healthcare staff recorded throughout the rest of the year that Mr Webb was incontinent, frequently of urine and occasionally of faeces. He had a pressure-relieving mattress and healthcare staff turned him up to every 2 hours to relieve pressure. They dressed his pressure sores. A nurse created more care plans on 18 December, including for his weight and treatment of his legs, which she regularly updated.

14. On 13 February 2016, a prison GP sent Mr Webb to hospital for poor kidney function tests. Hospital doctors fitted a catheter, and a nurse created a care plan to manage it. On 24 February, Mr Webb returned to Preston. On 19 March, a prison GP gave Mr Webb antibiotics for a urinary tract infection.

15. On 28 March, a healthcare support worker thought Mr Webb was having a stroke. Mr Webb went to hospital having first refused. He returned the next day after hospital doctors prescribed clopidogrel (anti-clotting medication).

16. On 28 April, a nurse said that Mr Webb's catheter was blocked and she removed it. On 5 May, a healthcare support worker saw Mr Webb, who struggled to speak or open his eyes and was unable to bear his own weight. A prison GP said he was dehydrated and admitted him to hospital. He prescribed a replacement on 29 April. On 10 May, the nurse said the replacement catheter for Mr Webb had still not arrived, 12 days after it became blocked.

17. On 18 May, Mr Webb returned to Preston. Hospital staff had fitted a new catheter. He said that he had not been out of bed while he was in hospital. His strength had deteriorated and he was unable to stand. A nurse said she spoke to hospital staff, who said he had arrived at hospital with a pressure sore on his sacrum and a heel blister. She said there were no records about the heel blister.

18. On 23 May, a healthcare support worker cleaned, measured and dressed the sore on Mr Webb's heel. On 27 May, a nurse created a care plan for the sore, which she said by early September had almost healed.

19. On 29 August, a nurse saw Mr Webb and removed his blocked catheter. The next afternoon, 24 hours later, another nurse fitted a new one, which drained a large amount of urine (1200mls).

20. On 1 September, a healthcare support worker saw Mr Webb. She said he had a NEW score of 5. A prison GP requested blood tests for urea and creatinine. The results were abnormal and he told Mr Webb he needed to go to hospital but he refused. Mr Webb's renal function did not improve and the GP referred him to a renal consultant. Mr Webb was in turn reassigned to urology services who took more blood samples.

21. In October, healthcare support workers recorded Mr Webb's NEW score, which was frequently above normal, took his blood pressure and frequently noted his physical condition. Prison GPs and nurses frequently accessed his medical records but did not record any comments about his vital signs and took no action despite his elevated NEW score and poor physical condition.

22. In the early hours of 1 November, a nurse saw Mr Webb. She said that his catheter was blocked and despite attempts to flush, it did not drain so she removed it. At 3.00pm that day, another nurse replaced it.

23. At 4.27pm, a prison GP saw Mr Webb, who said his condition had worsened over the past 24 hours. He could not stand and had a right-sided droop. The GP sent him to hospital. Hospital staff said he had urinary sepsis and his health had deteriorated. He remained on the same medication. He returned to Preston on 4 November.

24. On 9 November, healthcare and prison staff completed an application for early release on compassionate grounds. (Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.)

25. A prison GP said that Mr Webb had reduced renal function and an enlarged prostate. He said that his prognosis was poor. His offender supervisor said she was unable to endorse the application because he remained assessed as a very

high risk of serious harm to the public. On 30 December, a prison manager did not recommend early release but agreed to reconsider if the medical evidence changed.

26. On 9 January 2017, a nurse saw Mr Webb, who had a pain down the right side of his abdomen. He offered to move him in his bed to reduce the pain. He said he could not give pain relief as Mr Webb had recently taken his night time medication.

27. At 11.03am, a healthcare support worker saw Mr Webb. She recorded his NEW score as 5. His blood pressure (82/52) and his oxygen saturation level were low (92-92%). There is no record that she told senior healthcare staff of these observations.

28. At 1.21pm, a healthcare support worker saw Mr Webb. She said he was in pain and hard to understand. She took a urine sample and told a nurse. A prison GP said that his urine looked infected and prescribed antibiotics.

29. On 10 January, a student nurse saw Mr Webb. She recorded his NEW score as 4 and his blood pressure was low (78/53). There are no recorded comments about his blood pressure reading in the medical record.

30. At 8.49am on 11 January, a healthcare support worker saw Mr Webb. She recorded his NEW score as 6, his blood pressure was low (95/57) and oxygen saturation low (89%). She spoke to a nurse, who said that Mr Webb should see the doctor as soon as he arrived and for blood to be taken for kidney and liver function.

31. At 9.51am, a healthcare support worker recorded Mr Webb's NEW score as 7. His pulse rate was high (108 beats per minute), his blood pressure low (83/52) and oxygen saturation low (87%). A prison GP reviewed him. He diagnosed renal failure and admitted him urgently to hospital.

32. On 12 January, healthcare and prison staff started a new application for early release on compassionate grounds. A prison manager said that while Mr Webb's life expectancy was assessed as poor, there was no information available to confirm how his healthcare needs would be managed, other than in a hospital bed. She did not endorse the application.

33. On 17 January, Mr Webb returned to Preston to receive palliative care. A prison GP signed an order to say he did not want anyone to resuscitate him if his heart or breathing stopped. A nurse spoke to a hospice for advice and support. Prison and healthcare staff adopted an open-door policy and a member of the healthcare team remained with him at all times. Mr Webb died on 19 January.

Contact with Webb's family

34. On 19 January, the Head of Operations at Wymott appointed a chaplain as the family liaison officer. He was unable to identify a next of kin for Mr Webb and the Coroner's office confirmed that he had no living relatives. Mr Webb had previously told prison staff that he had no contact with anyone in the community.

35. On 6 March, Mr Webb's funeral took place. The prison arranged and met the costs of the funeral in line with national instructions.

Support for prisoners and staff

36. After Mr Webb's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. She told them what care was available and how to access it.

37. Both Preston and Wymott posted notices informing other prisoners of Mr Webb's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Webb's death.

Post-mortem report

38. A post mortem examination found that the immediate cause of Mr Webb's death was sepsis, caused by a subphrenic abscess (an accumulation of infected fluid between the diaphragm, liver and spleen). Mr Webb also had empyema of the gall bladder secondary to choleliathiasis (a bacterial infection of the gallbladder) and obstruction of the cyst duct.

Findings

Clinical care

39. The clinical reviewer said that at both Wymott and Preston, there were areas of well organised, effective and compassionate care. Mr Webb refused help from the health and social care teams, which resulted in his chronic conditions becoming worse and in him developing pressure sores and leg ulcers. The clinical reviewer said that the healthcare and social care team had to work hard to make up lost ground for these treatments. Healthcare staff created good care plans and regularly reviewed them.

40. However, the care that Mr Webb received at Preston was not equivalent to that which he could have expected in the community. The clinical reviewer made a number of recommendations, which while not related to Mr Webb's death, the Head of Healthcare will need to address.

Replacement of blocked catheters

41. Despite a care plan being in place for managing the catheter, there were no effective plans to deal with removing it and promptly replacing when it became blocked, which happened frequently. On one occasion a catheter was not replaced for 12 days. This left Mr Webb incontinent of urine which caused further pressure sores. We make the following recommendation:

    The Head of Healthcare should ensure that when catheters become blocked, replacements are made available and urgently changed to avoid the risk of infection.

Escalation of NEW score and physical condition

42. Healthcare support workers appropriately recorded Mr Webb's NEW score and physical condition which frequently indicated that his condition had deteriorated. Despite this, there is no evidence that non-registered healthcare support workers who recorded the NEW score and his physical condition were supported by senior healthcare staff or that they alerted them that Mr Webb needed medical attention. While the clinical reviewer highlighted the shortage of healthcare staff in inpatient and primary care services, healthcare support workers should have escalated their concerns about Mr Webb's health needs to more senior members of the team. Furthermore, senior healthcare staff had access to this information and we have seen from the medical records that they regularly accessed the notes which recorded Mr Webb's elevated NEW score and poor physical condition. However, they took no action to respond to Mr Webb's urgent care needs. We make the following recommendation:

    The Head of Healthcare at Preston should ensure that:

    - **Healthcare support workers escalate relevant information to senior healthcare staff when it is clear that a prisoner's health is deteriorating; and**
    - **All healthcare staff act on information recorded so that prisoners receive appropriate and prompt care.**

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