Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Creevy, a prisoner at HMP Garth, on 25 January 2022

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

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 John Creevy died at HMP Garth on 25 January 2022. His cause of death is unascertained. Mr Creevy was 51 years old. I offer my condolences to his family and friends.

I am concerned that there was no healthcare handover when Mr Creevy was transferred from HMP Lowdham Grange to HMP Garth around two weeks before he died. Healthcare staff at Lowdham Grange did not pass on to Garth important information about his medical history and upcoming hospital appointments. This meant that Mr Creevy missed a hospital consultant appointment shortly after he was transferred. I am also concerned that Mr Creevy was transferred without the prescribed medication he needed and that his health was not fully assessed when he arrived at Garth.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. In September 2015, Mr John Creevy was sentenced to seven years in prison for robbery and violence against a person and was sent to HMP Liverpool. He had epilepsy.

2. On 12 March 2020, Mr Creevy was transferred to HMP Lowdham Grange.

3. Between March 2020 and 25 January 2022, Mr Creevy had 24 epileptic seizures.

4. On 27 October 2021, Mr Creevy was taken to hospital after he reported having shortness of breath and cellulitis in his left leg. At hospital, he was diagnosed with several serious illnesses relating to his heart and lungs. He remained in hospital until 5 November.

5. On 13 January, Mr Creevy was transferred from Lowdham Grange to HMP Garth. Lowdham Grange did not inform Garth about Mr Creevy's epilepsy, important impending follow-up appointments nor his recent admission to hospital. Mr Creevy arrived at Garth without his critical prescribed medications and an initial health screen was not completed.

6. The next day, Mr Creevy did not attend an epilepsy review at hospital as information about the appointment was not handed over to Garth.

7. At around 8.30am on 25 January, an officer found Mr Creevy unresponsive. The officer shouted for assistance from another officer and radioed a medical emergency code blue (used when a prisoner is unconscious or has breathing difficulties) and an ambulance was called straightaway. Healthcare staff found no signs of life and did not try to resuscitate Mr Creevy. At 9.11am, paramedics arrived and confirmed that Mr Creevy had died.

Findings

8. The clinical reviewer found that the physical care that Mr Creevy received was not always equivalent to that which he could have expected to receive in the community. She found that Lowdham Grange did not pass information to Garth about Mr Creevy's epilepsy, his recent hospital admission and follow-up appointments. Mr Creevy arrived at Garth without critical medication, and he was not fully assessed on arrival.

Recommendations

- The Head of Healthcare at HMP Lowdham Grange should ensure that prisoners with significant health needs are transferred in line with national instructions, including that:
    - significant health information is shared with the receiving prison, including about significant diagnoses, recent emergency hospital admissions and hospital follow up appointments; and

- all critical prescribed medications are transferred with prisoners to enable continuity of care.

- The Head of Healthcare at HMP Garth should ensure that reception health screens are completed for all newly arrived prisoners, in line with NICE guidelines.

The Investigation Process

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

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

11. The investigator interviewed six members of staff using Microsoft Teams on 23 March and 4 November.

12. NHS England and NHS Improvement (NHSE&I) commissioned a clinical reviewer to review Mr Creevy's clinical care at the prison. The clinical reviewer joined the investigator for interviews with healthcare staff.

13. We informed HM Coroner for Lancashire and Blackburn with Derwen of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

14. The Ombudsman's family liaison officer contacted Mr Creevy's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond to our letter.

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

Background Information

HMP Garth

16. HMP Garth holds up to 846 prisoners serving sentences of four years or longer or indeterminate sentences. Primary care services are provided by Bridgewater NHS Foundation Trust. Greater Manchester Mental Health NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Garth was in December 2018 and January 2019. Inspectors reported that several aspects of healthcare provision had improved and was now reasonably good. However, they found there were still difficulties in ensuring prisoners could attend hospital appointments. Inspectors reported governance structures and partnership-working were reasonable and that staffing levels had improved. The management of long-term conditions had also improved, and patients received regular reviews and a good level of care.

Independent Monitoring Board

18. 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 May 2022, the IMB reported that each new prisoner goes through the standard arrival procedure. They noted that a healthcare representative is available at each induction and that prisoners receive a triage medical check (ensuring that prescribed medication is provided from the first day). The induction includes full healthcare checks being carried out within a week of prisoners arriving and ensures that health needs are met in a timely and efficient manner. The IMB noted from its observations that procedures in Reception and ongoing induction are carried out courteously and correctly, with prisoner queries responded to appropriately.

Previous deaths at HMP Garth

19. Mr Creevy was the eleventh prisoner to die at Garth since January 2020. Seven of the previous deaths were from natural causes, two were self-inflicted and one was drug-related. Since Mr Creevy's death, there have been two further two deaths, one from natural causes and one in which the cause is unclear. We have previously raised a concern about welfare checks.

Key Events

20. In September 2015, Mr John Creevy was sentenced to seven years in prison for robbery and violence against a person and was sent to HMP Liverpool.

21. Mr Creevy had several chronic health conditions, including diagnosed epilepsy, hepatitis C, anxiety and depression, schizophrenia and psychosis, emotionally unstable personality disorder, antisocial personality disorder, low back pain and cellulitis (a common bacterial skin infection that causes redness, swelling and pain in the infected area) in his legs.

22. On 12 March 2020, Mr Creevy was transferred from Liverpool to HMP Lowdham Grange.

23. Between March 2020 and 25 January 2022, records show that Mr Creevy had 24 epileptic seizures, most of which were unwitnessed.

24. On 14 April 2020, Mr Creevy's epilepsy care plan was reviewed.

25. On 18 January 2021, Mr Creevy's consultant neurologist at Queen's Medical Hospital changed his epilepsy medication and on 23 July, increased the dose. The consultant scheduled a review for 14 January 2022. There were no further reviews of Mr Creevy's epilepsy care plan.

26. On 8 October, Mr Creevy was admitted to hospital following a seizure.

27. On 27 October, a health professional assessed Mr Creevy because he was short of breath, had cellulitis in his left leg and his haemoglobin (iron) levels had decreased. She sent him to hospital, where he was diagnosed with sepsis (a generalised infection that overwhelms the body), cellulitis, pericardial effusion (a build-up of fluid around the heart) with possible cardiac tamponade (excess fluid around the heart that prevents the heart from pumping properly) and pulmonary embolus (a lung clot).

28. On 5 November, Mr Creevy was discharged from hospital and returned to Lowdham Grange. Healthcare staff saw him almost daily to administer medication and change his leg dressings until he was transferred to HMP Garth (in January 2022).

29. On 15 December, Mr Creevy missed a cardiology telephone appointment because the consultant did not have the prison's telephone number. An echocardiogram (when an image of the heart is made using sound waves) was booked for January 2022.

30. On 13 January, a nurse reviewed Mr Creevy in his cell before he was transferred to Garth. She recorded that he raised no concerns and that his medication had been sent on transfer.

HMP Garth

31. On 13 January 2022, Mr Creevy was transferred to Garth. He arrived at around 5.30pm. Healthcare staff did not complete a full initial health screen. A nurse

observed Mr Creevy through his open cell door. She described the brief assessment as "meet and greet". She recorded that Mr Creevy said that he was well and had no concerns about his health and wellbeing. She noted that some of Mr Creevy's critical medications had arrived with him from Lowdham Grange. The remaining medication was obtained from Garth's out-of-hours cupboard. No health risks were recorded, and she did not record that Mr Creevy had a history of epilepsy.

32. The Head of Healthcare at Garth told the investigator that Lowdham Grange did not provide a handover of Mr Creevy's complex health needs.

33. The next day, a nurse completed Mr Creevy's initial health screen. She took his clinical observations and recorded Mr Creevy's medical history as suspected heart disease, epilepsy and hepatitis C.

34. That day, Mr Creevy missed his epilepsy review at hospital. It had been booked when he was at Lowdham Grange, but he apparently missed it because staff at Lowdham Grange had not informed Garth about the appointment.

35. On 17 January, Mr Creevy did not have his scheduled secondary health screen due to a lack of staff.

36. On 20 January, a nurse completed Mr Creevy's full health assessment. She recorded that he had memory impairment, a history of head injury, regular headaches, a heart condition, epilepsy, medications and regular check-ups for long-term conditions and hospital reviews. She advised Mr Creevy how to make an application for a health appointment and to inform wing staff of any emergency.

Events of 25 January

37. At around 5.47am, an officer completed the morning roll check. The officer looked into the cell observation panel with a torch light for about three seconds. He said that he saw nothing that caused him concern.

38. At around 8.25am, while conducting welfare checks, an officer looked through the cell observation panel and noted that Mr Creevy's bed was made and that he could see Mr Creevy's feet in the toilet area. He said that he assumed Mr Creevy was on the toilet and so continued with welfare checks along the landing. He returned to Mr Creevy's cell two minutes later. He looked through the cell observation panel and unlocked the cell door. As he opened it slightly, he noticed Mr Creevy slumped on the floor next to the toilet. He shouted for assistance from another officer and called a medical emergency code blue on his radio (triggering the control room operator to call an ambulance). He went into the cell, checked for signs of life and noted that Mr Creevy was cold. Another officer attended the cell with a defibrillator, and a nurse also attended. The nurse assessed Mr Creevy and found no signs of life and that Mr Creevy was cold and rigid. The staff therefore decided not to attempt resuscitation.

39. At 9.11am, paramedics confirmed that Mr Creevy had died.

Contact with Mr Creevy's family

40. At 10.40am, a prison family liaison officer telephoned Mr Creevy's mother and told her of his death. The prison contributed to funeral costs, in line with national policy.

Support for prisoners and staff

41. After Mr Creevy's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

42. The prison posted notices informing other prisoners of Mr Creevy'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 Creevy's death.

Post-mortem report

43. The cause of death was not available when we issued our report.

Findings

Clinical care

44. The clinical reviewer found that the physical care that Mr Creevy received was not always equivalent to that which he could have expected to receive in the community.

45. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners instructs that prisoners' current healthcare needs must be assessed and continuity of care ensured when they transfer between prisons. It instructs that this should include the identification of physical health problems and ensuring that information on continuing care is conveyed to other prisons on transfer. Prisoners with more complex health needs may require detailed planning such as communicating directly with the receiving health care team in advance of transfer.

46. National Institute for Health and Care Excellence (NICE) guidelines (NG57) instruct that continuity of care should be ensured for people transferring between prisons by, for example, accessing relevant information from their patient clinical record. When a prisoner arrives at a new prison, a full health assessment should be carried out and NICE guidelines identify questions that should be put to all new arrivals.

47. The clinical reviewer found that there was no healthcare handover when Mr Creevy was transferred from Lowdham Grange to Garth. This meant that his epilepsy risks and information about his recent hospital admission were not shared with Garth. It also meant that Mr Creevy missed a consultant epilepsy review scheduled for 14 January, and also missed a repeat echocardiogram. Additionally, he arrived at Garth without some critical medications, and he was not fully assessed on arrival. We make the following recommendation:

    The Head of Healthcare at HMP Lowdham Grange should ensure that prisoners with significant health needs are transferred in line with national instructions, including that:

    - **significant health information is shared with the receiving prison, including about significant diagnoses, recent emergency hospital admission and hospital follow up appointments; and**
    - **all critical prescribed medications are transferred with prisoners to enable continuity of care.**

    The Head of Healthcare at HMP Garth should ensure that reception health screens are completed for all newly arrived prisoners, in line with NICE guidelines.

48. The clinical reviewer also made several recommendations about continuity of care and healthcare processes which the Head of Healthcare at Lowdham Grange will need to address.

Welfare check on 25 January 2022

49. During the COVID-19 pandemic, Garth introduced additional welfare checks for prisoners which it decided to keep while emerging from the pandemic. Garth's local policy on welfare checks during restricted regime period says, "Best practice on a welfare check is that staff must ensure they have full sight of the individual and gain a verbal response from occupant/occupants located within the cell."

50. When an officer completed his welfare check on Mr Creevy, he saw his feet in the toilet area and assumed that he was on the toilet. The landing was noisy and Mr Creevy's bed was made which made the officer believe that he was up and using the toilet. Two minutes later, the officer returned to unlock Mr Creevy and realised that he was slumped on the floor. The officer responded immediately, called for help from a nearby officer and appropriately radioed a medical emergency code blue.

51. The officer did not complete his welfare check in line with Garth's published guidance. An operational manager told us that she spoke to the officer after Mr Creevy's death and gave him advice and guidance. She also told us that the prison's local welfare check policy had been reissued to all staff. We do not therefore make a recommendation.

Inquest

52. The inquest, held from 20 to 22 June 2023, concluded that Mr Creevy's death was due to natural causes.

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