

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Wolten, a prisoner at HMP Liverpool, on 10 November 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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Summary

1. 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.
2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.
3. Mr Alan Wolten died in hospital of oesophageal cancer on 10 November 2023, while a prisoner at HMP Liverpool. He was 86 years old. We offer our condolences to Mr Wolten's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Wolten received at HMP Liverpool was of a reasonable standard and was partially equivalent to that which he could have expected to receive in the community. They concluded that his mental health and psychiatry care exceeded that which could have been expected in a community setting.
5. However, the care in relation to falls management was not in line with national guidelines and there was no evidence that an advance care plan was discussed with Mr Wolten.
6. The clinical reviewer made one recommendation about Mr Wolten's end-of-life care. She made a further five recommendations about matters not directly related to Mr Wolten's death but which the Head of Healthcare at HMP Liverpool will want to address.
7. We found that the family liaison officer did not have any contact with Mr Wolten's family before he died. Despite Mr Wolten's health deteriorating on 9 October 2023, the prison did not inform his family of his condition. They were not notified until the hospital told them on 24 October.

Recommendations

- The Head of Healthcare should ensure that end-of-life care planning is held with terminally ill prisoners, including discussing DNACPR, and involving family members, where relevant.
- The Governor should review the family liaison process and assure themselves that when a prisoner becomes seriously or terminally ill, timely arrangements are made for a family liaison officer to be appointed, who will initiate contact with their next of kin.

The Investigation Process

8. HMPPS notified us of Mr Wolten's death on 10 November 2023.
9. NHS England commissioned an independent clinical reviewer to review Mr Wolten's clinical care at HMP Liverpool.
10. The PPO investigator investigated the non-clinical issues relating to Mr Wolten's care.
11. The PPO family liaison officer wrote to Mr Wolten's next of kin, his daughter, to explain the investigation and to ask if she had any matters she wanted us to consider. She asked for a copy of the report.
12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
13. Mr Wolten's family received a copy of the draft report. They did not make any comments.

Previous deaths at HMP Liverpool

14. Mr Wolten was the nineteenth prisoner to die at HMP Liverpool since 10 November 2020. Of the previous deaths, twelve were from natural causes, four were self-inflicted, one was drug-related, and one was unascertained. We have made previous recommendations about the need for the next of kin to be informed promptly when a prisoner becomes seriously or terminally ill and that the family liaison officer supports families before and after a prisoner's death. We have also previously recommended that Liverpool should have more effective oversight of the work of family liaison officers so that the role can be reallocated promptly when needed.
15. Liverpool agreed to implement these recommendations. They told us that next of kin information is tracked through weekly performance meetings, and all prisoners who become seriously or terminally ill are assigned a family liaison officer who will inform family members at the earliest opportunity. Liverpool acknowledged that they had a low number of trained family liaison officers, and told us that as of June 2022, they had two more in post. In addition, Liverpool told us that family liaison officers were assigned by the Safer Custody team who track progress.

Key Events

16. On 25 April 2018, Mr Alan Wolten was sentenced to fourteen years in prison for sexual offences and sent to HMP Liverpool. His diagnosis of dementia was noted during his initial reception health screen.
17. On 18 April 2019, Mr Wolten was diagnosed with lung cancer while in hospital.
18. On 14 May, Mr Wolten told his offender supervisor that he had declined chemotherapy as he felt it would negatively impact on his quality of life considering his age.
19. On 21 August, Mr Wolten attended a hospital appointment to discuss his diagnosis. A hospital doctor told him that he would have an appointment in around four weeks to discuss surgery for his lung tumour. They also told Mr Wolten that the cancer was not aggressive.
20. On 5 November, Mr Wolten attended a hospital appointment. He decided not to have an operation for his lung tumour and opted for radiotherapy instead.
21. On 7 November, a nurse put Mr Wolten's radiotherapy care plan in place. He was scheduled to attend hospital daily (Monday to Friday) for four weeks. She offered to move him to the healthcare unit, but he declined.
22. On 1 November 2020, Mr Wolten received a clear computerised tomography (CT) scan. It was agreed that he would have a scan for lung cancer every six months.
23. Mr Wolten attended hospital throughout 2021 and 2022 for appointments with the urology department (which treat disorders of the kidneys, ureter, bladder, prostate and male reproductive organs).
24. On 9 December 2022, a GP operating at Liverpool made an entry in Mr Wolten's medical record noting that Mr Wolten's health remained remarkably stable, and his previous diagnosis of lung cancer had not shown progression on his CT scan results. She identified that Mr Wolten was at risk of falls, his cancer reoccurring, his physical health deteriorating and his dementia progressing.
25. On 17 January 2023, healthcare staff told a prison GP that they had noticed a general deterioration in Mr Wolten and he was appearing more confused.
26. On 5 October, a nurse asked for a doctor to see Mr Wolten due to symptoms of dysphagia (problems swallowing), vomiting, constipation, a distended abdomen and poor communication.
27. On 6 October, a GP operating at Liverpool reviewed Mr Wolten and carried out a full physical examination. He noted Mr Wolten's frailty, hearing impairment and dementia diagnosis. He noted that he would not be surprised if Mr Wolten passed away in the next 12 months but he was not actively dying at present. (There is no evidence that the cancer had returned at this stage.)
28. On 9 October, when nursing staff saw Mr Wolten to give him his medication, he appeared more confused, and he declined his medication. They arranged for an

urgent GP review. A GP saw Mr Wolten and noted that he was more alert and rousable. He subsequently took his medication. A nurse discussed arranging a palliative assessment with a colleague due to Mr Wolten's recent deterioration.

29. On 10 October, healthcare staff agreed that Mr Wolten should be sent to A&E because of his general deterioration, vomiting and risk of dehydration. An ambulance was called at 10.15am and paramedics took over his care at 11.00am. Mr Wolten was not restrained during this escort because he was frail and could not walk well.
30. On 16 October, hospital staff informed a prison nurse that Mr Wolten had an oesophageal stricture (a narrowing of the food pipe which can restrict the passage of food through to the stomach) and was being fed through a nasogastric tube.
31. On 23 October, a hospital nurse told a prison nurse that Mr Wolten had a soft thickening of the oesophagus and was on an intravenous line for aspiration pneumonia (which occurs when food or liquid is breathed into the airways or lungs, instead of being swallowed). They said that Mr Wolten was very unwell and may not survive. A palliative care plan was put in place for him.
32. On 24 October, an officer was allocated as Mr Wolten's family liaison officer.
33. On 25 October, the hospital told healthcare staff that Mr Wolten was nearing the end of his life and was likely to pass away within seven days. They said that his daughter had been informed of his hospital admission and a do not attempt cardiopulmonary resuscitation (DNACPR) instruction had been put in place.
34. On 27 October, Mr Wolten's Prison Offender Manager started Mr Wolten's application for early release on compassionate grounds. She tried to secure accommodation for Mr Wolten, but he passed away before the application could be finalised.
35. On 31 October, hospital staff told a prison nurse that as Mr Wolten's condition had stabilised and he did not need palliative medication or a syringe driver (a device which administers a continuous supply of medication), they wanted to discharge him to Liverpool's care and refer him to the community palliative team. The nurse told the hospital that they did not currently have any inpatient beds available.
36. On 7 November, hospital staff told a prison nurse that a syringe driver had been put in place and Mr Wolten was being managed by the palliative care team. The hospital said that in light of this, Mr Wolten would not be returning to Liverpool but may be eligible for a hospice bed.
37. At approximately 1.30am on 10 November, Mr Wolten died in hospital.

Post-mortem report

38. The post-mortem report concluded that Mr Wolten died of oesophageal cancer.
39. At an inquest held on 14 November 2023, the Coroner concluded that Mr Wolten died of natural causes.

Findings

Clinical Findings

40. The clinical reviewer concluded that the clinical care Mr Wolten received at HMP Liverpool was partially equivalent to that which he could have expected to receive in the community. The clinical reviewer stated that the healthcare he received from the mental health and psychiatry team exceeded that which he could have expected to receive in a community setting. There was good practice in the high standard of care for Mr Wolten's dementia, the high level of input from healthcare staff in discussions about his care and the high level of social care input which was appropriately tailored to Mr Wolten's needs and deteriorating health.
41. However, she noted that the care in relation to falls management and prevention was not in line with national guidelines.
42. The clinical reviewer also found that despite Mr Wolten's age, frailty and cancer diagnosis, there was no evidence that a discussion had taken place in relation to his advance care planning or whether he wanted to be resuscitated if his heart or breathing stopped. She stated that people approaching the end of their lives should be offered comprehensive, holistic assessments so that a personalised care plan is developed to meet their changing needs and preferences.
43. The General Medical Council's definition of end-of-life care is that people are 'approaching the end of life' when they are likely to die within the next 12 months. We recognise that a GP at the prison noted on 6 October – just over a month before Mr Wolten died - that "he wouldn't be surprised if Mr Wolten passed away in the next 12 months, but that he was not actively dying at present". We also note that nursing staff were prompt in requesting a palliative assessment due to Mr Wolten's recent deterioration. However, given his age, poor health and deteriorating condition, the advance care planning process should have been discussed with him and started sooner. This may have resulted in healthcare staff identifying earlier that he was reaching the end of his life and allowed them to put in place palliative care. We make the following recommendation:

The Head of Healthcare should ensure that end-of-life care planning is held with terminally ill prisoners, including discussing DNACPR, and involving family members where relevant.

44. The clinical reviewer also made five recommendations about matters not directly affecting Mr Wolten's death, which the Head of Healthcare at HMP Liverpool will want to address.

Liaison with Mr Wolten's family

45. Prison Service Instruction (PSI) 64/2011 on safer custody states that prisons must have arrangements in place for an appropriate member of staff to engage with the next of kin of prisoners who are either terminally or seriously ill.
46. Mr Wolten should have been assigned a family liaison officer on 9 October 2023, when his health deteriorated, and nurses discussed a palliative assessment. Mr

Wolten was then admitted to hospital on 10 October. Liverpool should have initiated contact with Mr Wolten's family to notify them of his condition and his hospital admission.

47. Although an officer was appointed as Mr Wolten's family liaison on 24 October, there is no record that she contacted Mr Wolten's family before he died on 10 November.
48. The officer told us that when she was appointed, she was completing a family liaison training course so was not available to carry out her family liaison role. She said that she was then on annual leave until 6 November. On return from leave, she tried to get an update from the bed watch officers, who told her that Mr Wolten had received a visit from his family on 27 October and 1 November. However, she did not contact Mr Wolten's family.
49. Having been notified of Mr Wolten's death on 10 November, the officer asked for a family liaison officer from another prison to visit and break the news in person to Mr Wolten's next of kin.
50. The officer's first contacted Mr Wolten's next of kin by email on 12 November to introduce herself as their family liaison officer.
51. Given that we have raised issues about family liaison previously, and Liverpool assured us that improvements had been made, we make the following recommendation:

The Governor should review the family liaison process and assure themselves that when a prisoner becomes seriously or terminally ill, timely arrangements are made for a family liaison officer to be appointed, who will initiate contact with their next of kin.

**Adrian Usher
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May 2024

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