

**Investigation into the circumstances surrounding the
death of a man
at HMP Liverpool in July 2010**

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

May 2011

This is a report into the death of a man at HMP Liverpool on 16 July 2010. He was 39 years old when he died. The post mortem showed that he died from a heart attack.

I offer my sincere condolences to the man's family and friends for their loss. One of my Family Liaison Team contacted the man's family to inform them about the investigation and offer them the opportunity to raise any issues about the care he received in custody.

The investigation was carried out on my behalf by my colleague. Both he and I would like to thank the Governor and his staff for their co-operation during the course of our enquiries.

I also thank the local Primary Care Trust for appointing a clinical reviewer to review the man's clinical care. As he died from natural causes, the findings of the clinical review play an essential part in my report. The reviewer judges that the standard of care he received was not equitable to that which he could have expected to receive in the community. I make three recommendations regarding the follow up of hospital appointments, continuity of care and appropriate level and grade of nursing cover.

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

Jane Webb
Acting Prisons and Probation Ombudsman

May 2011

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SUMMARY

1. The man was born in September 1970, and lived in the Birmingham area. He was single and had a close relationship with his family. He had a history of mental illness for which he was prescribed medication, and he had also used illicit drugs.
2. The man was remanded into custody at HMP Hewell for drug offences on 20 September 2008, and was given a four year sentence on 30 January 2009. He was transferred to four different prisons between 10 February 2009 and 18 May 2010. They were HMP Birmingham, HMP Featherstone, HMP Dovegate and HMP Ranby. During this period he continued to take his medication, which was regularly reviewed by prison doctors. He was also admitted to hospital in August 2009 and April 2010 and treated on each occasion for pancreatitis.
3. On 24 May 2010, he transferred to HMP Liverpool. He continued to take his prescribed medication, however on two separate occasions he refused to attend an appointment arranged with the prison doctor.
4. At 7.00am on 16 July, the man was found not breathing in his cell. Staff started cardio pulmonary resuscitation (CPR) and an emergency ambulance was called. The paramedics arrived and took over CPR but he was pronounced dead at 7.41am. The post mortem showed that he died of a heart attack.
5. The prison records showed that his next of kin lived in Birmingham. Due to the distance and time of day, the decision was taken by Liverpool to ask HMP Birmingham to notify the family of his death. His family were duly notified later that day by Birmingham staff. The prison family liaison officer from Liverpool also spoke to the family in the days that followed and offered support and financial assistance towards the funeral costs.
6. There are several issues arising out of this investigation. The clinical reviewer judges that the care the man received was not equitable with what he could have expected in the community. There are several shortcomings which should be addressed. Specifically the Primary Care Trust should review the level and expertise of the night time staffing levels at HMP Liverpool. I am also very concerned that HMP Featherstone did not follow up his hospital appointment after he was discharged from hospital.

THE INVESTIGATION PROCESS

7. The investigation was opened on 19 July 2010 when I appointed my colleague to investigate the man's death. Notices were issued announcing the investigation to staff and prisoners. No one came forward as a result.
8. The investigator visited HMP Liverpool on 22 July. During his visit he was also given copies of all documentation relating to the man. My investigator returned on 10 and 11 August and interviewed six members of staff and one prisoner.
9. The local Primary Care Trust asked a clinical reviewer to review the man's clinical care. The investigator and the clinical reviewer discussed aspects of treatment during his time in custody and jointly conducted interviews at Liverpool. I am grateful to the clinical reviewer for her involvement in this investigation and her timely report which is annexed to my report.
10. As part of the investigation the investigator also interviewed two staff at HMP Birmingham on 12 August, two staff at HMP Featherstone on 26 August and two staff at HMP Ranby on 9 September. The investigator contacted HMP Dovegate to obtain the relevant information and documentation and no interviews were conducted.
11. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report, which was eventually received on 9 February 2011. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.
12. A member of my Family Liaison Team contacted the man's family to inform them about the investigation and invite them to ask any questions or raise any concerns about the care he received in prison. The family liaison officer and investigator visited the family on 6 August and they raised the following concerns:
 - Was he alone at the time of his death?
 - What time were the paramedics called?
 - Whether his health and medical needs were met?
 - Why he transferred between so many different prisons?
 - Specifically the family wish to know why he was transferred from Birmingham as they lived locally and could easily visit him.
13. I hope that this report answers the family's questions and helps them to understand the treatment which the man received and the events leading to his death.

HMP LIVERPOOL

14. Liverpool is one of the country's largest prisons, with a maximum operational capacity of 1,439. It serves courts from the Merseyside area, and holds remanded, unsentenced and convicted adult male prisoners. There are seven residential wings, including those for drug support, vulnerable prisoners, detoxification, and resettlement. One of the wings holds people who are unsentenced or on remand, and it is here that prisoners spend their first night and complete an induction process to help familiarise them with the prison regime.
15. Healthcare services at Liverpool are provided by the local Primary Care Trust (PCT). A purpose-built hospital unit, which opened in 2007, allows healthcare staff to provide outpatient and inpatient facilities. A doctor is on duty every day during normal working hours, and nursing staff remain on duty throughout the night. The night nursing cover consists of two Band 5 Nurses and one healthcare assistant.
16. HM Chief Inspector of Prisons carried out an inspection of Liverpool in September 2009. The Chief Inspector found that the support for people at risk of suicide or self-harm was variable. The quality of education and employment was good, though access to these activities was a problem for some prisoners. Relationships between prisoners and staff however, were generally good.
17. The inspection report said of healthcare:

“The prison had good relationships with the primary care trust (PCT), with the governor and head of healthcare as members of the partnership board. The head of healthcare was a member of the prison senior management team, which provided support for the development of healthcare provision.

There was a comprehensive range of primary care services equivalent to that provided in the community. Prisoners received care in good conditions that maintained their privacy and dignity. They were escorted to their healthcare appointments by discipline staff, who continued to supervise those in the holding rooms. The environment was clean, with measures to manage the control of infection. The head of healthcare managed a large team of nursing and support staff in addition to three full-time GPs.”
18. Each prison has its own Independent Monitoring Board (IMB) made up of volunteers from the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated fairly. Each Board produces an annual report for the Secretary of State. The most recent report from the Liverpool IMB was produced 2009.
19. In their report the IMB specifically commented on the healthcare unit as follows:

“The opening of the purpose built facility in 2007 has proved to be a

considerable asset to HMP Liverpool. The Board considers the general care to be a high standard in excellent facilities.”

20. The man’s death is one of 24 to occur at Liverpool since April 2004, when my office began investigating all deaths in prison custody in England and Wales. Seven of the previous deaths were due to natural causes. There are no similarities between those and the death of the man.

HMP RANBY

21. HMP Ranby is an adult male training prison located on the outskirts of Ranby, Nottinghamshire. Holding sentenced category C prisoners, it is a large site, incorporating both new and old accommodation as well as workshops. 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. The prison also has a large plastics factory where prisoners are able to work various shifts making a variety of plastic items that are used across the wider prison estate.

22. Her Majesty’s Chief Inspector of Prisons undertook an announced inspection of Ranby from 12 – 16 March 2007. The report said the following regarding healthcare services:

“Healthcare provision at Ranby had developed well, and prisoners had good access to a wide range of clinical services. Highly qualified staff delivered a good standard of care and were committed to progressing the service, but many felt frustrated at the lack of support at a strategic level for health services. The department was extremely busy and nurses were employed on non-clinical duties. Wing-based treatments were in place, but the volume of prisoners who attended treatment rooms was, in some areas, overwhelming and prisoners were very demanding. The local Primary Care Trust directly commissioned GP and mental health services, and the prison had an overarching clinical governance framework with relevant policies. There was good access to GP clinics. The mental health service was slowly developing, although there was a lack of structured primary mental health systems and staff could only deliver primary mental health care when other pressures permitted. Pharmacy provision had improved since our last inspection, and there were excellent dental services, despite major faults in equipment.”

23. The most recent report from the Ranby IMB covers the period from 1 April 2008 – 31 March 2009. The Board commented positively on the progress in the education and skills facilities at the prison, and noted how many prisoners are able to gain qualifications to help their prospects once released. The Board also expressed concerns about the lack of 24-hour healthcare services at the prison and felt that this was unacceptable in a prison the size of Ranby, which is one of the largest Category C prisons in the country.

HMP FEATHERSTONE

24. HMP Featherstone is a category C closed training prison for adult men situated about six miles north of Wolverhampton. It holds a maximum of 679 prisoners. The prison was built in 1976 and adjoins HMP Brinsford Young Offenders Institution.
25. The local Primary Care Trust commissions the health services for prisoners at Featherstone. The healthcare department offers a wide range of primary care services, including health promotion and the management and treatment of long term and acute medical conditions. Featherstone has no inpatient facility and the health services are not available 24 hours. Badger Harmoni (an independent provider of primary care services) provides out-of-hours services on behalf of the NHS.
26. The NHS Trust provides specialist mental health care to the prison. The Mental Health In-Reach Team comprises community psychiatric nurses (CPNs) and a consultant psychiatrist. The CPNs work closely with the primary care nurses and doctors to assess prisoners with potential mental health problems.
27. Her Majesty's Chief Inspector of Prisons undertook an announced inspection of Featherstone from 20 – 24 October 2008. The report made the following comments:

“There was a GP surgery every morning and the GP was on call until 6.30pm. Out-of-hours medical cover was provided under contract by the local out-of-hours service, and included coming to the prison rather than just telephone advice.

“Prisoners were referred to mental health services from a variety of sources, including self-referral. After they were assessed by one of the two primary care RMNs [Registered Mental Nurse], a weekly meeting between the primary care and secondary care team decided the best course of action for them. This included referral to the chaplaincy, GP, primary care RMN support or mental health in-reach team.”
28. The most recent report from the Featherstone IMB covers the period from 1 November 2008 – 31 October 2009. The report makes the following comments:

“The healthcare department provides daytime cover although no in patient facilities are available. Prisoners who are ill are either transferred to prisons where in patient facilities are available, or to hospital, as appropriate.

“Two new prisoner Health Trainers now work in the department, providing advice about diet, smoking cessation, and health promotion. There are now medication rooms on the wings, and in-cell medication continues to be allowed where possible.

HMP BIRMINGHAM

29. HMP Birmingham is a large local prison serving the courts of Birmingham and much of the West Midlands. It holds up to 1,450 adult male prisoners, both on remand and sentenced. The prison has undergone significant improvement over the last few years, including the building of a new healthcare centre.
30. HM Chief Inspector of Prisons last conducted a full follow up unannounced inspection of the prison in December 2009. The Chief Inspector noted that, since the last full inspection in February 2007, “while some progress had been made, there was still a considerable amount to do to ensure a safe, decent and effective prison”. Relationships between staff and prisoners were found to be “a considerable weakness”.
31. Healthcare provision at the prison was found to be “mostly satisfactory”. It was largely delivered from a “modern, purpose-built unit” by three distinct groups of staff working in primary care, in-patient care and visiting specialists. Relationships between healthcare staff and prisoners were identified as good, particularly on the in-patient wards. All in-patients had a care plan and a named nurse and officer.
32. The last annual report by the Birmingham IMB covers the period July 2007 to June 2008. The Board noted that overcrowding within the entire prison system, and at Birmingham specifically, remained a concern. Healthcare provision was recognised as having gone through significant changes over the year. The Board highlighted that healthcare facilities at Birmingham were viewed as both a local and national resource and that, as a result, “more robust partnerships” were necessary. Overall, however, the Board was “impressed with the dedication and professionalism of the staff”.

KEY EVENTS

33. The man was born in September 1970 and lived in the Birmingham area. He was single and had a close relationship with his family. He had a history of mental illness and had also used illicit drugs. He received treatment from his community general practitioner. He had a history of previous convictions relating to drug and theft offences.
 34. The man was remanded into custody at HMP Hewell for drug offences on 20 September 2008, and was given a four year sentence on 30 January 2009. He was then transferred to HMP Ranby on 10 February. (His medical records for the period he was at Hewell were not included in the documentation given to the investigator.)
 35. On arrival at Ranby, the man saw Nurse A who carried out a routine initial healthscreen (a health assessment for all new arrivals into a prison). He told the nurse about his history of mental illness and that he had been prescribed:
 - olanzapine (treatment of schizophrenia and acute mixed or manic episodes associated with bipolar disorder)
 - quetiapine (used alone or in combination with other drugs to treat schizophrenia and bipolar disorder)
 - venlafaxine (anti-depressant).
- He also told the nurse that he smoked cigarettes and had used illicit drugs in the past.
36. The man was transferred to HMP Featherstone on 8 May and saw Nurse B who conducted a further initial health screen noting his medication. Prison Doctor A reviewed his medication four days later but made no changes. The next contact with healthcare staff was on 31 May when he saw Nurse C as he complained of toothache and the nurse prescribed ibuprofen (pain relief) for three days.
 37. On the morning of 26 June, the man complained of abdominal pain that had become worse over the previous two days. His blood pressure was recorded as 150/90. (The normal range for blood pressure is 100/70 to 140/90, although the pressure does vary throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) Prison Doctor A assessed that his symptoms indicated the possibility that he was passing a kidney stone and referred him to the emergency department at hospital for further tests.
 38. A risk assessment was completed that authorised a two officer escort and the use of an escort chain which was authorised to be removed for treatment purposes only. (On each occasion when a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escorting officers and

the type of restraint to be used, that is single cuffs or a two metre long escort chain with cuff at either end. It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed by a prison manager each day that the prisoner is in hospital and amended where necessary.)

39. The hospital made the diagnosis that he suffered from colic (intermittent abdominal pain) and he returned to the prison the same day. Three days later Prison Doctor B saw him and prescribed a seven day course of Buscopan (treatment of intestinal spasms). After a further ten days, he saw Nurse B as he complained of having diarrhoea. The nurse gave him advice on his diet and advised him to rest in his cell for three days.
40. Healthcare staff were called to see the man on 16 August by prison officers as he had collapsed. Nurse D noted that he had been found on the floor, lying on his side apparently unconscious however he was able to get up and sit in the chair in the cell. He told the nurse that he had pain in his stomach. The nurse recorded his blood pressure as 104/68 with a pulse of 98, gave him paracetamol and made an appointment for him to see the doctor the following morning.
41. The next morning Prison Doctor B saw the man who said that the pain in his stomach had become worse overnight. The doctor referred him to the emergency department at the hospital for further tests. A new risk assessment was completed that authorised a two officer escort and the use of escort chain authorised to be removed for treatment purposes only.
42. Following an assessment by hospital staff, he was admitted to hospital for treatment. Whilst he was in hospital, healthcare staff from Featherstone liaised with the hospital staff to check on his progress. Nurse E, from Featherstone, also visited him in hospital on two separate occasions. A hospital nurse told the nurse that the diagnosis was that the man had pancreatitis (infection of the pancreas) and pneumonia (inflammatory condition of the lung).
43. Prison records show that, whilst he was in hospital, the man attempted to obtain drugs and get them into the prison with the intent to supply them to other prisoners. For this matter he was charged by the police to appear at Magistrates Court at a later date.
44. The man was discharged from hospital back to prison on 30 August. There is no discharge letter found in his medical records from the hospital. The Healthcare Manager said at interview that discharge letters were received and scanned into the electronic medical record and did not know why there was no discharge letter for his period in hospital. The investigator has subsequently obtained a copy of the discharge letter from the hospital.
45. Prison Doctor B saw him two days later and recorded that he had been prescribed tramadol (for moderate to severe pain) on discharge from hospital with the diagnosis of acute pancreatitis. The doctor changed the prescription

of tramadol to tradorec (for moderate to severe pain) for a period of seven days.

46. A week later the doctor saw him again who said that he still experienced abdominal pain. The doctor prescribed a reduced dose of tradorec from 200mg to 100mg for a further seven days.
47. Between 17 September and 24 February 2010, the man saw the mental health team on seven occasions of which two appointments were with a consultant forensic psychiatrist. Changes were made to the levels of his existing medication with the addition of mirtazapine (anti-depressant). During the same period prison doctors reviewed his prescribed medication on four separate occasions.
48. He was transferred to HMP Dovegate on 24 February, as a short term measure, due to security concerns regarding his attempts to get illicit drugs into Featherstone and supply them to other prisoners. (His medical records for the period he was at Dovegate were not included in the documentation given to the investigator.)
49. The man was transferred to Ranby on 11 March, and a further healthscreen assessment was conducted by Nurse F. The nurse confirmed his current medication and referred him to the Mental Health Team.
50. Two weeks later he saw Nurse G as he complained of back pain. He described to the nurse that the pain radiated from the bottom of his back down to his toes on his right leg. The nurse advised him to keep moving his back and prescribed diclofenac (anti-inflammatory).
51. On 21 April, at approximately 1.45pm, officers found the man collapsed on the floor of his cell and immediately requested urgent medical assistance. Two nurses arrived at the cell within a minute and found him on the floor. He told the nurses that he had been on the toilet, felt in pain, become dizzy and passed out. He told the nurses that he had felt like this before he was admitted to hospital in August the previous year.
52. The nurses asked for an emergency ambulance to be called. His blood pressure was recorded as 95/62, which increased to 110/72 after a couple of minutes. Paramedics arrived and assessed that he needed to be admitted to hospital for further treatment and so he was taken to hospital. A risk assessment was completed that authorised a two officer escort and the use of escort chain which was only to be removed for treatment purposes.
53. The man was discharged from hospital back to Ranby on 28 April. There is no evidence in the medical records that healthcare staff from Ranby maintained contact with staff at the hospital to check on his progress. Prison Doctor C saw him, who said that the hospital wanted to operate on him but he refused. The doctor recorded that the discharge summary from the hospital confirmed the diagnosis of pancreatitis and that no pain relief had been prescribed. He

prescribed paracetamol and requested that blood tests were to be done the following week.

54. The medical records show that the man did not attend appointments arranged with a nurse for the blood samples to be taken on 4, 6 and 10 May. However he did see Prison Doctor D on 14 May who recorded that he still experienced pain in his abdomen but it was not significant. The doctor recorded blood pressure as 110/80, took the blood samples, prescribed further paracetamol, advised that he rested in his cell for two weeks and wished to review him the following week.
55. On 18 May, the man had a court appearance and was taken to the Magistrates Court. At interview a governor said that when a prisoner from Ranby has to attend court it is usual that they return to the same prison. He went on to explain that, if there was a distance involved, then the prisoner might be sent to a prison close to the court to stay and then return to Ranby as soon as practicable. He also said that it was healthcare's responsibility to notify any medical issues that would affect a prisoner's court appearance or transfer. The Healthcare Manager at Ranby said at interview that when a prisoner leaves the establishment for a court appearance a printout of their medical records and a seven day supply of any medication for the prisoner is sent with the security staff in case the prisoner does not return immediately to Ranby.
56. The man was given a three month custodial sentence that was to be concurrent with his existing sentence. Following his court appearance, he was taken to HMP Birmingham. On arrival he saw Nurse H at 7.36pm who conducted a healthscreen check. The nurse recorded that the man had prescribed medication and confirmed the details of his medical history from his medical records. The same evening Prison Doctor E confirmed his medication was to continue.
57. The following day Nurse I conducted a second healthscreen with the man. The nurse recorded that his blood pressure was 110/72, that he smoked 30 cigarettes a day, had been in hospital previously with pancreatic problems and was taking medication for mental health problems. The nurse assessed that he was fit to attend the gym and gave health education advice.
58. On 20 May, healthcare at Ranby received a letter from a consultant surgeon at the hospital, which was dated 12 May and had been dictated on 7 May. The letter said:

“The man was admitted recently with clinical features suggestive of pancreatitis. He responded to conservative management. The ultrasound scan during this admission did not show any gallstones.

“I am arranging for him to see me in my clinic in a few months time to assess his progress.”

This letter was scanned into the electronic medical records system by healthcare administration. There is no evidence to show that this letter had been seen by any medical professional at Ranby.

59. Four days later, the man was transferred from Birmingham to HMP Liverpool as the result of an overcrowding draft. At interview Senior Officer (SO) A explained that overcrowding drafts are controlled at a national level within the National Offender Management Service to minimise overcrowding in prisons by moving prisoners around the prison estate. The SO said that on the day when the man was transferred, Birmingham had been instructed to send ten prisoners to HMP Liverpool. He told the investigator that the criteria for prisoners to be put on the overcrowding draft would be those with short sentences and no outstanding medical appointments. He said that healthcare staff would advise her if a prisoner could not be transferred on medical grounds.
60. When the man arrived at Liverpool, he saw Nurse J who completed an initial healthscreen. The nurse recorded that he appeared fit and well, and was taking medication for mental health illness. He was seen that same afternoon by Prison Doctor F who authorised that his medication should continue and he was to be reviewed in two weeks time.
61. On 9 June, the man was due to have the review with a doctor. However Healthcare Assistant A recorded that he refused to see the doctor as he had to wait and so he was taken back to the wing. A further appointment for a review was arranged for 28 June but he did not attend this either. There was no further healthcare interventions with him until 16 July.
62. The investigator interviewed the man's cellmate to establish how the man had been during the day on 15 July. He said that the man was very friendly and easy to talk to. He said that the man had been in the cell for the previous four days but he had not told the cellmate that he felt unwell. The cellmate said that during the evening the man had what he believed were four sleeping tablets. He took three of the tablets and gave the cellmate the other one.

Events of 16 July

63. In the early hours of the morning the cellmate recalled that the man was awake and complaining about pain in his chest and arms. He told the investigator that the man pressed the cell bell and some officers came to see what the matter was.
64. At approximately 5.00am Officer A responded to the cell bell from the man's cell. The officer said at interview that he arrived at the cell door and looked through the observation flap to see what the problem was. The man asked the officer to get a doctor or a nurse as he was in pain. The officer recalled that he indicated that the pain was in his abdomen and chest area. He went to get medical assistance from the nurse who was on duty and also informed the officer in charge of the prison, SO B, that medical assistance had been requested. (Prisons go into patrol state during the night and nursing staff are

not permitted to have cell keys. This means that they can only enter a cell when officers are present.)

65. Within a couple of minutes Nurse K, along with SO B and Officer B, went into the cell which the man was sharing with his cellmate. The nurse recorded that he was sitting in his chair and appeared calm. He told the nurse that he had coughed up blood and he had no feeling in his left arm. He also said that he had been in hospital with pancreatitis. The nurse recorded his blood pressure as 128/74. The nurse also checked his pupils which appeared to be dilated and so he wondered whether he had taken an illicit drug. The nurse reassured him that that he would come back and review how he was after 30 minutes.
66. The nurse confirmed at interview that there are two nurses on duty during the night, one based in the healthcare department the other based in the main prison. During the early hours of 16 July, the nurse said that he was the nurse on duty to respond to request for medical assistance for the main prison population. He explained that, after seeing the man, he was called to see another prisoner elsewhere in the prison.
67. At approximately 5.50am, the nurse went back to check on the man. He saw him through the observation hatch, sitting reading and smoking a cigarette. The nurse asked how he was and he said that he had a pain in the side of his head. The nurse told him that he would check again in 30 minutes. He returned 30 minutes later and the man said that the pain was bad. The nurse gave him some paracetamol and advised him to see the doctor later that morning.
68. He returned to review him at 7.00am before handing over to the day staff. He was lying on the floor and the nurse called but got no response and then asked officers to open the cell straight away.
69. On going into the cell, the nurse found that he was not breathing and immediately called for an emergency ambulance, started cardio pulmonary resuscitation (CPR) and asked one of the officers to get the emergency bag with the first aid equipment. The emergency bag was brought into the cell and the nurse continued CPR and was quickly joined by Nurse L. The automated external defibrillator. (The defibrillator, or AED, is a portable electronic device that diagnoses rhythms after cardiac arrest and can deliver defibrillation (an automated electric shock). The AED was attached to him and it advised not to deliver any defibrillation. The nurses continued with the CPR as directed by the AED until the paramedics arrived at approximately 7.25am and took over. The paramedics continued to attempt to resuscitate him but they confirmed at 7.41am that he had died.
70. Later that morning a debrief was held with staff involved in the incident and support was made available. Particular consideration was given to the support and needs of the man's cellmate and his relocation to another cell.
71. Prison Service Order (PSO) 2710 'Follow-up to deaths in custody' recommends that the next of kin is told in person about a death in custody.

Due to the distance between Liverpool and the man's family's home, HMP Birmingham was asked to visit them. A family liaison officer and the Imam from Birmingham went to their home to break the news of his death. Following the initial contact made by staff from Birmingham, the prison family liaison officer from Liverpool maintained contact with the family. Liverpool appropriately followed the PSO, including offering financial assistance towards funeral expenses.

ISSUES

Clinical care

72. The clinical reviewer is not satisfied that the care the man received was equitable to that which he could have expected to receive in the community. The conclusion of the clinical review was that:

“The care received in custody by the man was not equitable with the care he would have expected to have received within the wider community.”

Communication between HMP Featherstone and NHS hospital

73. There are concerns about the man’s continuity of care and the clinical reviewer highlights issues following his discharge from hospital, having been treated for pancreatitis. The reviewer comments:

“The prison clinical records include an entry stating admission date, discharge date and that follow-up would be in six weeks. However there is no copy of that discharge letter in the clinical records. This document was received by the investigating team following a request as part of this investigation. The information on this letter is conflicting: it initially states no follow-up will be arranged and then later states that follow-up will be in six weeks.

“There is no record of a hospital follow-up appointment being arranged or attended. Following his discharge from hospital the man was seen by medical or nursing staff on four occasions complaining of abdominal discomfort or indigestion. There is no record of any hospital follow-up arrangements being checked.”

74. It is clear from the clinical records that no action was taken by healthcare staff at Featherstone to follow-up his discharge from hospital. Furthermore he was seen on four more occasions complaining of abdominal pain but no reference was made to the previous admission to hospital. He was at Featherstone for five months after being in hospital and I find it unacceptable that no follow-up action was taken. I therefore make the following recommendation:

The Head of Healthcare at HMP Featherstone should review the process for managing discharge of prisoners from hospital back to prison. This should include engaging with the PCT as commissioners, to ensure that prisoners with follow up appointments to see hospital specialists do so in the time that could reasonably be expected in the community.

Transfer of medical information between prisons

75. Prison Service Order (PSO) 3050, ‘Continuity of healthcare for prisoners’ contains the guidance for the continuity of healthcare received by prisoners,

which includes guidance on reception, transfer and discharge of prisoners. This PSO specifically states:

“Transfers between prisons are generally planned. The Health Standards for Prisoners performance standard states that the following must take place.

“Current healthcare needs are assessed and continuity of care ensured when prisoners are transferred between establishments, from establishments to outside NHS hospitals for inpatient care, or released into the community.

“Ensuring information on continuing care is conveyed to other establishments on transfer and to NHS hospitals for outpatient and in/outpatient appointments.

“Previously prisoners have been passed ‘fit’ for transfer. In future, local policies should ensure that there are systems in place to ensure appropriate and continuing care in any transfer or release.

“Ensuring continuity of care and effective communication with colleagues that this implies is essential to patient care and thus central to good practice.”

76. Prior to his court appearance on 18 May 2010, the man had been admitted to hospital with a second episode of pancreatitis. He was discharged back to HMP Ranby and a discharge letter stated that he was to have a follow-up appointment in a few months time.
77. After the court appearance, which was held in Walsall, he did not return as expected to Ranby. Instead he was taken to HMP Birmingham but he only stayed there for five days before being transferred to HMP Liverpool because of an overcrowding draft. The clinical records show that healthcare staff from Ranby contacted their colleagues at Liverpool to inform them of his outstanding mental health issues, but no mention was made of the pancreatitis episodes nor the proposed follow-up hospital appointment. The clinical reviewer makes the following comment:

“Follow-up appointments are usually arranged by hospitals after the patient has been discharged. Therefore the clinic appointment date and time may be sent to the patients address some weeks after discharge. If the patient has changed address then this appointment may be missed.”

78. Whilst I accept that prisoners are regularly transferred between prisons for a variety of reasons, there is an expectation that clinical records are swiftly and effectively transferred. Healthcare departments should speak to each other to ensure that there is continuity of care.

The Governor and Head of Healthcare at HMP Featherstone, HMP Ranby and HMP Birmingham, and the Director and Head of Healthcare at HMP

Dovegate should adhere to PSO 3050 “Continuity of healthcare for prisoners” so that prisoner’s clinical records on transfer from other establishments are fully appraised by healthcare staff for any family medical history, ongoing treatment or outstanding clinical requests.

Level and grade of nursing cover at HMP Liverpool

79. The clinical reviewer has considered the staffing levels and grade of nurses on duty at night at Liverpool and makes the following comments:

“At HMP Liverpool the night nursing cover consists of two Band 5 Nurses and one Health Care Assistant. Nurse K was the Band 5 Nurse on duty in the main prison. Nurse L was the Band 5 Nurse on duty in the in-patient wing along with a Health Care Assistant.

“Band 5 Nurses without clinical examination skills training are not qualified to perform clinical examinations and therefore may be unable to make appropriate clinical decisions

“Outside of the custodial system the man would reasonably have expected to have been fully assessed and examined by a clinician qualified in clinical examination skills.

“Arrangements should have been made for him to be assessed by a more senior clinician. This may have necessitated attendance at a hospital.”

80. Had his symptoms been appropriately assessed in the early morning of 16 July, it may have resulted in him being admitted to hospital and earlier intervention could have taken place. Whilst accepting that we cannot know whether an admission to hospital would have affected the outcome, I support the clinical reviewer’s findings and make the following recommendation:

The Primary Care Trust and Head of Healthcare at HMP Liverpool should urgently review the level and grade of nursing staff available on duty throughout the night, to ensure appropriate clinical assessment of symptoms is possible at all times.

Emergency response

81. I judge that the staff who responded to the man’s need for emergency assistance acted with great speed and professionalism. The clinical reviewer makes the following comment:

“When he was discovered collapsed and unresponsive, there was an immediate and appropriate response by Nurse K and Prison officers. Emergency equipment was immediately made available and cardiopulmonary resuscitation was commenced. Paramedics attending gained swift access to the prison and cell.”

82. I agree with the comments made by the clinical reviewer and recognise the actions taken by the staff at Liverpool in responding to the emergency situation.

Family liaison

83. I am pleased to note that Liverpool contacted HMP Birmingham to ask their family liaison officer to contact the man's next of kin. As Birmingham was closer to the family home, it meant that the news of his death was given face to face in a timely manner, by an appropriately trained member of Prison Service staff, accompanied by an appropriate faith representative. Liverpool followed the guidance set out in PSO 2710 'Follow up to deaths in custody', and I am pleased that Birmingham readily agreed.

CONCLUSION

84. I recognise the issues highlighted in the clinical review and accept the reviewer's judgement that the standard of care that the man received whilst he was in custody was not fully equitable to what he could have expected to receive in the community.
85. In particular, I am concerned that there was no follow up of a hospital appointment whilst he was at HMP Featherstone. Continuity of care suffered as information was not properly assessed at each of his subsequent transfers to other establishments. I appreciate that he was being treated for pancreatitis, which was not the cause of his death, but nevertheless I am concerned that his condition was not investigated properly.
86. More importantly, the clinical reviewer judges that the absence of appropriately trained nurses at night at HMP Liverpool meant that his symptoms could not be appropriately assessed, meaning that a chance of earlier intervention was missed. There is no way that I can know whether this would have saved his life, but nevertheless it is a serious concern that should be addressed.
87. Following his death Liverpool appropriately followed the guidance given in PSO 2710, "Follow up to death in custody". I am pleased that HMP Birmingham readily assisted to ensure that his family were properly informed and supported.

RECOMMENDATIONS

1. The Head of Healthcare at HMP Featherstone should review the process for managing discharge of prisoners from hospital back to prison. This should include engaging with the PCT as commissioners, to ensure that prisoners with follow up appointments to see hospital specialists do so in the time that could be reasonably expected in the community.

Accepted

2. I recommend that the Governor and Head of Healthcare at both HMP Featherstone, HMP Ranby and HMP Birmingham, and the Director and Head of Healthcare at HMP Dovegate should adhere to PSO 3050 "Continuity of healthcare for prisoners" so that prisoner's medical records on transfer from other establishments are fully appraised by healthcare staff for any family medical history, ongoing treatment or outstanding clinical requests.

*Accepted,- However In response HMP Ranby said that they:
"meet this recommendation through existing practice. The entries on system 1 show that on 20/5/10 the administrator at Ranby scanned a letter received from the clinic that the man attended before leaving the establishment. Although no telephone call is recorded it is normal practice for the administrator to contact the prison holding the prisoner to follow this up. The evidence of an appointment letter being generated by HMP Birmingham demonstrates that they were aware of this matter."*

3. The Head of Healthcare at HMP Liverpool should urgently review the level and grade of nursing staff available on duty throughout the night to ensure that appropriate clinical assessment of symptoms is available at all times.

Accepted - A full review of night staff has been undertaken by the Head of healthcare.