Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Mowbray, a prisoner at HMP Hewell, on 1 April 2020

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*

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

3. Mr Ronald Mowbray died in hospital of inanition (exhaustion caused by lack of nourishment), congestive cardiac failure, atrial fibrillation (irregular heartbeat), dementia and frailty on 1 April 2020, while a prisoner at HMP Hewell. He was 82 years old. We offer our condolences to Mr Mowbray's family and friends.

4. The clinical reviewer concluded that the care Mr Mowbray received at Hewell was equivalent to that which he could have expected to receive in the community. She made two recommendations.

5. We did not find any non-clinical issues of concern.

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

Recommendations

- The Head of Healthcare should ensure that a process for requesting and obtaining special diets for prisoners who are unable to eat a normal diet is in place. The Governor should ensure there is daily management of the provision of special diets, so that such requests are met.

- The Head of Healthcare should review the procedures in place to screen for malnutrition, to include the use of screening tools such as MUST (Malnutrition Universal Screening Tool).

Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Mowbray's clinical care at HMP Hewell.

8. The PPO investigator has investigated non-clinical issues, including Mr Mowbray's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.

9. One of the PPO's family liaison officers wrote to Mr Mowbray's next of kin, his son, to explain the investigation. He did not raise any issues in respect of his father's death.

10. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Hewell

11. Mr Mowbray was the fifth prisoner to die of natural causes at Hewell since April 2018. There are no similarities between our findings in the investigation of Mr Mowbray's death and our investigation findings for the previous deaths.

Key Events

12. On 19 February 2020, Mr Ronald Mowbray was remanded to HMP Hewell, charged with the murder of his wife. He had a history of high blood pressure, irregular heartbeat and chronic kidney disease. He was a Jehovah's Witness and had an Advanced Decision to Refuse Treatment (ADRT) from 2017.

13. At an initial health assessment, Mr Mowbray appeared confused, incoherent and needed assistance with simple tasks. A nurse referred him to a prison GP for review. Staff obtained his community medical records and created care plans to manage his conditions. Mr Mowbray's prescribed medications were reviewed and updated.

14. A prison GP reviewed Mr Mowbray later the same day. He thought Mr Mowbray might have Parkinson's disease (a progressive disorder of the nervous system that affects movement) and referred him to the neurology department at Worcester Royal Hospital. Mr Mowbray was admitted to the prison's inpatient unit.

15. On 20 February, Mr Mowbray appeared very confused and generally unwell. He was taken to Worcester Royal Hospital and diagnosed with heart failure and suspected dementia. A CT scan (computerised tomography) showed chronic bilateral infarcts (obstructions in the blood vessels of the brain which can result in a stroke). Mr Mowbray returned to prison the following day, 21 February.

16. Mr Mowbray often refused help and intervention from the prison medical team. He had difficulty swallowing and eating a normal diet. He was given soft foods and Fortisip high calorie supplementary drinks, but often refused to eat despite encouragement by healthcare staff. They monitored his weight and food consumption, but he continued to deteriorate.

17. On 25 March, Mr Mowbray said he did not want anyone to resuscitate him if his heart or breathing stopped and signed an order to that effect.

18. On 26 March, a prison GP contacted staff at Alexandra Hospital for advice and they requested blood samples. The results were received the same day and showed kidney failure. Mr Mowbray was taken to hospital by ambulance and admitted as an inpatient.

19. Mr Mowbray received end of life care in hospital and died on 1 April.

20. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave the cause of death as inanition, congestive cardiac failure, atrial fibrillation, dementia and frailty.

Lisa Burrell
Assistant Ombudsman **December 2020**