Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gareth Warburton a prisoner at HMP Hewell on 1 April 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 I oversee can improve their work in the future.

Mr Gareth Warburton died on 1 April 2018 of an inflammation of the lungs and chronic lung dysfunction while he was a prisoner at HMP Hewell. He was 58 years old. I offer my condolences to Mr Warburton's family and friends.

We agree with the clinical reviewer that the standard of healthcare Mr Warburton received at Hewell was not equivalent to that which he could have expected to receive in the community.

Between July and August 2017, Mr Warburton only received half of the correct dose of an anti-rejection drug he needed following an earlier lung transplant. Although we cannot say whether this contributed to his death, it was clearly a serious error and should not have happened.

We are also concerned that on two occasions, Mr Warburton was unable to attend hospital because there were no staff available to escort him, and on another occasion an appointment to review his lung function was rearranged twice due to errors of communication.

There was also confusion about Mr Warburton's diagnosis and prognosis. Mr Warburton's terminal diagnosis was not fully understood by most healthcare and prison staff. He was not placed on the palliative care register, and the compassionate release process was hindered by poor management of correspondence from the hospital.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **November 2018**

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Summary

Events

1. On 1 April 2017, Mr Gareth Warburton was remanded to HMP Hewell, charged with sexual offences. He was convicted on 28 April and sentenced to 12 years imprisonment.

2. Mr Warburton had had a double lung transplant in 2006 due to interstitial lung disease (ILD). He also had type 2 diabetes, a history of deep vein thrombosis in his right leg and a recurrent hiatus hernia.

3. At Mr Warburton's initial health screening, all his medications and existing health issues were recorded correctly. Mr Warburton was assessed as suitable for in-possession medication.

4. On 1 July 2017, Mr Warburton's prescription was incorrectly completed and his dose of mycophenolate mofetil was halved. (Mycophenolate mofetil is used to keep the body from rejecting transplanted organs.)

5. On 25 August 2017, Mr Warburton told a nurse that he thought his mycophenolate mofetil prescription was incorrect. He was taken to hospital and the correct dose was prescribed but his lung function was not reviewed.

6. On 25 September 2017, Mr Warburton had his lung function reviewed by the hospital. It was one third of full capacity. His lung function had last been tested on 3 July and at that time had been close to full capacity.

7. Between December 2017 and February 2018, Mr Warburton received a course of radiotherapy to try to slow the deterioration of his lungs. This was not successful and Mr Warburton was told he might only have a few months left to live.

8. On 14 March, an emergency was called as Mr Warburton was having difficulty breathing. He was taken to hospital by ambulance. Mr Warburton remained in hospital until his death on 1 April 2018. The cause of death was later identified as bronchopneumonia and bronchiolitis obliterans syndrome (BOS) – a form of chronic lung transplant deterioration.

9. The prison's healthcare providers, Care UK, carried out a Root Cause Analysis (RCA) of the prescribing error. This was an internal investigation led by a Head of Healthcare and a non-medical prescriber from another prison, which was then quality-assured by NHS England. Hewell have implemented the recommendations of the RCA report.

Findings

10. The clinical reviewer found that the care that Mr Warburton received in prison was not equivalent to the level of care he would have received in the community. The clinical reviewer was concerned that there was a significant error in the prescribing and administration of mycophenolate mofetil, between July 2017 and August 2017, but could not determine whether the deterioration in Mr Warburton's lung function predated or was due to the medication error.

11. The clinical reviewer found that there was also confusion over Mr Warburton's diagnosis and prognosis. Neither his diagnosis of BOS given in October 2017, nor the subsequent radiotherapy treatment to try and manage this condition, appear to have been fully understood by either healthcare or prison staff. Mr Warburton was not placed on the palliative care register, and information was incomplete when staff were considering Mr Warburton's application for compassionate release.

12. Mr Warburton also missed several hospital appointments due to lack of staff and miscommunication with Mr Warburton about the appointments.

Recommendations

- The Head of Healthcare should provide the PPO with evidence that the recommendations in the RCA report into the prescription error have been implemented.
- The Head of Healthcare should review the system for the management of complex long-term conditions, and implement a Case Finding and Risk Stratification system in line with NHS England guidance.
- The Head of Healthcare should ensure that prisoners with terminal diagnoses are placed on a palliative care register to receive appropriate care.
- The Head of Healthcare should review the process for the management of external correspondence from other healthcare providers to ensure that appropriate actions are taken to provide continuity of care.

The Investigation Process

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

14. The investigator visited Hewell on 11 April 2018. She obtained copies of relevant extracts from Mr Warburton's prison and medical records. She spoke to one member of staff and one prisoner, the cell mate of Mr Warburton. The prisoner subsequently wrote to her and further criticised the medical care Mr Warburton received. She reviewed this information and spoke to the prisoner a second time and concluded that the points raised had already been covered during the investigation.

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

16. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.

17. The investigator wrote to Mr Warburton's next of kin, his sister, to explain the investigation and to ask whether she had any matters she wanted the investigation to consider. Mr Warburton's sister passed our letter on to his ex-wife as the executor of his estate. The family were concerned about the error in prescription of Mr Warburton's medication between July and August 2017.

Background Information

HMP Hewell

18. HMP Hewell is an amalgamation of two prisons, the former HMP Blakenhurst and HMP Hewell Grange, and holds over 1,200 adult men. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local prison. Mr Warburton was held at the Blakenhurst site. Care UK provides health services and there is an 18-bed inpatient unit.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Hewell was conducted in September 2016. Inspectors reported that prisoners surveyed were very negative about access to, and the quality of, healthcare. The environment in the inpatient unit was very poor, the regime was limited and there was little therapeutic activity. Medicine management processes were weak despite efforts to address the problem. Too many prisoners regularly experienced delays in receiving their repeat prescriptions, resulting in unacceptable gaps in treatment, sometime for serious conditions. HMIP made a recommendation that Hewell improve the management of medication to ensure that there are no gaps in continuity of care, which Hewell accepted.

Independent Monitoring Board

20. 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 30 September 2017, the IMB reported no current concerns with the healthcare provider. The report states that board members had regularly visited healthcare and observed appropriate interaction between staff and prisoners. The board was not aware of any problems relating to escort to or bed watch at hospital. The report sets out the board's concerns about insufficient staffing levels at the prison and the impact this had had on the prison's ability to manage violent behaviour, bullying and the use of psychoactive substances (PS), causing both staff and prisons to feel unsafe.

Previous deaths at HMP Hewell

21. Mr Warburton was the seventh prisoner to die from natural causes at HMP Hewell since April 2015. In one investigation into a death that occurred in December 2017, we found problems with a prisoner attending hospital appointments due to a lack of escort staff. We made a recommendation which Hewell accepted.

Key Events

22. On 1 April 2017, Mr Gareth Warburton was remanded to HMP Hewell, charged with sexual offences. He was convicted on 28 April and was sentenced to 12 years imprisonment on 6 June 2017.

23. Mr Warburton had had a double lung transplant in 2006 due to interstitial lung disease, or ILD. (This is a group of conditions that causes scarring to the lungs resulting in a stiffening of the tissue, restricting the ability to breath.) He also had type 2 diabetes, a history of deep vein thrombosis in his right leg and recurrent hiatus hernia.

24. Mr Warburton's lung transplant surgery took place in 2006. His care was subsequently transferred to another hospital under the care of a Consultant in Respiratory Medicine. He attended regular six-monthly outpatient reviews.

25. The reception screening at Hewell was carried out on 1 April 2017 by a nurse. Mr Warburton was prescribed 13 medications in total, including mycophenolate mofetil, an anti-rejection drug.

26. A locum GP examined Mr Warburton on 1 April 2017, and checked the list of medications. Mr Warburton entered Hewell with one month's supply of his medications and these were taken and held by healthcare staff and prescribed back to him.

27. On 3 April, Mr Warburton was due a routine review of his lung function at the hospital. This appointment was changed, initially to 5 June 2017, but then cancelled for security reasons. (Hewell had told Mr Warburton the details of his appointment in breach of prison policy, which states that prisoners should not be made aware of the details of their appointments so they cannot inform anyone outside prison.) A subsequent appointment was arranged for 19 June. This appointment was also cancelled as healthcare staff did not inform Mr Warburton that he should not take his anti-rejection drugs before attending hospital. A further appointment was arranged for 3 July 2017.

28. On 1 July, a new prescription was issued for Mr Warburton's medications. His dose of mycophenolate mofetil was incorrectly halved to one tablet a day. This drug is used, in combination with other medication, to prevent the body from rejecting transplanted organs.

29. Mr Warburton received most of his medication in-possession, meaning he was responsible for taking the correct medication each day. The exception was medication to prevent blood clots, which he collected from the medication hatch daily. He was given seven days of medication at a time in a dosette box – a compartmentalised box that separates each day's medication for ease of use.

30. On 3 July, Mr Warburton attended his appointment at hospital. The consultant concluded that Mr Warburton was medically stable with no new respiratory symptoms, stable lung function and an unchanged x-ray. There was no change in medication and a review was set for six months.

31. On 5 July, a paramedic reviewed Mr Warburton's diabetes. She found no issues and made an appointment to review him again in a month's time.

32. On 17 August, a paramedic assessed Mr Warburton and found he had a ten-day history of a productive cough with green phlegm. She consulted a prison GP, who prescribed a course of antibiotics. On 23 August, the GP reviewed Mr Warburton following completion of the antibiotic course and concluded that no further interventions were required.

Discovery of prescribing error on 25 August 2017

33. On 25 August, Mr Warburton went to the medication hatch and queried his dose of mycophenolate mofetil with the nurse on duty. Mr Warburton told him he had been "doubling up" on his in-possession medication and was now short of the mycophenolate mofetil. The nurse arranged for an urgent prescription to be completed by the prison GP.

34. There is no evidence in Mr Warburton's medical records that Mr Warburton would have had access to extra tablets of mycophenolate mofetil with which he would be able to top up. Mr Warburton was prescribed 28 mycophenolate mofetil tablets on 1 July 2017, and a further 28 tablets on 25 August 2017. Mr Warburton would have been issued with seven tablets every week when his dosette box was dispensed, instead of the 14 tablets he should have received. It is unclear what Mr Warburton meant when he said he was 'doubling up' or why it took him two months to alert staff to the shortfall in his medication.

35. The nurse told the investigator that he could not be sure what Mr Warburton meant when he referred to doubling up on his mycophenolate mofetil, as it had been several months since this incident occurred.

36. The medication error was reported by Care UK, who provide the healthcare service at Hewell. As this was categorised as a serious incident, a Root Cause Analysis (RCA) investigation was completed. The conclusions of the RCA are discussed later in the report.

37. A prison GP was concerned that Mr Warburton had been complaining of a chest infection. He tried to speak to the transplant team at hospital but was not able to. Instead, he consulted the Clinical Decisions Unit Coordinator at hospital, who said that Mr Warburton should come to A&E as an emergency case and that he needed to be reviewed by the transplant team.

38. On 25 August, at 7.43pm, Mr Warburton was taken to A&E where he was given 20 capsules of mycophenolate mofetil and then discharged, without a discharge note. On 26 August, a nurse called the hospital and asked for the discharge note to be faxed to the prison. There is no record that the prison received it and it is not clear whether the transplant team saw Mr Warburton.

39. Mr Warburton returned to Hewell at around 3am on 26 August. A nurse saw him upon his return. He told her that when he had been at hospital he had not been reviewed by the transplant team so she booked Mr Warburton an appointment with the GP for later that day.

40. At approximately 5.30pm, a locum GP reviewed Mr Warburton, who reported that he still had a productive cough with green sputum. They prescribed a further course of antibiotics in addition to his regular medications.

41. On 6 September, Mr Warburton was seen by a prison GP who prescribed a further course of antibiotics for the suspected chest infection and a seven-day course of nystatin for a yeast infection. The following day, a paramedic reviewed Mr Warburton and requested that support staff find out when his next review with the transplant team was due. The hospital confirmed that it was due on 8 January 2018.

42. On 9 September, a prison GP reviewed Mr Warburton. He still had a productive cough and he asked them whether the transplant team at the hospital should know about the medication error and chest infection. The prison GP sent a referral for a chest x-ray and sought clarification with the pharmacy about Mr Warburton's mycophenolate mofetil prescription.

43. On 14 September, Mr Warburton was seen by a paramedic as he told staff that he continued to struggle with shortness of breath. She contacted the consultant at the hospital and an appointment was booked for 18 September.

44. On 18 September, Mr Warburton's hospital appointment was cancelled because there were no escort staff available. Mr Warburton was reviewed by a paramedic who told the officer in charge of the prison that Mr Warburton should be prioritised over other escorts for that day. This did not happen and Mr Warburton did not leave the prison. Instead, Mr Warburton was reviewed by a prison GP. The GP decided that Mr Warburton should be transferred to the prison's inpatient unit until he could be reviewed by the transplant team at the hospital. Mr Warburton declined as he said he felt safer on the wing.

45. The prison GP re-arranged the hospital appointment for 25 September. They wrote in the prison medical record that Mr Warburton must not miss the re-booked appointment.

46. On 21 September, a prison GP reviewed Mr Warburton and recorded that Mr Warburton should be taken to A&E if his condition worsened. Later the same day, a nurse saw Mr Warburton who said he felt worse and that his shortness of breath had increased. She decided he should be taken to A&E as a precautionary measure even though his vital signs and oxygen levels were normal. However, this could not happen as the prison was in lock-down. There were no beds available on the inpatients unit so Mr Warburton remained on a normal wing. A GP appointment was arranged for the following day.

47. On 25 September, Mr Warburton attended hospital and was reviewed by a doctor. He gave Mr Warburton intravenous antibiotics and diagnosed his lungs as being just below one third of their full capacity. On 5 October the hospital phoned healthcare and reinforced that it was critical that Mr Warburton received his medication as prescribed, and it was arranged that Mr Warburton would be discharged the next day to the inpatient unit at Hewell.

48. On 6 October, Mr Warburton was discharged from hospital and admitted to the inpatient unit at Hewell. On 9 October, Mr Warburton decided he wanted to return to his cell, and discharged himself against medical advice.

49. On 19 October, a locum GP reviewed Mr Warburton who was concerned about his deteriorating condition (increased shortness of breath, difficulty walking, weight loss) and transferred him to hospital. Mr Warburton was admitted, and received treatment for his diabetes, and remained at hospital until 7 November when he was discharged and returned to the inpatient unit at Hewell. Mr Warburton discharged himself again against medical advice on 8 November.

50. On 25 October, a doctor referred Mr Warburton for assessment for radiotherapy. The referral letter was copied to the prison. In the letter, Mr Warburton's diagnosis of rapidly progressive BOS is recorded. The doctor explained that there had been a rapid decline in his FEV1 (forced expiratory volume – a lung capacity test), and suggested that radiotherapy could be used to slow down this deterioration. Receipt of this letter is recorded in the prison medical records but there is no indication that any action was assigned to it.

51. On 13 November, a prison GP reviewed Mr Warburton. He was struggling to walk and required help using the toilet. The prison GP sought advice from the hospital transplant team, who confirmed that this was normal, given his decrease in lung function, but that further deterioration would be much slower.

52. A prison GP strongly advised Mr Warburton to return to the inpatient unit where his healthcare could be managed better but Mr Warburton declined, as he was worried about being left alone. Mr Warburton complained of increasing anxiety so the prison GP prescribed medication to help with his anxiety. Mr Warburton was moved to a cell closer to the medication hatch to help him collect his medication. He was also given a wheelchair.

53. On 24 November, Mr Warburton, a prison GP, Deputy Head of Healthcare, and a pharmacy technician met to discuss the restrictions on Mr Warburton's treatment on the houseblock. Mr Warburton's decreasing mobility caused by the fall in his lung function made it difficult for him to get medication and to attend healthcare appointments. Mr Warburton refused to be relocated to the inpatient unit, saying that he wanted to be with his friends and that he did not like being in a cell alone.

54. On 27 November, Mr Warburton attended hospital and was reviewed by a doctor. The doctor wrote to the prison, saying that CMV reactivation was now included in Mr Warburton's list of diagnosed conditions. CMV is a virus that lays dormant in many people and causes very few problems in healthy people. However, it can be very dangerous when it reactivates in people who have compromised immune systems, such as from organ transplants. The doctor explained that Mr Warburton would receive some radiotherapy to try to control the deterioration in lung function but that if this was unsuccessful, he might only have months to live. The doctor said he had discussed this with Mr Warburton. The letter is date stamped as received on 21 December but there is no evidence that it was seen by any member of healthcare or that any action was taken.

55. On 6 December, a doctor wrote a letter to Mr Warburton, at his request, as Mr Warburton was seeking his support in applying for compassionate release. The

doctor repeated that, if the radiotherapy did not stabilise the deterioration in his lung function, he 'might have as little as three months to live'. The letter is date stamped as being received on 19 December 2017. A copy of the letter in Mr Warburton's medical records includes a handwritten note requesting that the letter be passed to a paramedic.

56. On 19 December, Mr Warburton received his first radiotherapy treatment to try to slow down the progression of his BOS.

2018

57. On 10 January 2018, Mr Warburton was having difficulty breathing and was taken to hospital. On the same day a prison GP, Deputy Head of Healthcare and a pharmacist met at Hewell to discuss Mr Warburton. They decided that Mr Warburton's care plan needed to be reviewed by the palliative care team.

58. While in hospital, Mr Warburton had said he did not wish to be resuscitated if his heart or breathing stopped, and signed an order to that effect. Records show regular communication between the hospital and the prison, and Mr Warburton returned to Hewell on 27 January.

59. On 22 January, an application for Mr Warburton's release on compassionate grounds was completed. The governor refused the application on 30 January. Mr Warburton was still considered a high risk of harm to children, he had not completed any work to reduce his risk, he had no accommodation to be released to and there was no confirmation of end of life care being offered by the hospital. The application included the doctor's letter, dated 6 December 2017, in which he said Mr Warburton "might" have as little as three months to live, if there was further lung deterioration.

60. On 31 January, Mr Warburton returned to hospital, again due to breathing difficulties. He remained in hospital until 9 February, and records show regular communication between the hospital and the prison. Mr Warburton was advised to return to a bed on the prison inpatient unit but he refused.

61. On 26 February, Mr Warburton was seen by a doctor. The same day the doctor wrote a letter to Hewell healthcare staff, Mr Warburton and the Governor. The doctor said that the radiotherapy treatment of his BOS had been stopped as it was not working and Mr Warburton was too unwell to tolerate it. The doctor expressed concern about the deterioration in Mr Warburton's lung function and wrote that the prison environment was not 'ideal' for Mr Warburton, and he would be happy to offer further information if required.

62. On 1 March, a multidisciplinary meeting was held to reconsider compassionate release. This meeting was documented by a nurse, and the Governor, a nurse, a probation officer, and Head of Safer Custody were present. All parties agreed that Mr Warburton remained a threat to the public, that there was not sufficient medical evidence that Mr Warburton was at end of life, and therefore did not meet the criteria for compassionate release. The nurse was tasked with contacting the doctor at the hospital to get clarification on Mr Warburton's diagnosis and life expectancy. The application remained open in case Mr Warburton deteriorated.

63. The nurse emailed the doctor on 11 March, requesting "a clear diagnosis/prognosis". The doctor responded the same day, he said he would estimate a "median survival of 3-4 months, and that options for further treatment were limited to palliative care". The Head of Healthcare was copied into these emails.

64. On 14 March, Mr Warburton was having difficulty breathing, he had developed a popping sound on his lungs and his oxygen saturation had dropped to 88%. He was taken to hospital by ambulance and admitted. No restraints were used. This decision was approved by the Governor who said that officers should not restrain Mr Warburton in hospital because of his serious ill health.

65. On 29 March, a multidisciplinary meeting was held in preparation for Mr Warburton's discharge from hospital, attended by a nurse, the inpatient manager at Hewell, the hospital ward manager, two hospital doctors and Mr Warburton. They discussed future care options at Hewell and Mr Warburton reluctantly agreed that admission to the prison inpatient unit would be better for him than remaining on the houseblock.

66. On 1 April, Mr Warburton died, before he could return to Hewell.

Contact with Mr Warburton's family

67. On 22 January 2018, two officers were appointed as the family liaison officers (FLO). Mr Warburton was in hospital at the time, so a FLO spoke to him on the telephone to explain her role. She then met him when he returned to prison on 9 February.

68. The FLO had difficulties finding a telephone number for Mr Warburton's next of kin. On 10 February, she introduced herself to Mr Warburton's family when they were visiting Mr Warburton. She maintained regular email and phone contact with the family, giving them updates on Mr Warburton's health, telling them when he went into hospital and ensuring they could visit him.

69. On 1 April, the day that Mr Warburton died, the FLO contacted his family and met them at the hospital. She offered them her support and condolences.

70. Mr Warburton's funeral was held on 26 April. The prison contributed to the costs, in line with national policy. At the request of the family, prison staff did not attend.

71. The FLO continued to support Mr Warburton's family until 15 May, ensuring that all his personal property, including money, was either returned to the family or donated to other prisoners. The family thanked the FLO for the care and support she and the other FLO had offered them, particularly on the day of his death.

Support for prisoners and staff

72. After Mr Warburton's death, a member of the staff care team attended the hospital and a Custodial Operations Manager debriefed the officers who were at the bedwatch to ensure they had the opportunity to discuss any issues, and to offer support.

73. The prison posted notices informing other prisoners of Mr Warburton'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 Warburton's death.

Post-mortem report

74. The coroner concluded that the cause of Mr Warburton's death was 1a) bronchopneumonia; 1b) obliterative bronchiolitis; and, 1c) bilateral lung transplant for interstitial lung disease.

Findings

Clinical care

75. Mr Warburton died in hospital due to an inflammation of the lungs and chronic lung dysfunction. The clinical reviewer concluded that the care Mr Warburton received at Hewell was not equivalent to the level of care he could have expected to receive in the community in respect of the management of his lung transplant and resulting complications.

76. The clinical reviewer comments that Mr Warburton's diabetes was managed appropriately and within NICE guidelines.

Mycophenolate mofetil prescribing error

77. There was a significant error in the prescribing and administration of mycophenolate mofetil (an anti-rejection drug for Mr Warburton's lung transplant). As a result, Mr Warburton received half of his correct dose between 1 July and 25 August 2017. Mr Warburton reported the error to staff on 25 August, after several weeks of taking the wrong dose. We do not know why he did not raise a concern sooner.

78. This error was investigated for Care UK by Head of Healthcare at HMP Drake Hall, as part of the prison's Serious Incident Reporting procedures. The investigation found that the prescription was not clinically screened by a pharmacist on site before being sent to the pharmacy provider. The British National Formulary clearly states that the medication should be prescribed twice daily and she concluded that a pharmacist would have been aware of this and should have picked up on the error. A further opportunity was missed to identify the error by the pharmacy provider when dispensing the medication and making up the dosette boxes.

79. The Root Cause Analysis (RCA) report, its recommendations and the prison's actions are at Annex 2.

80. The clinical reviewer, was unable to determine whether the prescription error caused the deterioration in lung function that led to Mr Warburton's death, or whether there was already long-term deterioration in lung function taking place.

81. This was a very serious error. We, therefore, make the following recommendation:

    The Head of Healthcare should provide the PPO with evidence that the recommendations in the RCA report have been implemented.

Action taken after the prescribing error

82. Once the prescribing error was discovered on 25 August 2017, there appears to have been a lack of coordination in addressing Mr Warburton's care. On four occasions between 26 August and 13 September 2017, Mr Warburton was seen by a GP because of breathing difficulties and a suspected chest infection. It was not until 14 September that a member of healthcare staff contacted the transplant

team directly and made an appointment for Mr Warburton to be reviewed by a consultant, on 18 September.

83. Although each healthcare professional who saw Mr Warburton made a reasonable clinical decision in respect of his treatment, the bigger picture was missed. Mr Warburton was a lung transplant patient, who had missed two months of an important anti-rejection drug, and presented with respiratory distress. It was not clear whether a member of the transplant team at hospital had seen him when he went to A&E on 25 August, or whether anyone had told them about the prescribing error because there was no discharge note. If someone had considered these factors together, Mr Warburton might have been referred back to the transplant team earlier. We cannot know whether this would have made a difference for Mr Warburton but it might, in future, make a difference for another prisoner.

84. Primary care services in the community are required to implement a process of Case Finding and Risk Stratification in line with NHS England guidance to identify and provide timely and appropriately coordinated care for high risk individuals. An equivalent process within HMP Hewell would assist in ensuring that prisoners with complex care needs are identified and their care suitably coordinated. If Mr Warburton's care had been managed in this way someone would have been responsible for coordinating his care; instead, a number of professionals were working in isolation from one another.

The Head of Healthcare should review the system for the management of complex long-term conditions, and implement a Case Finding and Risk Stratification system in line with NHS England guidance.

Mr Warburton's location

85. There is evidence throughout the SystemOne record that there was a clear view from healthcare staff that Mr Warburton should have been located on the prison's inpatient unit. Mr Warburton, however, refused to remain there, preferring to share a cell on a houseblock, because he was anxious about being left alone and wanted to stay with his friends.

86. Mr Warburton signed 'discharge against medical advice' disclaimers on two occasions (6 October and 8 November 2017). Healthcare staff made reasonable efforts to ensure that care was delivered as flexibly as possible on the houseblock and they took every opportunity to try to persuade Mr Warburton to return to the inpatient medical unit.

Communication about Mr Warburton's diagnosis and prognosis

87. The clinical reviewer found that prison healthcare staff were confused about Mr Warburton's diagnosis and prognosis. They appear not to have fully understood his diagnosis of BOS and the subsequent radiotherapy treatment intended to manage it. The BOS diagnosis, later compounded by the reactivation of CMV, was communicated to the prison in letters from the transplant team consultant in October and November 2017. However, there is no evidence that the information in these letters was properly understood or interrogated by

healthcare staff, or that any action taken following this diagnosis. There was a failure to recognise how serious Mr Warburton's diagnosis was.

88. Mr Warburton's consultant at hospital first indicated that his prognosis was likely to be terminal in a letter sent in November 2017. At this point Mr Warburton should have been placed on the palliative care register, but he was not.

89. Another letter from the same consultant, written in December, indicated that it was likely Mr Warburton might only have months to live. Although this information was included in his compassionate release paperwork, he was still not placed on the palliative care register.

90. There were further indications from the consultant in February 2018 that Mr Warburton's lung function had deteriorated further. In an email dated 11 March 2018 the consultant stated that, although the prognosis was difficult to judge, he would estimate a "median survival of 3-4 months, and that options for further treatment were limited to palliative care". There is no record of any action being taken in response to this information.

91. Recognition of the serious and ultimately terminal nature of Mr Warburton's BOS diagnosis, and placement on the palliative care register, would have provided better coordinated care for Mr Warburton while he was in the final stages of life. Recognition that his diagnosis was terminal might also have made a difference to his applications for compassionate release (as one of the reasons for refusal was lack of clarity over whether he was in the final stages of his life), or resulted in the prison considering transferring Mr Warburton to a hospice.

The Head of Healthcare should ensure that prisoners with terminal diagnoses are placed on a palliative care register to receive appropriate care.

The Head of Healthcare should review the process for the management of external correspondence from other healthcare providers to ensure that appropriate actions are taken to provide continuity of care.

Hospital appointments

92. Mr Warburton had his lung function checked by the transplant team at hospital every six months and was due a review in April 2017, shortly after he arrived at Hewell. This appointment had to be rearranged for security reasons as Mr Warburton came to know the appointment details. This delayed the appointment by a month, but this was not the fault of the prison. The new appointment had to be rearranged twice more when staff mismanaged communication about the appointments with Mr Warburton. This delayed the appointment by a further two months.

93. On two occasions in September 2017, after Mr Warburton had not been receiving the correct dosage of mycophenolate mofetil, Mr Warburton could not attend hospital. On the first occasion, there were no escort staff available, although this was a planned appointment for Mr Warburton to be reviewed by the lung transplant team. On the second occasion, the prison was on lock-down. This had been an unplanned trip for Mr Warburton to be reviewed at A&E due to

concerns about his breathing. We are concerned that the general management of hospital appointments, both planned and emergency, was not sufficiently robust and may, in fact, have endangered the health of prisoners at Hewell.

94. We made the following recommendation following an investigation into a death at Hewell in December 2017:

'The Head of Healthcare and the Governor [should] review processes for the management of hospital appointments and communication of information about these appointments with prisoners.'

95. Hewell accepted the recommendation. In response, the prison introduced a regime management plan to ensure resources were not diverted away from important tasks without management oversight. Healthcare should be involved in the decision to cancel an appointment; this decision should be recorded to ensure a subsequent appointment is not missed. As of May 2018, Duty Governors are responsible for maintaining oversight of this process to make sure an appropriate decision is reached. The appointments that Mr Warburton missed due to lack of staff predate these changes. We are satisfied with Hewell's actions in response to our earlier recommendation and therefore we will not repeat it in this report.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141