Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Prince Albert Wright, a prisoner at HMP Wymott, on 19 September 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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.

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

Mr Prince Albert Wright died on 19 September 2018 of throat cancer at a regional healthcare inpatient facility at HMP Preston. (He remained, technically, a prisoner of HMP Wymott, where he had been for three years before transferring to Preston.)

Mr Wright was 84 years old. I offer my condolences to his family and friends.

I am satisfied that Mr Wright received a good standard of care at Wymott and Preston and am pleased to see that there was a good multidisciplinary approach to his care.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **February 2019**

Contents

Summary

Events

1. On 26 April 2010, Mr Wright was given a seven-year, indeterminate sentence for public protection. He arrived at HMP Wymott in October 2014.

2. Mr Wright had no pre-existing health concerns but a cognitive test conducted on arrival showed that he had possible signs of dementia. He refused any further investigations into this condition.

3. In April 2016, wing staff first noticed that Mr Wright had a lump in his neck. Mr Wright told a doctor that the lump was the result of an assault in prison some years earlier. He declined to be examined.

4. Mr Wright was referred to hospital for investigation but refused to be examined, despite knowing that the lump could be cancerous. He was put on the palliative care register and referred for a regional bed at HMP Preston's inpatient palliative care facility.

5. On 27 April 2017, Mr Wright transferred to Preston. He continued to refuse assessment of the lump in his neck. Healthcare staff were supported by the local hospice who reviewed Mr Wright regularly. Medication and equipment was put in place in case a sudden bleed occurred.

6. Mr Wright said that he wanted to be resuscitated if the need arose. A hospice consultant considered that Mr Wright did not have the capacity to make an informed decision about this and a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) was put in place on 15 December 2017. Mr Wright's Independent Mental Capacity Advocate disagreed with the decision and the order was revoked. The order was reinstated on 12 April 2018 after the agreement of a multidisciplinary team.

7. Appropriate care plans were put in place for Mr Wright and he was seen regularly by doctors and nursing staff. In early September, nurses noted that Mr Wright seemed to be unsettled.

8. At 9.20am on 19 September, Mr Wright came out of the shower and asked for help. He was having difficulty breathing. An ambulance was called and Mr Wright was made comfortable. Paramedics arrived and Mr Wright was pronounced dead at 9.45am.

Findings

9. We are satisfied that Mr Wright was seen regularly by doctors, the palliative care team and relevant professionals. He was also involved in the decision-making process about his care as much as possible. The care he received was equivalent to what he could expect to receive in the community.

10. We make no recommendations.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMPs Wymott and Preston informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

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

13. NHS England commissioned a clinical reviewer to review Mr Wright's clinical care.

14. We informed HM Coroner for Preston and West Lancashire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. HMP Wymott was unable to identify a next of kin for Mr Wright and we were therefore unable to notify anyone of our investigation.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

17. The investigation has assessed the main issues involved in Mr Wright'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.

Background Information

HM Prison Wymott

18. Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Geometric Results International provides locum GP services, including 24-hour nursing cover, and the out of hours GP is via the local provider. There are no inpatient beds.

HM Prison Preston

19. HMP Preston is a local prison holding up to 811 adult men. Spectrum CIC has been responsible for healthcare services at the prison since 1 April 2017. There is an inpatient unit for up to 30 prisoners, which is used as a regional facility, including for end of life care.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Wymott was conducted in October 2016. Inspectors reported that Wymott remained a reasonably safe prison and relationships between staff and prisoners were generally respectful, but healthcare provision was weak and in some areas potentially unsafe. They considered that the clinical care of prisoners with chronic conditions was not good enough.

21. The most recent inspection of HMP Preston was conducted in March 2017. Inspectors noted that healthcare provision had deteriorated. Care for prisoners with long-term conditions was inconsistent and care plans were inadequate. Inspectors found that the standard of care in the inpatient unit was generally good.

Independent Monitoring Board

22. 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.

23. In its latest annual report for Wymott, for the year to May 2018, the IMB repeated its concerns from the previous year that the provision of healthcare fell short of the statutory duty to provide care equivalent to that outside of prison. It was concerned about long waiting times to see doctors and dentists and the cancellation of clinics at short notice.

24. In its latest annual report for Preston, for the year to March 2018, the IMB reported improvements since Spectrum took over healthcare services and the number of nurses was increasing. It considered healthcare facilities could be improved to provide better services to prisoners.

Previous deaths at HMP Wymott and Preston

25. Mr Wright was the twenty-first prisoner to die of natural causes at Wymott since 2015. There are no similarities to previous deaths. He was the sixth prisoner to

die of natural causes at Preston and there are no similarities in his case to these previous deaths.

Findings

Diagnosis of Mr Wright's terminal illness and informing him of his condition

26. On 26 April 2010, Mr Wright was sentenced to a seven-year indeterminate sentence for public protection for attempted murder. He had previously served a life sentence for manslaughter.

27. On 7 October 2014, he arrived at HMP Wymott with no noted health concerns.

28. On 10 October, a prison GP reviewed Mr Wright and recorded that he displayed a mild cognitive impairment on the Mini Mental Test. (This is a widely-used test of cognitive functioning among the elderly.) Mr Wright refused any further dementia screening.

29. On 26 April 2016, wing staff first noticed that Mr Wright had a lump on his neck and asked healthcare to see him. The prison GP reviewed Mr Wright the next day but Mr Wright declined to have his neck examined and said the lump was a result of an assault in prison some years earlier. She recommended that he have a dementia screening test and requested a social care assessment to provide him with extra support for his daily needs.

30. On 10 May, the Head of Healthcare put Mr Wright on the palliative care register after a multidisciplinary meeting. On 26 July, a mental health nurse completed the Addenbrooke's Cognitive Examination with Mr Wright in preparation for his appointment with a psychiatrist. Mr Wright scored 36 out of 100, indicating cognitive impairment.

31. On 4 August, a psychiatrist reviewed Mr Wright and concluded that he did not have capacity to make decisions about the investigation and treatment of the lump in his neck. She recommended a 'best interests' meeting to plan Mr Wright's care and ensure transparent decision making. A first meeting took place on 14 August and an Independent Mental Capacity Advocate (IMCA) was appointed shortly afterwards.

32. Mr Wright was referred to the rapid access lump clinic at the ear, nose and throat (ENT) department at hospital for assessment in December 2016 and March and April 2017. Mr Wright refused to be assessed despite understanding that the lump in his neck might be cancerous.

33. On 19 April 2017, a referral was sent to HMP Preston for a regional inpatient hospital bed. Mr Wright transferred there on 27 April.

34. The clinical reviewer concluded that although Mr Wright did not have a definitive diagnosis, putting him on the palliative care register at Wymott was good practice as it provided an opportunity for better-coordinated care. We agree. We also agree that steps were taken to empower Mr Wright to be part of the decision-making process.

Mr Wright's clinical care

35. Mr Wright transferred into the healthcare inpatient unit at Preston and was supported through the transition process by staff on the unit.

36. On 3 July 2017, a nurse from St Catherine's Hospice first met with Mr Wright. She noted that the exact nature of his tumour could not be confirmed without further tests and that he should be provided with supportive care. His palliative care plan was reviewed the next day and the prison GP was asked to prescribe anticipatory medication in case of a sudden bleed from his tumour. (This provides prompt symptom relief in the event of developing distressing symptoms.)

37. On 15 December, a 'Do Not Attempt Cardiopulmonary Resuscitation' order (DNACPR) was put in place by a consultant of St Catherine's Hospice. This was against Mr Wright's wishes. (A DNACPR order means that in the event of cardiac or respiratory arrest no attempt at resuscitation will be made. All other appropriate treatment and care will continue to be provided.)

38. On 20 December, the consultant discussed the DNACPR with Mr Wright's IMCA and explained why she had put it in place. She visited Mr Wright the next day and deemed that Mr Wright did have capacity and that the DNACPR should therefore be revoked. This decision was immediately communicated to all staff.

39. On 12 April 2018, a 'best interests' multidisciplinary team meeting concluded that a DNACPR should be put in place, despite Mr Wright's objections. It was considered that resuscitation efforts would be unpleasant and painful because the tumour would make it difficult to insert a breathing tube into Mr Wright's windpipe, and would deprive him of a dignified death.

40. On 3 May, Mr Wright refused to attend a ENT appointment at hospital. On 7 May, a nurse reviewed Mr Wright's care plans and noted that protective equipment had been prepared in case of a sudden bleed from the lump in his throat. Black towels were also made available.

41. A first referral to speech and language therapists (SALT) was made by the Head of Healthcare on 15 March 2018. Due to issues around funding for this service, Mr Wright did not receive a speech and language assessment until 1 June. A speech and language therapist assessed Mr Wright and provided guidance to staff on how to support him. A care plan for eating was created which included observation during mealtimes and textured food to protect his airway. Nutritional food supplements were also prescribed.

42. During July and August 2018, Mr Wright continued to be reviewed regularly by healthcare staff with no concerns being raised. In early September, nurses noted that Mr Wright was unsettled, saying that he was being held against his will.

43. On 19 September, at 9.20am, Mr Wright came out of the shower and asked for help. A nurse noted that Mr Wright was making strange gargling noises and appeared to be having difficulty breathing. An ambulance was called and the nurse went to collect the anticipatory medication. Mr Wright was given morphine to make him comfortable but pushed away attempts to give him oxygen. He was

assisted into a wheelchair and then into bed. Staff comforted Mr Wright while he took his final breaths and paramedics pronounced him dead at 9.45am.

44. A post-mortem report found that Mr Wright died of pharyngeal (throat) cancer and bronchopneumonia.

45. The clinical reviewer concluded that the care that Mr Wright received was equivalent to what he could expect to receive in the community. She found that Mr Wright was seen regularly by doctors, palliative care teams and relevant professionals. He was involved in the decision-making process about his care as much as possible.

46. Although there were delays in putting the DNACPR order in place, the clinical reviewer is satisfied that open communication took place between all the relevant parties and the final DNACPR was lawful. The clinical reviewer makes a recommendation about the DNACPR process and dementia training that the Head of Healthcare at Preston will want to consider.

Mr Wright's location

47. Mr Wright lived on a general residential wing while at Wymott. On 19 April 2017, he was referred for a regional in-patient bed at Preston and transferred there on 27 April. Mr Wright remained in the healthcare unit at Preston until he died in September 2018.

48. We are satisfied that Mr Wright was located appropriately during his illness.

Restraints, security and escorts

49. When prisoners have to travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

50. Mr Wright transferred to Preston in April 2017 and after that there were no further occasions when he left the prison.

Liaison with Mr Wright's family

51. A managing Chaplain was appointed as family liaison officer at Wymott before Mr Wright transferred to Preston. He visited Mr Wright regularly at Preston and tried to identify a next of kin but was unsuccessful. In the absence of a next of kin, the family liaison officer arranged Mr Wright's funeral which took place on 17 October. The prison contributed to the funeral costs in line with national policy.

Compassionate release

52. 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.

53. A compassionate release application was completed for Mr Wright in April and July 2018. On both occasions the Governor decided not to approve release on compassionate grounds on the basis that no suitable accommodation had been found for Mr Wright.

54. We are satisfied that the prison acted appropriately in relation to compassionate release.

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