

**Investigation into the circumstances surrounding the
death of a man on 7 May 2009 in hospital whilst in the
custody of HMP Liverpool.**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

June 2010

This is the report of an investigation into the death of a man who died on 7 May 2009, in hospital whilst he was in the custody of HMP Liverpool. The man had been in prison for ten days and was being treated on a drug detoxification programme. Healthcare staff were called to his cell after he became unwell. There was blood on the man's bed sheet and an emergency ambulance was summoned. As the paramedics arrived, the man stopped breathing and cardiac pulmonary resuscitation (CPR) was started. He died shortly after arriving at hospital, aged 35 years.

Her Majesty's Coroner for Liverpool was informed of my investigation. A post mortem was undertaken which found that the man died of natural causes from an aneurysm in the right femoral artery (groin area). I extend my sincere condolences to the man's family and friends. I apologise for the delay issuing my report and any additional distress this may have caused.

The investigation was undertaken by one of my colleagues. I would like to thank the Governor of Liverpool and his staff for their help and assistance. I am particularly grateful to a Senior Officer who acted as liaison officer.

A review of the man's healthcare was commissioned by Liverpool Primary Care Trust (PCT). I am grateful to a doctor for the clinical review.

My report has been delayed whilst waiting for the clinical review. However, the thorough review documents a full chronology of the events leading to the man's death, meeting notes with healthcare staff and a professional judgment by a consultant in vascular surgery.

I make four recommendations to the Prison's Head of Healthcare, including one to be shared with the Department of Health. Three recommendations relate to medication being administered at the earliest opportunity, in possession medication and microbiological testing. The fourth recommendation refers to guidance on the potential presence of aneurysms when intravenous drug users complain of swelling and pain in the groin area. I note the professionalism of wing and healthcare staff in their response to the man's emergency.

In this final report all four recommendations have been accepted and actions to those recommendations are noted on page 19 of this report. The man's family have been sent the draft report and their comments are noted on page 17.

Jane Webb
Acting Prisons and Probation Ombudsman

June 2010

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SUMMARY

The man was sentenced to 28 days imprisonment in April 2009 for theft. He arrived at Liverpool where a full healthcare screening identified his history of drug misuse, which included the intravenous use of heroin. The man was on a methadone (a heroin substitute) maintenance programme through a community drug support agency. He told the nurse that he did not have any other medical problems. The man's urine sample tested positive for opiates, tranquilizers and methadone. He was prescribed a relaxant and placed in the first night centre.

The following day the man saw a doctor and his methadone maintenance programme was prescribed alongside Diazepam (an anti depressant) to help him with his withdrawal symptoms. He saw a nurse on 2 May and told her that he had pain in his leg and was prescribed pain relief.

A doctor examined the man on the morning of 5 May and noted that he was unwell, flushed and in pain from an infection in his groin which he had used as an injection site. The doctor prescribed an antibiotic and recorded that, should the man's condition deteriorate, it should be reported to senior healthcare staff. The man received his first dose of antibiotic at 8.00pm that evening. A nurse visited the man in his cell at 6.00am the following day, his temperature was near to normal and he seemed much better.

At 8.10am on 7 May, the man's cell mate approached a member of the wing staff and told them the man needed medical help. Staff visited him in his cell and saw that he looked pale and was sweating in bed. A member of the healthcare staff was alerted and shortly afterwards a healthcare manager went to the man's cell. The manager examined him and saw blood on his bottom bed sheet. She immediately asked for an emergency ambulance to be called and for oxygen and medical equipment to be brought to the cell.

The healthcare manager stayed with the man, who was alert though in pain. The paramedics examined the man and, whilst moving him for transfer to hospital, he stopped breathing. He was placed on the floor of the cell and cardiac pulmonary resuscitation (CPR) was started. The man was taken to hospital at 9.30am escorted by two officers but without restraints. Despite attempts by hospital staff, the man was confirmed dead at 10.30am.

I make four recommendations in relation to healthcare issues and note the professionalism of wing and healthcare staff in attending to the man on the day of his death.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by my colleague on 19 May 2009, when she visited Liverpool. She was met by a senior officer and visited H wing, where the man was located. My colleague reviewed the man's prison and medical file and was given copies of documents from those files. Later, she informally spoke to a principal officer, the healthcare manager and a cell mate of the man.
2. Notices of the investigation and the Ombudsman's terms of reference had been sent to Liverpool in advance of my colleague's visit. She met briefly with the Chair of the Independent Monitoring Board. (The IMB monitors the day to day regime of the prison and ensures that proper standards of decency and care are maintained.) The Prison Officer's Association did not ask to see my colleague. Liverpool has previous experience of the procedures for a death in custody investigation. Members of staff and prisoners did not respond to the notices.
3. A review of the man's healthcare was commissioned by Liverpool PCT which was undertaken by an independent doctor. The review was commissioned by the PCT on 18 June 2009, but was not received until the 9 March 2010. The doctor undertook a thorough examination of the healthcare interventions, including a review of the circumstances around the aneurysm, which was noted to be the cause of the man's death. A consultant in vascular surgery reviewed the man's medical notes to offer an opinion of his care and whether the aneurysm could have been identified at an earlier stage. The doctor also met nursing staff at Liverpool to clarify healthcare issues. I acknowledge the comprehensive and detailed clinical review but, its attention to detail delayed the completion of this report.
4. His Majesty's Coroner for Liverpool held the inquest into the man's death in October 2009 and, due to the delayed clinical review, my report was not available for him. A copy of this report will be sent to the coroner for his records.
5. One of my family liaison officers contacted the man's mother, as his chosen next of kin. She explained the purpose of the investigation and invited the man's family to ask any questions about the care he received at Liverpool. At the time of circulation of this draft report, the man's family had not raised any specific issues. In response to the draft report, the man's mother said she agreed with the Ombudsman's findings, however, requested further clarity about whether her son's death could have been prevented. This is addressed in paragraphs 62 – 64. I hope the findings of the report have helped the man's family better understand the events leading to his death.

HMP LIVERPOOL

6. HMP Liverpool was constructed in 1855 and replaced a much older prison situated in the centre of the city. There are eight wings, all of which have been refurbished and provided with integral sanitation. The prison serves the courts of the Merseyside area. Liverpool is the second largest prison in England and Wales judged by population, and has a very high throughput of prisoners.
7. H wing provides accommodation for prisoners receiving detoxification from drug abuse. A healthcare centre is located between several wings and nursing staff are based on this unit to provide medical services for prisoners from the nearby wings. Healthcare services are the responsibility of Liverpool Primary Care Trust.
8. Her Majesty's Chief Inspector for Prisons, carried out an unannounced inspection of Liverpool in 2007. She said of the healthcare service:

“Staffing levels were good and care was delivered by a highly motivated, committed and well trained team of health professionals. Staff were divided into teams to cover wing-based primary care, out-patients and in-patients. This provided a high level of continuity for prisoners on the wings and in the in-patient unit. Access to prison and professional training and clinical supervision was very good. All staff had completed annual training in resuscitation procedures. The prison provided clinical training modules for student nurses.”

9. An annual report by the Independent Monitoring Board (IMB) in 2008 gave an overall judgement of Liverpool's performance. An extract from that report said;

“The management, officers and staff provide generally a very high standard of professionalism in dealing with prisoners, in sometimes difficult circumstances given the infrastructure of a 'Victorian' prison that is in desperate need of capital investment. The Board has serious concerns with regard to bullying, drugs and mobile phones amongst inmates and whilst the Board has considerable admiration for the work undertaken by management, staff and officers in this area it is felt greater resource should be directed at this area to assist them in detecting the supply of drugs and mobile phones and assisting inmates overcome addictions. The Board has also concerns with the support services available to prisoners being released and the link with support agencies available outside prison to assist ex-offenders return to law-abiding lives and address re-offending. The Board acknowledges the work undertaken by management, officers and staff in improving Liverpool Prison's overall performance during 2007.”

10. There have been five previous deaths from natural causes in Liverpool since the Ombudsman's office started investigations in 2004. There are no similarities between the circumstances of the man's death and those previously.

KEY FINDINGS

11. The man was born in 1973 in Merseyside. He had misused drugs since his teenage years by smoking cannabis and injecting heroin. The man was a client of the community drug support agencies in Merseyside and taking methadone on a support programme. This was not his first time in prison.
12. In April 2009, he was sentenced to 28 days imprisonment for theft and was sent to Liverpool. The man's medical notes recorded his history of drug misuse, which included his daily maintenance prescription of methadone. He told the nurse he was using heroin on a daily basis, and drank two to three bottles of sherry per week.
13. The man told the nurse that he did not have any medical problems, although he had recently asked his doctor for a sick note. (There was no mention as to why he would have needed a sick note.) It was further written that two years previously he was seen by a psychiatric nurse for schizophrenia and prescribed Olanzapine (an anti psychotic medication). However he said he had stopped taking the medication as it made him feel drowsy. A sample of his urine was tested for drugs and proved positive for Benzodiazepine (tranquilizer), opiates and methadone.
14. At 8.25pm, the man was assessed by a nurse from the drug dependency unit, who noted his methadone prescription. The man told her that he smoked three bags of heroin daily and injected drugs into his right groin. He told the nurse he had previously had an abscess in his groin but the area had healed. The man had also been prescribed Diazepam (an anti depressant) on a daily basis, which he took in addition to non-prescribed Diazepam. He also told the nurse that he had drunk a quarter bottle of sherry that morning. The nurse prescribed Zimovane (a relaxant), and arranged an appointment for him with the doctor the following day.
15. The next day, a nurse wrote in the man's medical notes that she had telephoned his community drug support worker and confirmed his methadone prescription. Later, the man's medical record noted that a doctor had prescribed his drug maintenance programme of methadone and Diazepam. His prescription of Zimovane was stopped in favour of Diazepam.
16. On 2 May, a nurse wrote that whilst receiving his daily methadone medication, the man complained of pain in his right groin. The nurse prescribed three ibuprofen tablets to be taken with meals for his pain. (It was not noted in the man's medical record whether the nurse examined his leg.) The following day, a nurse noted that the man had taken his ibuprofen inappropriately the previous day. His medication would be given to him at the medication hatch rather than held in his own possession.

17. The man was seen by a doctor on 5 May at 11.10am. The doctor wrote that the man had pain, was flushed, had a fast heart rate and mottled hands. Furthermore, there was swelling in his right groin a site that the man used for injecting drugs. He had a temperature of 37 degrees (36.5 is a normal reading), blood pressure reading of 111/64 (normal reading is 130/80) and a pulse rate of 110 beats per minute (normal reading is 60 to 100 beats per minute). The doctor prescribed an antibiotic (to treat the infection) and pain relief, noting that there was no evidence of blood poisoning. However, the doctor wrote that, if the infection worsened, then it should be reported to senior healthcare staff.
18. Later that day, a nurse, wrote that she had advised the man to inform staff if the pain from his infection deteriorated. The nurse gave the man more pain relief medication and told him his antibiotic would be ordered from the pharmacy.
19. At 8.00pm, a nurse saw the man in his cell. The nurse noted his pulse rate of 100 and temperature of 38.8. He appeared to be unwell and complained of nausea. The nurse gave paracetamol for pain relief and Metoclopramide, for nausea, in addition to the antibiotic and Diazepam. A few hours later, the nurse returned to see the man, who was feeling more comfortable although his temperature was still higher than normal.
20. The nurse saw the man at 6.00am, and wrote that his temperature was 36.2 and he appeared to be much improved. At 3.55pm the man was visited in his cell by a psychiatric nurse. The nurse noted that the man had his legs elevated due to an infection in his groin. The man told the nurse that he was going to live with his brother on release. No mental health issues were noted.
21. The man saw a nurse at 5.02pm. The nurse wrote that he was feeling better than the previous night, although the infection in his groin had leaked slightly. The nurse noted that he would be reviewed the next day.
22. On 7 May about 8.10am, a senior officer (SO) was approached by the man's cell mate. The cell mate told the SO that the man was unwell and unable to go to the medical hatch for his medication. The SO and an officer went to see the man in his cell. They saw him lying on his bed, with a duvet covering his body. He looked pale and there were beads of sweat on his face.
23. The man told the officers that he could not move and needed medical attention. The SO went to the treatment hatch on H wing and spoke to a nurse, who was dispensing medication. The nurse advised the SO to seek help from the centre surgery whilst she telephoned for Hotel 1 (the call sign for medical assistance) to go to the man's cell. As the SO

arrived at the centre surgery, he was told that the healthcare manager was already on her way and the SO returned to the man's cell. The nurse made the decision to stop treatments and also went to the man's cell.

24. The healthcare manager arrived at the man's cell and he told her that his abscess had bled and he had an infection. The manager looked under the duvet and saw blood in his groin. The nurse arrived with the 'red bag' which contains equipment to deal with bleeding. The manager examined the man's groin. She saw an open abscess which might have bled, but was not bleeding now. The man looked pale and clammy, his blood pressure was 120/75 and his pulse rate was 57 beats per minute. However, he was alert and orientated.
25. The man said that he had been treated for an infected abscess, and that when he had first woken up there had been no sign of blood. The healthcare manager decided to try and move the man from his bed to an area where a doctor could examine him.
26. The healthcare manager and the nurse started cutting off the man's tracksuit leggings for a further examination and saw that he was lying in a large amount of blood. The manager immediately asked the officer, who was outside the cell, to call for an emergency ambulance. A second nurse arrived at the cell and the manager asked her to fetch the 'green bag' (which contains oxygen) and ensure the ambulance had been called for. This nurse brought in the green bag and a nurse administered the oxygen.
27. The healthcare manager saw that two abscesses in the man's groin were not bleeding and his stomach was soft to touch. She concluded that the blood was from his rectum. The nurses and the manager stayed talking with the man until the paramedics arrived at 9.00am.
28. The paramedics gave the man a quick examination and a nurse assisted them by helping to put the man into an evac chair (a chair used by paramedics for transporting patients). As they were placing him into the chair, a paramedic saw the man had stopped breathing, and asked for more assistance to place him on the floor.
29. The nurse attached a defibrillator (a machine that monitors heart activity and can be used to assist re-start the heart) whilst the paramedics began cardiac pulmonary resuscitation (CPR). After a few minutes, the man was moved from the cell floor onto the landing, as there was more space to continue with the CPR. At 9.18am, another paramedic arrived to assist with the resuscitation.
30. At 9.30am, the man was again placed in an evac chair and transferred to the ambulance. He was taken to the Accident and Emergency Department at a hospital, with an escort of two officers. The man's death was confirmed shortly after arriving at the hospital at 10.03am.

31. The man's cell mate was taken to a side room on the landing and an officer sat with him. After the cell mate was told of the man's death, he was given the opportunity to speak to a Listener. (Listeners are prisoners trained by the Samaritans to offer confidential help and support to other prisoners in times of distress.)
32. After checking the details of the man's next of kin, a governor, a family liaison officer and a member of staff from chaplaincy, left the prison at 10.45am. They went to an address in Merseyside where they were told that the man's mother was at work and were advised to see her there. The prison staff then spoke to his mother at her work place.
33. The family liaison officer gave support to the man's family in days after his death and assistance towards funeral expenses were offered. Prayers were said for the man in the prison chapel.

ISSUES

Clinical care

34. A review of the man's clinical care was carried out by an independent doctor on behalf of Liverpool PCT. The doctor reviewed the man's medical notes, met with healthcare staff and asked a consultant in vascular surgery to comment on the diagnosis of the man's illness as taken from his medical notes. A full chronology of the events leading to the man's death is noted in the clinical review and the notes of meetings with staff are annexed to the clinical review.

In possession medication

35. On 2 May, the man was given three ibuprofen tablets for pain relief and advised to take them with his meals. However, the following day he told a nurse that he had taken all his pain relief at once. The nurse noted in his medical records that the man should not hold his own medication and should go to the treatment hatch and be observed taking it.
36. The clinical reviewer said:

“It would appear that there is a policy in relation to drugs in possession but this was not implemented in this case. It would be appropriate for the head of healthcare to review the implementation of the policy.”
37. Liverpool has a medication compact for prisoners. On his arrival at Liverpool the man signed this document by agreeing to abide by the guidelines as noted. One of those guidelines says, “Amounts of ‘Ad Hoc’ medication stipulated in the non prescription list must not be exceeded.”
38. The compact concluded that there may be disciplinary action for failing to comply to those guidelines. There is no record that any disciplinary action was taken when the man was given the three ibuprofen tablets and took them at once, rather than following the nurse's instructions.
39. The Offender Health Research Group recently published an evaluation of in possession medication procedures in England and Wales in August 2009. An extract from the summary of that research said:

“Historically, healthcare staff have been responsible for supervising and administering single doses of all but the most benign of medications. However, the drive for equivalence of care has led towards allowing in-possession medication to become the default position, rather than the exception. In-possession medication means that where possible, prisoners are given autonomy and responsibility for the storage and

administration of their medication, dependent on individual risk assessment.”

40. Taking into account the above findings, the prisons in possession medication policy should ensure that prisoners signing the medication compact guidelines are fully aware of the penalty if they do not adhere to the guidelines. Furthermore, the risk assessments for in possession medication must be completed.

I therefore endorse the recommendation by the clinical reviewer:

The head of healthcare should review the working of the policy relating to drugs in possession and take appropriate steps to improve the implementation of the policy.

The infection in the man's groin

41. A doctor examined the man's right groin on 5 May and diagnosed an infection. The doctor submitted a statement to the clinical reviewer as part of his clinical review. In that statement the doctor said:

“On examination he [the man] appeared unwell, flushed and in obvious pain. He had a mottled hand which I expressed concern about but he dismissed as usual. His inner thigh was very tender, with a patch of erythema [redness] and induration medial and distal [swelling] to his injection site. There were two scars, one complex one in the groin around the injection site, the other at the medial end of the area of tenderness in the upper thigh. There was no mass or lump palpable and no discharge from the injection site. He was tachycardic [fast heart rate] with a pulse of 110 but BP [blood pressure] 111/64 temperature 37 degrees centigrade and heart sounds and respiratory system without abnormality. I was more concerned about the possibility of deep sepsis [serious bacterial infection] or septicaemia, but he had no signs to suggest this had taken place at that point, and was really not that ill.”
42. Following the examination the doctor diagnosed an infection in the site of the injection area and there was no sign of septicaemia. The doctor prescribed pain relief and an antibiotic.
43. The man did not receive his first dose of antibiotic until 8.00pm that evening. There is no on-site pharmacy at Liverpool. Prescriptions are faxed to a pharmacist a few miles from the prison every day at 10.00am. Deliveries are made to the prison at around 3.00pm and given to prisoners at the evening medication time of around 5.30pm. However, the man did not receive his antibiotic until 8.00pm that day, when a nurse visited him in his cell to administer it.
44. The clinical reviewer commented:

“I take the view that in light of the man’s recorded condition he should have been given the antibiotic very shortly after he was prescribed this and further that this should have been made clear by the prescriber. It should be noted that even though there was a delay [in my view] in administering the first dose of medication, the man appeared to be recovering from the infection in that his temperature which rose after he had seen the doctor did fall and was within normal range at 6.02am on 6 May .“

I endorse the following recommendation.

The head of healthcare should ensure that there is a policy in place which ensures that the prescriber makes explicit the time scale within which a prescribed medication must be administered to a patient.

45. The clinical reviewer considered whether swabs or another method of medical analysis should have been taken to ascertain the exact nature of the infection. He noted that, when examined by the doctor, the man’s groin was intact. On 6 May, when he was seen by a nurse, the swelling was slightly leaking. The man was now taking an antibiotic and any swab taken at this time would not have been helpful.
46. A blood sample should have been taken on 5 May when the man was seen by the doctor and submitted for a microbiological examination. The clinical reviewer raises this issue to highlight a desired practice although there is no evidence that this was detrimental to the man’s care.

I endorse the recommendation made by the clinical reviewer:

The head of healthcare should ensure that relevant members of the healthcare staff give due consideration to whether clinical samples should be submitted for microbiological examination prior to a patient being prescribed an antibiotic.

Femoral artery aneurysm

47. The clinical reviewer asked a consultant of vascular surgery to review the man’s medical record and a summary of events provided by him.
48. The consultant was uncertain whether the man’s groin was examined by the nurse on 2 or 3 May. However, he commented that it would have been appropriate to have done so. An examination at this time may have found the swelling and redness. This would be in keeping with the development of the abscess or an abscess and false aneurysm. (A false aneurysm is when blood leaks out of a small hole in the artery.)

49. I understand that the detection of a false aneurysm is particularly difficult to identify in people who inject into the groin and have had previous abscesses. An examination by healthcare staff would most likely have diagnosed the formation of an abscess or a haematoma (a collection of blood outside the blood vessels).
50. It was the consultant's opinion that the man was appropriately prescribed an antibiotic on 5 May. It would have been difficult to confirm a false aneurysm. The only way to have confirmed its presence would have been by a duplex ultrasound scan (a procedure that uses sound waves so see how blood is flowing through a blood vessel). To access a scan the man would have to be transferred to hospital.
51. Examination of the groin and the presence of swelling, redness and bruising could have easily been understood to be an abscess. Because of the man's discomfort in this area, which was associated with the infection, it was difficult to clinically assess the area.
52. The consultant concluded his findings by noting that an abscess would pulsate against the femoral artery making the diagnosis difficult to detect. The diagnosis of a groin abscess would be made by the majority of doctors. An aneurysm is difficult to diagnose and needs a high level of suspicion and a specialist scan to confirm its presence.
53. The clinical reviewer noted that an aneurysm of the femoral artery is a recognised and documented complication of drug users, who inject into their groin. Prisons tend to have a high population of intravenous drug users than in the community. Therefore the clinical reviewer commented;

“On this reasoning one would expect a healthcare worker in this setting to possess a higher index of suspicion. In light of this I have taken the view that with the appropriate degree of suspicion it is reasonable to assume that the aneurysm could have been diagnosed at an earlier stage. However, I also take the view that the fact it was not diagnosed at an earlier stage does not itself render the care offered to the man to be of an inadequate standard”.

I endorse the following recommendation made by the clinical reviewer:

I recommend that the Department of Health issues explicit and clear guidance that where a patient with a history of known and established intravenous drug misuse, complains of pain and swelling in the groin area, the diagnosis of an aneurysm must be considered even if the clinical diagnosis of an abscess is permissible. The guidance should also recommend the steps which should be taken to either rule out or establish the existence of an aneurysm.

54. The clinical reviewer completed his review with an overview of the man's medical care. The man had two health problems, each the result of intravenous drug use. The doctor noted that, whilst there are some minor critical observations on the management of the man's abscess, he thought it was treated in an appropriate manner.
55. The aneurysm might have been detected an earlier stage and treatment considered. However, the consultant in vascular surgery said it would have needed a higher degree of suspicion.
56. The clinical reviewer commented:

“I take the view that the man's attendants [healthcare staff] appear to have taken a reasonable view that they had a satisfactory explanation for the man's symptoms and had instituted appropriate therapy. Further as he appeared to be getting better the attendants probably, not unreasonably, took the view that the adopted explanation was likely to be the correct explanation and hence there was no need to consider the merit/s of an alternative explanation.”
57. The review concluded that whilst the man's death was technically preventable, it was not avoidable when he presented his current condition to a primary care team in a prison setting.

Response on the morning of 7 May

58. The man's cell mate went to a senior officer (SO) on the wing and told him that the man was unwell in bed. The SO and an officer went to his cell. They saw that the man was pale and sweating, so the SO then went to the medication hatch to tell a nurse that the man needed medical attention. He was advised to go to the centre surgery and ask for an emergency call should be made for assistance. On arrival at the surgery, the SO was told that the healthcare manager was already on her way.
59. The manager examined the man and saw an amount of blood on the bed sheet. She immediately asked for an emergency ambulance to be summoned and oxygen. The man was given oxygen whilst his condition was monitored by the manager and the nurse.
60. The paramedics arrived and following a brief examination began to move the man into an evac chair to take him to the ambulance. During this procedure he appeared to stop breathing and he was placed onto the floor and CPR was commenced. The man was later taken to hospital.

61. I note the good practice and response of both wing and healthcare staff to the man's deteriorating health and the professional manner in which they carried out their duties.

Family response to draft report

62. The man's mother responded to the draft report with the question of whether her son's death could have been prevented. As noted in paragraphs 55 and 56, the clinical reviewer commented that the man was appropriately treated for his presenting symptoms. The vascular surgeon had previously observed that a greater suspicion would have to be present to indicate an aneurysm.
63. Medical opinion noted in the clinical review concluded by saying,
- "That whilst the man's death was technically preventable, it was not avoidable when he presented his current condition to a primary care team in a prison setting."
- I am therefore unable to offer any other opinion other than that of the clinical reviewer.
64. The man's mother also told my family liaison officer that she was in agreement with the findings of the report. She hoped the national recommendation will result in earlier diagnosis and treatment of potentially life-threatening aneurysms.

CONCLUSION

65. The man had a long history of intravenous drug misuse which resulted in an abscess in his groin area. On his reception into Liverpool healthcare staff correctly identified his drug misuse and prescribed methadone to assist his withdrawal symptoms. Further medication was given to aid his comfort during this difficult time.
66. The clinical reviewer makes observations that in possession medication, prescribing and further medical tests, to establish the exact nature of his abscess, could have been more suitably managed. Furthermore, the clinical reviewer comments that guidance on clinical diagnosis where intravenous drug users present with an infection, an aneurysm should be considered.
67. I judge the care the man received to be appropriate, given his history of drug misuse, previous abscesses in the groin area and his presentation when examination by healthcare staff.
68. Both wing staff and healthcare staff responded to the emergency in a professional manner which I regard as good practice.

RECOMMENDATIONS

For the Head of Healthcare and Prison Health Partnership Board

1. The head of healthcare should review the working of the policy relating to drugs in possession and take appropriate steps to improve the implementation of the policy.

Accepted – “Policy will be reviewed and will be presented to HMP Liverpool Clinical Governance Committee for scrutiny and endorsement. An audit tool for implementation of the policy will be developed.”

2. The head of healthcare should ensure that there is a policy in place which ensures that the prescriber makes explicit the time scale within which a prescribed medication must be administered to a patient.

Accepted – “Policy will be developed and will be presented to HMP Healthcare Medicines Group for scrutiny and endorsement. An audit tool for implementation of the policy will be developed.”

3. The head of healthcare should ensure that relevant members of the healthcare staff give due consideration to whether clinical samples should be submitted for microbiological examination prior to a patient being prescribed an antibiotic.

Accepted – “Policy will be developed and will be presented to HMP Healthcare Medicines Group for scrutiny and endorsement. An audit tool for implementation of the policy will be developed.”

The Chief Executive of Liverpool Primary Care Trust and the Department of Health

I recommend that the Department of Health issues explicit and clear guidance that where a patient with a history of known and established intravenous drug misuse, complains of pain and swelling in the groin area, the diagnosis of an aneurysm must be considered even if the clinical diagnosis of an abscess is permissible. The guidance should also recommend the steps which should be taken to either rule out or establish the existence of an aneurysm.

Accepted – “Locally this will be taken forward by the area office medical director for further discussion with the PCT. A form of guidance will be determined and produced for the benefit of all clinical staff when agreement has been reached on how this will best be achieved.”