Investigation into the circumstances surrounding the death of a man at a local Hospital, in June 2009, while a prisoner at HMP Liverpool

Report by the Prisons and Probation Ombudsman for England and Wales

May 2010

This is the report of an investigation into the circumstances of the death of a man on 15 June 2009.

The man had been remanded into custody at HMP Liverpool in April 2009. A drug and alcohol misuser, he had been diagnosed with a serious liver condition prior to his imprisonment and was subsequently admitted to hospital as a result of his condition. He died from advanced liver disease at a local Hospital. I would like to offer my sincere condolences to his family, friends and to all those who knew and loved him. I regret the delay in issuing my report and any additional distress this may have caused.

One of my investigators conducted the investigation. An independent review into the man's care was undertaken by a clinical reviewer, from the local Primary Care Trust. I am grateful to him for his valuable contribution.

I also wish to thank the Governor of Liverpool for the help and assistance of his staff, particularly the liaison officer's for my investigator during the investigation.

The investigation finds that prison staff provided a good standard of care while the man was resident at the prison and he was transferred appropriately to an outside hospital when his condition worsened. I make one recommendation, relating to the procedure for obtaining medical notes from doctors and other agencies in the community, which the prison has accepted.

Jane Webb
Deputy Prisons and Probation Ombudsman **May 2010**

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SUMMARY

The man who died was arrested by Police on 2 April 2009 and charged with a number of offences. On 9 April, he appeared before the magistrates who remanded him into custody at HMP Liverpool until 15 July.

The man had a long history of alcohol and drugs misuse. Following his remand into custody, he volunteered to escort staff in the court cells the extent of his misuse as well as his liver problem and prescribed daily medication. This was recorded in readiness for his transfer to the prison in order to alert prison staff to his needs.

When he arrived at Liverpool prison, medical staff assessed the man and referred him to the prison doctor. Arrangements were also made to obtain information from his community doctor. It was established that he was positive for hepatitis B and C and was under the supervision of a local liver clinic.

On 16 April, he transferred from the wing to the healthcare centre because staff had become concerned that he was drowsy and jaundiced. His health fluctuated and, on 14 May, medical staff considered him fit to return to the main prison. Healthcare staff continued to review him every day on the wing and, on 26 May, he was examined by a doctor who found that he had deteriorated in that he was slow to respond to orders, jaundiced and had hand tremors. Later that evening, he was taken to a local Hospital by ambulance.

Hospital staff initially raised concerns with the prison that the man's symptoms might have been due to an overdose of an illicit substance earlier that day. However, there is no evidence to support this. Healthcare staff remained in contact with the Hospital about his condition and, on 5 June, he was moved to the intensive care ward.

The man's family visited him regularly in hospital. On 27 May, his partner and a woman claiming to be his sister visited him after seeking approval from the duty governor. It transpired that his supposed sister was an imposter and not related to him. The prison therefore issued instructions to staff to strengthen the identity checks on visitors.

A consultant reviewed the man on 4 June and, on the basis of this and an ultrasound scan, medical staff considered discharging him. However, his condition deteriorated the next day and he was admitted to the intensive care unit. He deteriorated further on 14 June. At 10.10am the following day, hospital staff placed him on the Liverpool Care Pathway for the dying, a planned care approach to managing the last hours of patients' lives. He died at 10.55am. Members of his family were at his side.

I endorse a recommendation by the clinical reviewer relating to the policy on obtaining medical notes from patients' community doctors.

THE INVESTIGATION PROCESS

1. I was notified of the man's death on 16 June 2009. Terms of Reference and notices were issued to staff and prisoners at HMP Liverpool telling them that an investigation would be taking place and inviting those who wished to see the investigator to make themselves known. My investigator asked for copies of the man's full prison records including medical records, wing sheets, security information, hospital bed watch logs and the family liaison log. (A bed watch log is a history, recorded by escort officers, of time and events while a prisoner is an inpatient at hospital outside the prison.)

2. My investigator also contacted HM Coroner's office in Liverpool to advise him of the nature and scope of the investigation and to ask for a copy of the post mortem report. The inquest was held at Liverpool on 16 June 2009, the day after the man's death and recorded a verdict of "died of natural causes". The Governor told my investigator that the man's mother, partner and daughter were present at the inquest. A copy of my report will be sent to the Coroner for his records.

3. My investigator visited Liverpool prison on 19 and 23 June. The Governor and a member of staff from Safer Custody were appointed as his liaison officers. An independent clinical review of the man's healthcare was carried out by a clinical reviewer from the local Primary Care Trust (PCT) and his report is attached as an annex.

4. One of the Ombudsman's family liaison officers contacted the man's partner and mother to explain the purpose of the investigation and to provide them with an opportunity to ask questions or raise any issues they would like addressed as part of my investigation.

5. His mother asked the Ombudsman's family liaison officer to clarify two points. She wanted to know whether or not anyone had been hurt in the commission of the man's offences and also how his health was managed by the prison given that he had been ill prior to his remand in custody. My investigator contacted the arresting police officer of Merseyside Police on 21 July, who confirmed that no members of the public had been harmed by the man. This report explains in detail the treatment he received at Liverpool.

6. The man's partner asked for enquiries to be made as to why the prison did not inform her of his death immediately. This point is also addressed in my report. The man's partner also raised concerns about the way she was treated by staff at the local hospital. My family liaison officer explained this matter was outside the remit of my investigation and provided her with information about NHS complaint procedures.

HMP LIVERPOOL

7. HMP Liverpool was built in 1855 and is one of the largest prisons in the country, holding up to 1359 prisoners. Liverpool is a category B prison that holds both convicted and unconvicted men aged 21 and over. (On arrival into prison, prisoners are risk assessed and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with Category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult.) In the most recent Ministry of Justice quarterly ratings for prison performance, Liverpool prison has been assessed as good.

8. The prison has a healthcare centre, constructed in 2007, which is run by North Liverpool PCT. It has 28 beds and is able to manage high dependency patients. The man who died spent five weeks as an inpatient in the healthcare centre.

Independent Monitoring Board

9. All prisons in England and Wales have an Independent Monitoring Board (IMB). The IMB is made up of local people who volunteer to visit the prison and deal with a range of issues, including prisoner complaints, commenting on the prison regime, the standard of healthcare and issues that affect security. IMB members have full access to the prison and prisoners. Each IMB is required to publish an annual report.

10. The IMB at Liverpool published their last report in 2008. They commented that there were excellent facilities within the healthcare department and also a high standard of professionalism was shown by prison staff of all grades.

HM Chief Inspector of Prisons

11. The prison is also subject to inspection by HM Inspectorate of prisons. Following the last inspection in 2009, HM Chief Inspector of Prisons described Liverpool as having improved since the previous inspection in 2003 but that the prison still faced considerable challenges.

12. The healthcare wing is staffed with a large team of nursing staff, support staff and three full time doctors. HM Chief Inspector of Prisons commented that the healthcare wing is well staffed, has a very good staff skills mix and staff supervision and training are well organised. Inpatient facilities and care are described as good, which is relevant to the man's care. Prisoners interviewed during the inspection were generally positive about healthcare services. HM Chief Inspector of Prisons concluded that health services and the quality of care were good and the prison healthcare team was well qualified, enthusiastic and well led. She also found that there were good relationships with the local Primary Care Trust.

13. There have been a number of deaths at Liverpool since 2004, when the Ombudsman was given responsibility for the investigation of deaths in prison. A recommendation similar to the one in this report has been made previously.

KEY FINDINGS

14. The man who died was arrested by police on 2 April, charged with a number of serious offences and released on bail. On 9 April, he appeared at a Magistrates' Court and was remanded into custody at HMP Liverpool until 15 July. This was not his first time in Liverpool prison.

15. A Prisoner Escort Record (PER) document was started by custody staff at the court. (The PER is a record of the time the man spent in the court cells, as well as a record of his transfer between the police station, court and prison.) The PER was opened by a prison custody officer an employee of GSL which provide prisoner escort services. The prison custody officer ticked the boxes that highlighted the man's medical problems as well as the box that highlighted his drug and alcohol problems. The man had advanced alcoholic liver disease as well as hepatitis B, a viral disease affecting the liver. He was also undergoing tests for hepatitis C, a more serious strain of the hepatitis virus. The prison custody officer also wrote in the box headed 'Further Information About Risk' that the man had "poor liver function- medication required, daily heroin dependant-methadone script".

16. When the man arrived at the prison later the same day, reception staff recorded on his Prison Personal Record (PPR) that he was "withdrawing from drugs otherwise no concerns". Other information from this record confirmed that he expected to be remanded into custody and his family were aware he was in prison. The PPR also shows that he had been in Liverpool prison before.

17. On reception into prison, all prisoners are interviewed specifically about the risk that they may pose to themselves or others and this includes questions about drug and alcohol problems. Information from this interview is recorded on a document called the Cell Sharing Risk Assessment form (CSRA). (This form is used to assess the risk a prisoner poses to a cellmate if they are required to share a cell.) The man's CSRA shows that he volunteered information to prison staff about his drug use in the community, specifically that he was using heroin, methadone, diazepam and crack cocaine every day.

18. A Nurse recorded details about the man's general health in his medical record. In particular, she noted that he "appears unwell, underweight and jaundiced". The Nurse also recorded that he was receiving medication, had liver problems, used drugs but was calm and rational. She assessed him as being fit for normal prison location, work and any cell occupancy. She also referred him to the doctor regarding his drug use.

19. At 6.00pm on the same evening, the man was reviewed by a Doctor who recorded that he was hepatitis B and C positive (an infectious disease affecting the liver). The Doctor wrote in the medical record that his appearance indicated cirrhosis but he was stable at that time. He did not drink alcohol but used heroin, crack cocaine and methadone. He added that the man had a history of depression but, his mood was normal and he had no suicidal thoughts.

20. Medical staff also obtained the man's permission to approach his general practitioner (GP) for details of any existing medication and details of treatment for cirrhosis of the liver. The request was faxed to his GP. The doctor's health plan was to continue with the medication he was receiving in the community, once the prescription had been confirmed with the man's GP. He was referred for drug detoxification and hospital medical appointments were to be followed up.

21. At 8.00pm that evening, a nurse from the drug dependency team assessed the man. The nurse confirmed details of his prescriptions from his GP. The prison healthcare team prescribed medications that would not affect his liver whilst treatment was being arranged. She noted that, despite his claim that he was receiving diazepam, this was not confirmed in the fax from the surgery.

22. The man told the nurse form the drug dependency team that the last time he took methadone was on 7 April, which was supervised at his local pharmacy. He had also used heroin and crack cocaine that day. The nurse recorded that the man had slight withdrawal symptoms but did not complain of feeling too bad. She referred him to the reception doctor for symptomatic relief and zopiclone, a drug that aids sleeping. She wrote that he should be reviewed at the next available drug dependency clinic.

23. The man was next seen by medical staff on the morning of 13 April. A doctor examined him and ordered a number of tests regarding his liver function. As part of his management plan, the doctor specified that his blood pressure and weight were to be monitored and his medication continued. He also wrote that he should be kept under review and contact should be made with the hospital for more information and for an outpatient appointment.

24. Later on 13 April, a second medical consent form was faxed to the man's GP asking for the release of any relevant medical information. The following day the man's GP, faxed a full medical history to the prison covering the period September 2000 to April 2009.

25. Another doctor reviewed the man on 13 April. During this interview, he told the doctor about the level of his illegal drug use, 50 mls of prescribed methadone and 30 mgs of illegally obtained diazepam a day. He told the doctor that, for more than a year, he drank four cans of strong lager a day and the doctor considered that he had features of physical dependence such as tremors and jaundice.

26. The doctor reviewing the man asked about his mood and he responded that he was not depressed. He told the doctor that he was under the care of a gastroenterologist at the Royal Liverpool University Hospital. The doctor diagnosed opiate dependence, diazepam misuse and alcohol abuse. He advised that a Librium (the brand name of a drug used in the treatment of alcohol dependency) detoxification programme for alcohol should be started, as well as a methadone programme of 20 mls per day for the next two days, followed by 40 mls a day thereafter.

27. On 15 April, a nurse reviewed the man. During this appointment, he told the nurse that he did not want or need to undergo a Librium detoxification. He also

told her that he had not had alcohol for over a week. The nurse wrote that she saw no signs of alcohol withdrawal and that he reported no symptoms. She asked him to sign a disclaimer to decline Librium which he did and asked for zopiclone. The nurse advised the doctor of his request and the record shows zoplicone was prescribed and Librium discontinued.

16 to 30 April

28. The man attended the prison outpatients clinic on 16 April when an attempt to take a blood sample was unsuccessful due to "poor vein access". A further referral was made to the GP blood test clinic for 22 April to repeat the tests.

29. Later on 16 April, the man was reviewed by another nurse, who recorded that he was drowsy, jaundiced and had slurred speech. A further examination by a doctor later that day, found him to be unsteady, drowsy and looking unwell. Medical staff decided to move him to the healthcare centre. Healthcare staff reviewed his methadone prescription on the understanding that, if his condition showed further cause for concern, his methadone treatment would be reduced. They put in place daily reviews and obtained his consent to obtain more information from his community doctor.

30. The next day, another doctor assessed the man and consulted the previous doctors that had seen the man. The three doctors agreed that he needed an urgent review by a liver specialist.

31. On 20 April, a multi-disciplinary meeting was held to review the man and a psychiatric assessment was requested. (This is not unusual when dealing with drug users undergoing or about to complete detoxification from illicit drugs.) A decision was made to undertake this assessment once he had completed his detoxification. On the same day, an appointment was made for him to see a liver specialist at the Liverpool Royal Hospital on 19 June.

32. The man stabilised over the next few days and asked to return to a cell in the main prison. This request was reviewed by medical staff and refused as they considered his condition could deteriorate suddenly. There was also the danger of him being offered illicit substances on the wing. The man accepted this decision. Prison records show that he mixed well with other patients and staff during this period in the healthcare centre.

33. The man's condition began to deteriorate again on 22 April. He suffered a period of discomfort with symptoms of alcohol and drug withdrawal. He was given medication and his symptoms improved. The next day, he asked for his methadone prescription to be increased. He told staff he was struggling to sleep, had body pains and muscle cramps. The doctor prescribed zimovane, a drug that helps with sleep problems, and a sleep chart was started to monitor his response.

34. Over the next few days, the man continued to report difficulty managing his drug withdrawal and was given treatment for leg and stomach cramps. On 27 April, a doctor wrote in his notes that there was no reason for him to remain in the

healthcare centre and he could return to the main prison if the drug dependency team agreed.

35. The man remained in the healthcare centre while the drug dependency team considered his location and, on 29 April, a lengthy entry on his medical record confirmed that he had liver, biliary (bile duct), pancreas and gastrointestinal disease. Medical staff explained to the man the full extent of his medical condition and the limited treatment options.

1 to 26 May

36. Healthcare staff continued to monitor him and entries in his medical record show that he cooperated with his treatment plan and continued to interact well with other patients and staff. On 3 May, staff recorded that he was brighter and had followed their dietary advice, took his medication, as well as exercise and association (when prisoners are out of their cells to make telephone calls, take part in other wing based activities and talk to each other).

37. The man went to the healthcare surgery unexpectedly on 5 May and asked for sleeping tablets and an antidepressant. A doctor refused his request, explaining the detrimental effect that the drugs would have on his liver. The man left the surgery very unhappy with the response to his request and told staff he would get what he wanted “anyway”.

38. The following afternoon, the man refused to take his medication, telling staff that he would only take it if he was given zimovane. Later that day, he repeated his intention not to take his medication. He then signed a medical disclaimer but agreed to reflect on his actions.

39. A doctor made an entry in the medical record on 8 May, advising that the man should be transferred to the main wing and reviewed regularly. A healthcare officer recorded on 11 May that he was now cooperating and taking his medication.

40. The man was discharged from the healthcare centre on 14 May and taken to H wing in the main prison. He continued to be seen every day on the wing by healthcare staff. This was at his request and was supported by prison officers who were concerned about him. He reported a number of symptoms such as vomiting, diarrhoea and chest pains.

41. A doctor examined the man on 26 May. Given the sudden deterioration in his symptoms, an urgent outpatient appointment was made at the Royal Liverpool Hospital with a consultant who knew him. The doctor also requested an urgent ultra sound scan and asked another doctor to examine the man to assess if he needed more urgent management. The first doctor suggested that the man might need to be admitted if he deteriorated, although it is not clear if she meant an outside hospital or the healthcare wing.

42. Later that day, the man appeared to be confused, drowsy and was very unsteady on his feet. An emergency ambulance was called and he was taken to a local

Hospital. Given the nature of the offences for which he had been charged, the man was handcuffed during the journey and while being treated at the hospital. The escort officers were told that, if his condition deteriorated, they could seek permission to remove the restraints.

26 May to 15 June

43. The man who died was diagnosed with severe deterioration of his existing liver condition. He was sedated and placed in the critical care unit. Managers at Liverpool prison authorised two prison officers to escort him to prison and remain with him at all times. This is known as a bed watch. The officers are required to complete a log of events, as well as recording contact with prison managers.

44. Prison healthcare staff remained in contact with the hospital. On admission, hospital staff initially believed the man was showing signs of an overdose from an illicit substance. However there is no evidence to support this.

45. The man's family were contacted and family members visited him regularly. He moved to the gastroenterology ward on 27 May and was described by medical staff as a lot more alert. That day, he was visited by his partner and a woman who identified herself as his sister, the visit having been approved by the duty governor. Family members told prison staff that the person who claimed to be his sister was an imposter and not related to him.

46. On 4 June, the man was reviewed by a consultant and ultrasound scans were undertaken which showed no unexpected abnormality. As a result of the scan, consideration was given to discharging him from hospital.

47. However, the man's condition deteriorated overnight and he was admitted to the intensive care unit on 5 June. His condition remained unchanged and on 14 June, he further deteriorated. At 10.10am on 15 June, he was placed on the Liverpool Care Pathway for the dying, a planned care approach to managing the last hours of patients' lives. He died at 10.55am with members of his family at his side.

48. The bed watch log for the day he died shows an entry by an officer whose name is illegible. The entry indicates that attempts were made by the hospital and the prison to contact his partner, however they only had an address and no telephone number. As a result, the police were asked to contact his partner.

49. The official cause of the man's death is chronic liver disease, and spontaneous bacterial peritonitis (the peritoneum is a membrane that lines the abdomen and supports the major organs such as the liver).

50. Liverpool prison appointed a family liaison officer. The man's mother expressed her appreciation for the help given by the prison. Representatives from the prison attended the funeral and a contribution was made towards the costs.

ISSUES

Clinical care

51. The clinical reviewer from the local PCT, carried out a full clinical review of the medical treatment and care the man was given at Liverpool prison. He reviewed all necessary records and conducted interviews with the medical staff.

52. The clinical reviewer considered there was clear evidence that the man received appropriate levels of health screening on reception to Liverpool prison and that his alcohol and drugs issues were properly identified by healthcare staff. He also commented that the man received a high standard of care within the prison and had appropriate access to skilled healthcare professionals.

53. The clinical reviewer concluded that the man already had advanced liver disease when he was received into prison. His condition was managed in an appropriate manner and the staff who looked after him demonstrated a high degree of professional skill and dedication. He makes one recommendation to the head of healthcare and the PCT, which I endorse:

    The Head of Healthcare should agree with the PCT a clear policy to obtain notes from a patient's GP and other relevant sources.

Use of restraints

54. All prisoners who leave the prison to attend hospital for planned appointments or emergencies are assessed for any risks they may pose to either themselves or the public. The assessment includes consideration of the use of restraints such as handcuffs or escort chains, both on the way to the hospital and on admission. The risk assessment indicated that the man should be handcuffed for the journey to hospital and whilst in treatment. However, if his condition deteriorated the officers escorting him could ask permission to remove the restraints.

55. The man's restraints were removed on 5 June when he was taken for a Computed Tomography (CT) scan, which gives a more detailed image than an ordinary x-ray. He was very poorly at this time and he remained without restraints until 12.55am on 7 June when they were reapplied.

56. Prison managers gave permission for the restraints to be removed permanently on 9 June when it became clear that he was unlikely to recover. I am satisfied that the restraints were used appropriately and that they were removed at the earliest opportunity.

CONCLUSION

57. The man, who habitually misused drugs, was remanded into custody at a time when he was being treated in the community for advanced liver disease. His condition when he went into prison was very serious and, in the opinion of the clinical reviewer, his chances of recovery were poor.

58. The man moved to the healthcare wing at Liverpool when his condition required full-time medical care. I concur with the clinical reviewers view that healthcare staff demonstrated a high degree of professional skill and dedication in caring for the man.

59. I also judge that prison managers demonstrated a balanced approach regarding security and dignity by removing his restraints at a time when hospital staff had advised that he was very sick and unlikely to improve.

RECOMMENDATION

The head of healthcare should agree with the PCT a clear policy to obtain notes from a patient's GP and other relevant sources.

The prison response was:

Accepted. The head of healthcare confirms a policy is now in place and has been agreed within the clinical governance plans.

The family commented that the man appeared to be well cared for and staff had done their best for him.