Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Karl Reavy, a prisoner at HMP Liverpool, on 15 February 2023

A report by the Prisons and Probation Ombudsman

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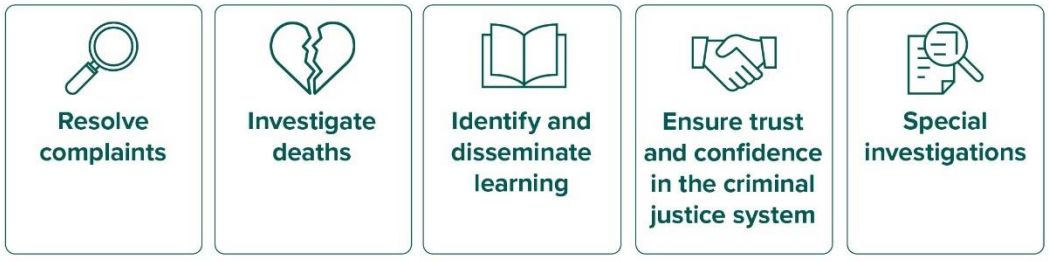
OUR VISION

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

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.

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.

Mr Karl Reavy died of ischaemic and hypertensive heart disease with citalopram (prescribed antidepressant medication) toxicity on 15 February 2023 while a prisoner at HMP Liverpool. He was 53 years old. The investigation found no evidence that Mr Reavy intended to overdose on his prescribed medication. I offer my condolences to Mr Reavy's family and friends.

Mr Reavy had a complex medical history. The clinical reviewer concluded that healthcare staff managed his conditions appropriately and provided a good standard of clinical care which was equivalent to what he could have expected to receive in the community.

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 **February 2024**

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Summary

Events

1. Mr Karl Reavy had a complex clinical history and suffered from several long-term medical conditions.

2. Mr Reavy was in prison between April 2021 and October 2022, when he was released on licence after serving a sentence for arson. In November, he was recalled to prison and taken to HMP Liverpool.

3. A GP at Liverpool continued his prescription of citalopram (antidepressant), codeine for abdominal pain and medication to manage his other clinical conditions, all of which he kept in his cell. Healthcare staff, including the long-term conditions nurse, saw Mr Reavy regularly.

4. On 19 January 2023, a nurse noted that Mr Reavy had asked for more codeine and that he might not have been adhering to his prescribed dose. The long-term conditions nurse reduced Mr Reavy's dose of codeine. A GP at the prison increased the dose on 25 January after Mr Reavy complained of nerve pain.

5. Mr Reavy went to hospital on 29 January and 8 February with chest pain. Hospital doctors diagnosed angina and advised a referral to a heart specialist if Mr Reavy continued to experience pain.

6. At around 8.00pm on 14 February, an operational support grade (OSG) locked Mr Reavy in his cell. At 11.00pm, Mr Reavy rang his cell bell because he felt light-headed. He rang his cell bell again at 1.00am on 15 February. He did not want to see the nurse and went back to sleep. The OSG completed a routine check at 4.40am and did not notice anything unusual.

7. As the prison was on a restricted regime due to a staff training day, Mr Reavy remained in his cell on the morning of 15 February. Staff did not complete a morning welfare check.

8. At 11.23am, a prison officer unlocked Mr Reavy's cell for lunch and found him unresponsive on the bed. The officer radioed a medical emergency code and staff responded quickly. Staff started cardiopulmonary resuscitation (CPR). Paramedics arrived at 11.30am and at 11.35am, confirmed that Mr Reavy had died.

9. The post-mortem examination established that Mr Reavy died from ischaemic and hypertensive heart disease with citalopram toxicity.

Findings

10. The clinical reviewer concluded that Mr Reavy received a good standard of clinical care which was equivalent to what he could have expected to receive in the community. Staff managed his complex clinical conditions appropriately and when he became unwell, he was sent to hospital for further investigation.

11. Mr Reavy was prescribed codeine throughout his time at Liverpool. When Mr Reavy's behaviour indicated that he was taking more than his prescribed dose, healthcare staff did not complete a medication in-possession risk assessment.

12. The lead pharmacist for Spectrum CIC agreed to audit all patients who were prescribed citalopram and to ensure that a robust monitoring process was in place.

13. Staff did not complete a welfare check between 4.45am and 11.23am on 15 February.

14. There was no evidence that Mr Reavy was at risk of suicide and self-harm or that he intentionally took more citalopram than he should.

Recommendation

- The Head of Healthcare at HMP Liverpool should ensure that regular medication in possession risk assessments (MIPRA) are undertaken when there are changes in patient's circumstances or there are concerns regarding the compliance and adherence of medications, in accordance with the Spectrum CIC Medicines In-Possession Policy 2022.

The Investigation Process

15. HMPPS notified us of Mr Reavy's death on 15 February 2023.

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

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

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

19. The investigator and clinical reviewer interviewed one member of staff at Liverpool on 23 March 2023.

20. We informed HM Coroner for Liverpool of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

21. We wrote to Mr Reavy's brother to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

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

Background Information

HMP Liverpool

23. HMP Liverpool is a category B local prison holding up to 750 adult men. Spectrum Healthcare UK Trust provides physical healthcare services and Mersey Care NHS Trust provides mental healthcare services.

24. There is a 26-bed inpatient wing to accommodate prisoners needing extensive personal care packages with a wide range of clinicians to provide support.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Liverpool was in August and September 2019. Inspectors found that the 24-hour nursing team was stable, although not fully staffed, and had been supplemented by two social carers. Clinicians and officers knew their patients and offered a high quality of shared care while maintaining professional boundaries. Care plans and clinical records were clear and informed the support delivered.

Independent Monitoring Board

26. 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 December 2022, the IMB reported that all prisoners were seen by healthcare as part of their initial assessment. The kiosk and the daily presence of healthcare staff on the wing enabled prisoners to book appointments and be seen by staff promptly. The Board found that staff responded quickly to concerns raised and often saw the prisoner the same day.

Previous deaths at HMP Liverpool

27. Mr Reavy was the sixteenth prisoner to die at Liverpool since February 2020. Of the previous deaths, 11 were due to natural causes, one was self-inflicted, two were drug-related and one was unascertained. Up to the end of 2023, there have been five deaths since Mr Reavy's, two from natural causes and two were self-inflicted.

Key Events

28. On 14 April 2021, Mr Karl Reavy was remanded to HMP Forest Bank. On 24 March 2022, he was sentenced to three years in prison for arson. This was Mr Reavy's first time in prison. On 13 October, he was released on licence. Mr Reavy was recalled to HMP Liverpool on 28 November after he failed to comply with the conditions of his licence.

29. Mr Reavy had a complex medical history and was under the care of the cardiology team and the gastroenterology department at Salford Royal Hospital.

HMP Liverpool

30. When Mr Reavy arrived at Liverpool on 28 November, a prison officer completed his first night induction interview. He noted that Mr Reavy engaged well and was aware of the support available to him. Mr Reavy did not express any thoughts of suicide and self-harm. He was allocated a keyworker who completed regular welfare checks. Mr Reavy was allocated a single cell on F wing.

31. A nurse completed Mr Reavy's initial health assessment and noted his history of depression, anxiety and excessive alcohol intake. Mr Reavy had several long-term health conditions, including asthma, problems with his intestines, hypertension (high blood pressure) and anaemia (low red blood cells). He had a heart attack in 2015 and suffered from ischaemic heart disease and angina. Healthcare staff obtained Mr Reavy's medical history and treatment information from Salford Royal Hospital. A GP at the prison prescribed citalopram (antidepressant) medication and medication to treat Mr Reavy's clinical conditions which he kept in his cell and was expected to take as prescribed.

32. Due to his complex medical history, the long-term conditions nurse saw Mr Reavy on 13 December. He created care plans for hypertension, asthma and coronary heart disease.

33. On 16 December, a GP at the prison reviewed Mr Reavy's prescribed medication. He prescribed Mr Reavy 30mg of codeine, to be taken four times a day for abdominal pain. He advised Mr Reavy that codeine was for short-term use only.

34. As the results of a routine blood test on 28 December were borderline, the test was repeated on 5 January 2023. The results showed that Mr Reavy was ferritin (a protein which stores iron in the body) and folate (folic acid) deficient and a prison GP prescribed medication to raise his levels.

35. On 4 January, healthcare staff gave Mr Reavy 28 days' worth of his prescribed citalopram.

36. On 17 January, healthcare staff gave Mr Reavy seven days' worth of his prescribed codeine.

37. On 19 January, a nurse recorded in Mr Reavy's medical record that he had asked for more codeine. The nurse noted that, if Mr Reavy was taking more than his prescribed dose, he might not be suitable for keeping it in his cell. That day, the long-term conditions nurse Williams reduced Mr Reavy's codeine dose to 30mg, to

be taken three times a day and added paracetamol. Another nurse recorded her concerns in Mr Reavy's medical record.

38. On 25 January, a GP at the prison saw Mr Reavy because he had pain in his left ulnar nerve (which helps with movement in the forearm, hand and fingers). He diagnosed Mr Reavy with medication for neuropathy (nerve pain) and increased his codeine dose to 30mg, two tablets to be taken four times a day with no more than eight tablets to be taken in 24 hours.

39. That day, another GP at the prison noted that Mr Reavy was not adhering to his prescribed dose of codeine. She asked nursing staff to monitor Mr Reavy when he came to the medication hatch. She noted that GPs should complete a medication review of the medication Mr Reavy kept in his cell. There is no evidence that anyone conducted this review and he continued to be prescribed his medication in possession.

40. On 29 January, Mr Reavy told staff he had chest pain. Due to his complex cardiac history nurses arranged for an ambulance to take Mr Reavy to hospital for further examination. Shortly after he arrived at hospital, Mr Reavy discharged himself and returned to Liverpool. A nurse assessed Mr Reavy and noted that his physical observations were normal, but his blood pressure remained raised (158/110mmHg). Mr Reavy told her that he felt fine.

41. On 2 February, a GP at the prison prescribed Mr Reavy 30mg of codeine, one to two tablets to be taken as required with no more than three tablets taken in 24 hours. He reviewed Mr Reavy's medical record the next day and noted Mr Reavy's recent hospital admission and said he needed an urgent GP review. There is no evidence that this took place.

42. On 8 February, Mr Reavy complained of pain in his rib cage that was radiating to his back, pain along his left arm and pins and needles in his right arm. Nurses arranged for an ambulance to take Mr Reavy to hospital. Hospital doctors diagnosed angina, increased his angina medication dose and advised a referral to a heart specialist if the breakthrough pain continued.

43. The long-term conditions nurse assessed Mr Reavy on 13 February. He noted that Mr Reavy's blood pressure remained raised, and he was still waiting for an angiogram test at Salford Royal hospital. The nurse asked the healthcare administration team to contact the hospital. A GP appointment was arranged for 24 February.

Events of 14 and 15 February

44. At approximately 8.00pm on 14 February, an Operational Support Grade (OSG) completed the evening routine count. In a written statement, she said that Mr Reavy was in his cell watching television and did not have any concerns. She gave Mr Reavy a breakfast pack.

45. At 11.00pm, Mr Reavy rang his cell bell and told the OSG that he felt lightheaded. Mr Reavy said his angina medication had recently changed and he did not want to see the nurse.

46. Mr Reavy rang his cell bell again at 1.00am on 15 February and the OSG went to his cell. Mr Reavy did not say why he had rung his cell bell and went back to sleep.

47. At approximately 4.40am, the OSG went to Mr Reavy's cell to complete the morning routine check. In a statement, her said she looked through the observation panel and saw Mr Reavy lying on his bed asleep, she thought, with his cell light on.

48. On 15 February, F wing was on a restricted regime due to a staff training day. This meant that prisoners remained in their cells and were only unlocked for essential work, to collect their meals and to receive their medication. Officer A was responsible for completing the welfare checks on F5 landing where Mr Reavy's cell was located.

49. In an email, a prison manager told the investigator that Officer A was sent on an emergency hospital escort, which left F5 without a detailed member of staff. As Mr Reavy had his medication with him in his cell, and did not work, he remained in his cell and staff did not complete a welfare check.

50. At 11.23am, Officer B went to Mr Reavy's cell to ask if he wanted lunch. Mr Reavy was unresponsive on his bed. The officer radioed a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room log recorded that this occurred at 11.25am, and an ambulance was called immediately. A nurse arrived and helped move Mr Reavy onto the cell floor so they could start CPR. She attached a defibrillator that did not detect a shockable rhythm. Paramedics arrived at 11.30am and at 11.35am, confirmed that Mr Reavy had died.

Contact with Mr Reavy's family

51. After Mr Reavy's death, the prison appointed a family liaison officer (FLO). On 15 February, the Governor telephoned Mr Reavy's family and informed them of his death. On 16 February, the FLO visited Mr Reavy's family and offered support.

52. The prison contributed towards the cost of Mr Reavy's funeral in line with national policy.

Support for prisoners and staff

53. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

54. After Mr Reavy's death, a prison 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.

55. The prison posted notices informing other prisoners of Mr Reavy'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 Reavy's death.

56. Safer custody spoke to the Samaritans and gave prison listeners and the wing manager postvention leaflets to share with prisoners and staff.

Post-mortem report

57. The post-mortem report gave Mr Reavy's cause of death as ischaemic and hypertensive heart disease with citalopram toxicity.

58. The pathologist commented that toxicological analysis revealed a raised level of citalopram in Mr Reavy's blood. The blood concentration was below recognised fatal levels in isolation but was in the toxic range and would be dangerous in conjunction with significant pre-existing cardiac disease. Citalopram is known to potentially interfere with cardiac conduction and in excess can cause tachycardia (a fast heart rate).

Findings

Clinical care

59. The clinical reviewer concluded that the healthcare that Mr Reavy received at Liverpool was of a good standard and equivalent to what he could have expected to receive in the community.

60. Mr Reavy had a complex physical health history. During the short time he was at Liverpool, healthcare staff appropriately managed his physical health needs, and he had regular appointments with the long-term conditions nurse. When Mr Reavy became unwell, he was sent to hospital for further investigation. Mr Reavy was under the care of the cardiology department at Salford Royal Hospital and was diagnosed with angina the week before he died.

61. The clinical reviewer noted that Mr Reavy was prescribed codeine for a considerable amount of time, which increased the risk of dependence and addiction. When a nurse raised concerns that Mr Reavy was taking more than his prescribed dose of codeine, and despite a GP noting that a review of Mr Reavy's in possession medication should take place, staff did not complete a medication in possession risk assessment as they should have done.

62. The toxicology tests revealed a raised level of citalopram in Mr Reavy's blood at a level which would be dangerous in conjunction with significant pre-existing cardiac disease (there is no evidence that the cardiologists considered that Mr Reavy should not be prescribed citalopram.) The clinical reviewer noted that the lead pharmacist for Spectrum CIC had agreed to audit all patients within Spectrum CIC prisons, including HMP Liverpool, who were prescribed citalopram to ensure that a robust process for monitoring these patients was in place. We recommend:

    The Head of Healthcare at HMP Liverpool should ensure that regular medication in possession risk assessments (MIPRA) are undertaken when there are changes in patient's circumstances or there are concerns regarding the compliance and adherence of medications, in accordance with the Spectrum CIC Medicines In-Possession Policy 2022.

63. Neither prison nor healthcare records made after Mr Reavy's death documented whether any citalopram (or if so, how much) was found in Mr Reavy's cell. We found no evidence that Mr Reavy deliberately intended to harm himself by taking more than his prescribed dose of citalopram.

Welfare checks

64. Due to staff training, Liverpool was operating a restricted regime on 15 February and some prisoners were not unlocked until lunchtime. Despite this, all prisoners should have been subject to a welfare check on the morning of 15 February. Mr Reavy was not checked between the early hours of the morning and 11.23am.

65. After Mr Reavy's death, the Governor issued a notice to staff about completing prisoner welfare checks and the action that must be taken if a prisoner is unresponsive. We were told that the officer responsible for welfare checks on Mr

Reavy's wing on 15 February was redeployed and the wing did not have any detailed staff that morning. This issue will not be resolved by the Governor's notice to staff and is something that the Governor will wish to consider.

Inquest

66. The inquest hearing into the death of Mr Reavy concluded on 15 January 2025 and confirmed that Mr Reavy died from natural causes. The Coroner commented that Mr Reavy had a pre-existing heart condition and consumed more than the prescribed dose of anti-depressant medication. This level of prescription drugs exacerbated his heart condition and led to a fatal cardiac event. The circumstances of Mr Reavy's death were facilitated by a lack of adequate procedures in place at Liverpool with respect of Mr Reavy's history.

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