Investigation into the circumstances surrounding the death of a male prisoner from HMP Liverpool at the Aintree Hospital Liverpool on 6 December 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2005

This is the report of an investigation into the circumstances surrounding the death of a 68 year old male prisoner from HMP Liverpool on 6 December 2004. The prisoner had been admitted to Aintree Hospital the day before he died.

A post mortem examination carried out on 7 December concluded that the prisoner died of bronchopneumonia due to myelofibrosis.

The investigation was carried out on my behalf by my colleague. I also commissioned an independent clinical review of the management of the prisoner's healthcare needs whilst he was at Liverpool prison. This was carried out by a representative of the North Liverpool Primary Care Trust.

My thanks go to the Primary Care Trust for their kind assistance, and to the Governor and staff of Liverpool for their co-operation throughout the investigation.

This published version of the report does not include any of the original annexes, which were extensive.

Stephen Shaw CBE **September 2005**
Prisons and Probation Ombudsman

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1. Summary

The prisoner was born in September 1936 in Ellesmere Port. After leaving school at the age of 15 with no qualifications, he took on manual work. He was married for 13 years and had three children. After the failure of his marriage, the prisoner had no further contact with any of his children. He lived with his mother until she died in 1981. Thereafter he lived in various types of temporary accommodation. He lived a lonely life.

The prisoner accumulated a considerable list of criminal convictions dating as far back as 1952 and spent many years in prison. At the time of his death, he was serving an 18 month prison sentence for the breach of a sex offender order. He was due to be released from prison in March 2005.

The prisoner was first received at Liverpool prison on 17 June 2004. No comments of any significance were recorded in his medical record after his reception healthcare screen carried out that day. The prisoner was allocated to the prison's vulnerable prisoners wing.

By August 2004, the prisoner began to show signs of illness and was admitted initially to the healthcare centre with chest pains and low blood pressure. On three occasions, he was admitted to Aintree Hospital but subsequently returned to prison. On 5 December 2004, he was again admitted to Aintree Hospital, this time as an emergency. He died the following day. The prisoner was 68 years old.

A post mortem examination later revealed that the prisoner had died of bronchopneumonia.

This investigation found that the prisoner was appropriately cared for while in custody at Liverpool.

I endorse the recommendations made within the clinical review.

2. Investigation methodology

The investigation was opened on Monday 13 December 2004, when my investigator met with the Governor of HMP Liverpool, two members of the Independent Monitoring Board, and two members of the local branch of the Prison Officers' Association. The following day, notices were issued to staff and to prisoners announcing the investigation and inviting anyone who wished to contribute views or concerns to the investigation to make themselves known to my investigator. No prisoner or member of staff took up that invitation.

I also commissioned an independent clinical review of the management of the prisoner's healthcare needs whilst he was at Liverpool prison. This was carried out by a representative of the North Liverpool Primary Care Trust.

One of my Family Liaison Officers made contact with the prisoner's brother on 6 January 2005. He confirmed over the telephone that there were no issues he wanted the investigation to address.

3. The deceased

The prisoner was born in September 1936 in Ellesmere Port. He was the middle child in a family of five children. His father worked as a crane driver. The prisoner had considered that he got on well with his family.

The prisoner did very poorly at school where he frequently misbehaved. He left at the age of 15 with no qualifications. After leaving school he took on manual work. His longest period of sustained employment was as a refuse collector for 11 years.

The prisoner left home at the age of 21 in order to get married. The marriage lasted for 13 years and the couple had three children. After the failure of his marriage, the prisoner had no further contact with any of his children and he lived with his mother until she died in 1981. Thereafter, he lived what must have been a lonely life in various types of temporary accommodation.

The prisoner was first convicted in his mid-teens in 1952. He was repeatedly convicted thereafter and spent many years in prison.

At the time of his death, the prisoner was serving an 18 month prison sentence for the breach of a sex offender order. He was due to be released in March 2005.

4. HM Prison Liverpool

Liverpool is Category B male local prison serving the whole of the Merseyside area. With an operational capacity of 1,473, it is the largest prison in the country. There are eight wings and a healthcare centre.

The North Liverpool Primary Care Trust has commissioned healthcare services at Liverpool since April 2004.

The establishment was last visited by the Her Majesty's Chief Inspector of Prisons in September 2004, when she made an unannounced inspection of the establishment. Six recommendations were made about health care but none was relevant to this investigation.

5. Events prior to the prisoner's death

The prisoner was first remanded into custody at Liverpool prison on 17 June 2004. Upon his arrival at the prison that day, he underwent a reception health screen. Although a suicide warning form had been raised at court as the prisoner had previously attempted suicide, he was not judged to be at risk of suicide by reception staff at Liverpool.

During the health screen, the prisoner said that he had been receiving medication from his GP, but was not sure of the name of the medicine he had been prescribed. He said he had been treated for a bad stomach and chest problems. The prisoner added that he was a smoker and a social drinker. However, he did not have any concerns about his physical health. Neither was he concerned about his mental well being or about substance misuse.

As he had admitted that he had previously self harmed, the prisoner was seen by a doctor who recorded that his health was "fair" and that he was fit for normal location. The prisoner was initially allocated to K wing, a vulnerable prisoner unit.

On 19 July, the prisoner was sentenced to 18 months imprisonment. On his return to Liverpool prison from court, he underwent a further health screen. The prisoner did not express any concerns about the fact that he was now a sentenced prisoner.

On 31 July, the prisoner was seen by a prison doctor at the morning surgery when he complained that he had been experiencing difficulty in breathing during the preceding four weeks. The prisoner reported that he was generally feeling unwell and was coughing up phlegm. He told the doctor that in June 2004 he had been given a transfusion of six units of blood at Arrowe Park Hospital on the Wirral. The doctor noted that there was no history of asthma or known allergies.

The doctor prescribed the use of a salbutamol nebuliser and a becotide inhaler each for 28 days, and amoxycillin 500mg for seven days. The doctor diagnosed the prisoner as suffering from chronic obstructive pulmonary disease and an associated chest infection.

On 4 August, the prisoner's case was reviewed by another prison doctor, who noted that the prisoner was still short of breath. The prisoner said that the inhalers were ineffective. The doctor prescribed 7.5 mg zoplicone by night to be taken for two nights for insomnia and decided to locate the prisoner on the ground floor because of his chest problems.

At 11:45pm that night, healthcare staff were called to see the prisoner in his cell because of his shortness of breath. They advised that he should prop himself up in bed and that he should still use his inhalers. A note was made in the prisoner's prison medical record that he was to attend surgery the next morning. However, no further entries were made in his record until 26 August.

It is not clear, therefore, whether the prisoner was seen on the morning of 5 August.

On 26 August, the prisoner complained of chest pains. He was immediately admitted to Aintree Hospital in Liverpool. On 2 September, the prisoner's case was reviewed by the haematology team at the hospital. On the same day, he returned to HMP Liverpool. It was later noted that the prisoner had discharged himself. No note was made of this in the prisoner's prison medical record. Upon his arrival at the prison, he was returned to K Wing.

On 26 September, the prisoner again complained of chest pains. Healthcare staff examined him in his cell and, after taking his blood pressure, pulse and temperature, advised him to use his inhalers and to see the doctor the next day.

On 27 September, the prisoner was seen by a doctor in the healthcare centre. He explained that he was still experiencing shortness of breath and that, during the previous week, this had become worse at night. The doctor decided to ask Aintree Hospital to forward to him the discharge information in relation to the prisoner's stay between 26 August and 2 September.

On 30 September, the prisoner's case was reviewed by a doctor in the healthcare centre at Liverpool who arranged for his further admission to Aintree Hospital. Here, the prisoner was given a transfusion of two units of blood. He was returned to the prison on 6 October. Once again, no record of his discharge from hospital was made in his prison medical record.

On 28 October, the prisoner complained of pains in his chest and upper abdomen. He was re-admitted to Aintree Hospital where further tests were carried out. On 30 October, the prisoner's condition was described as stable but poorly. There was a possibility that his spleen would have to be removed.

On 1 November, it was recorded that the prisoner's condition had improved over the preceding weekend. A surgical team was to review the need to remove the prisoner's spleen when he was more stable.

On 2 November, the prisoner was moved to a cardiology ward where his pain management was to be reviewed. His case was reviewed by the haematology team on 5 November. The next day, the prisoner was discharged back to prison. Although his discharge was recorded on LIDS (Local Inmate Database System), there is no record of it in his prison medical notes. Before discharge, the prisoner's medication was changed to paracetamol, augmentin - an antibiotic - for five days, and fortisip - a dietary supplement - for 28 days.

On 10 November, the prisoner attended an outpatient clinic. This was an appointment that had originally been scheduled for 20 October but had been missed as the prisoner was in hospital at the time. He was seen by a haematologist who diagnosed myelofibrosis (an increase of fibrous tissue within the bone marrow) and a recent splenic infarction (the death of tissue in

the spleen). The haematologist prescribed hydroxyurea - a drug for leukaemia - and allopurinal - a drug used to lower uric acid levels caused by other anti-cancer drugs.

On 16 November, the prisoner complained of further abdominal pain. He was seen by health care staff who took observations and advised him to see the doctor the next day. No record was made to show whether the prisoner saw a doctor or, if he did not, why he did not attend the healthcare centre.

On 5 December, the prisoner complained of diarrhoea and shortness of breath. He was seen in his cell by a nurse who checked his blood pressure, pulse and temperature. The prisoner was advised to drink plenty of fluids and to use his inhalers. Later that day, at 2.30pm, he was seen again by healthcare staff in his cell. His pulse, blood pressure and temperature were normal, and he was described as of good colour, alert, orientated and breathing regularly. The prisoner's cell door was left open to enable his cellmate to obtain fluids for him every hour. There is no evidence in the prisoner's medical record to show whether any consideration was given to admitting him to the healthcare centre.

At 4:28pm, he was seen again by healthcare staff. His blood pressure was now 80/40 and he was pale. Oxygen was administered to him and a blood sample taken. At 4:30pm, the prisoner's breathing became shallow. The administration of oxygen continued, but the prisoner's condition continued to deteriorate. At 5pm, he was taken by ambulance to the Accident and Emergency department at Aintree Hospital. At this point, the prisoner was responsive to speech, his eyes were open and his face was pink. His blood pressure remained at 80/40. The prisoner was admitted to the critical care unit at the hospital after experiencing two cardiac arrests. He was artificially ventilated, but did not respond.

The prisoner died from bronchopneumonia at the hospital at 11:30am on 6 December.

6. Consideration of issues arising from the investigation

The following issues arose during the investigation:

- ***Was the prisoner's medical condition properly screened on reception?***

During the initial health screen carried out as soon as the prisoner entered Liverpool on 17 June 2004, it was noted that he was suffering from stomach and chest complaints. He admitted that he had recently been prescribed medication but that he was not sure what it was.

The prisoner should have undergone a secondary health screen within five days of the first. This was not carried out until 10 September. However, he did undergo a further health screen on 19 July after receiving an 18 month prison sentence. At this interview, the prisoner told healthcare staff that he had no problems after receiving his sentence.

The clinical review acknowledges that, had the prisoner been screened earlier, he might have indicated the shortness of breath he had experienced and might therefore have been referred to a doctor sooner. The review also concludes that, although a second general health assessment was not completed within the recommended timescale, the prisoner had been seen by doctors in the prison, attended outpatient appointments as required and transferred to local secondary care services for his condition when clinically indicated.

- ***Once he was diagnosed did he receive appropriate care and treatment?***

The prisoner was diagnosed as having chronic obstructive pulmonary disease (COPD) within a month of being in prison. Those who suffer from this condition cannot inhale or exhale properly because of long-term damage to the lungs. Although the prisoner said that he had reduced from 20 cigarettes a day to five, he did not want to give up smoking altogether.

The prisoner had regular access to doctors and healthcare services while he was in Liverpool. He received all prescribed medication with no recorded omissions or delays in delivery, with the exception of the medication recommended at his outpatient appointment on 10 November 2004.

Healthcare staff responded promptly when the prisoner required support and assistance with his breathing. The prisoner attended all outpatient appointments when he was at HMP Liverpool, with the exception of one when he was an inpatient at the local acute trust hospital.

The prisoner had a rapid deterioration in his health on 5 December and was regularly monitored by both medical and nursing staff until his transfer to hospital by ambulance.

The prisoner received prompt clinical services from healthcare when it was required. There was no indication of any delay in sending him to local hospitals for further assessment when the clinical need warranted such action. There was no indication of any hospital stay being reduced due to escort pressures.

I judge that staff at Liverpool provided appropriate care for the prisoner.

- ***Was there effective communication between Liverpool prison and the prisoner's GP?***

There is no record of any attempt by healthcare staff at Liverpool to check with the prisoner's GP, on or after 17 June 2004, the details of previous prescriptions given to him or to identify whether any such medication needed to be continued. Furthermore, this would have enabled them to obtain a more comprehensive past medical history.

- ***Was there effective communication between Liverpool Prison and Aintree Hospital?***

The clinical review comments that the sharing of information about the prisoner by the local hospital and prison clinicians was slow, particularly when the prisoner had been discharged back to prison. The review draws attention to the need for this matter to be remedied in order to maintain continuity of care.

However, the review also comments that nursing staff at Liverpool made good daily contact with the local hospital when the prisoner was an inpatient.

- ***Was the standard of record keeping satisfactory?***

On 4 August, healthcare staff saw the prisoner in his cell because he was complaining of shortness of breath. They advised that he should prop himself up in bed and that he should use his inhalers. A note was made in the prisoner's medical record that he was to attend surgery the next morning. However, no further entries were made in the record for three weeks. It is therefore not clear whether the prisoner saw a doctor the next day.

On 2 September, the prisoner returned to Liverpool after being reviewed by the haematology team at Aintree Hospital. No entry was made in his prison medical record about either his discharge from hospital or the outcome of the review.

On 30 September, the prisoner's case was reviewed by a doctor in the healthcare centre at Liverpool who arranged for his further admission to Aintree Hospital. He returned to the prison on 6 October but again no record of his discharge from hospital was made in his prison medical record.

On 16 November, the prisoner complained of abdominal pain. He was seen by healthcare staff who took observations and advised him to see the doctor

the next day. No record was made to show whether the prisoner saw a doctor or, if he did not, why he did not attend the healthcare centre.

The clinical record had all the relevant documentation with the exception of the prisoner's last medication/administration chart. The records were generally in good order. However, the following comments are made in the clinical review:

- the document is difficult to read in relation to being able to identify specific reports and clinical notes;

- entries are often illegible and not clear as to which professional is making entries. Lack of times, legible signatures, along with qualifications, has made linking events difficult.

7. Recommendations

I endorse the recommendations made within the clinical review. They are repeated below.

The North Liverpool PCT, in conjunction with the establishment, should ensure that:

- protocols are developed with local hospitals to improve the speed and exchange of clinical information and recommended treatment options for prisoners discharged from hospital to HMP Liverpool.

- an audit check is developed and included in reception records so that confirmation of records from family GPs, or a request for clinical information from other NHS partners is actioned.

- there is an urgent review of the standard for first and second health screens so that Liverpool achieves the national standard that requires both reviews to be completed within five days of a prisoner's reception. This standard should be regularly audited.

- a protocol is established to ensure that when healthcare staff feel a prisoner needs to see a doctor within a set period, this information is passed on and appointments arranged. An audit check of this should be in place to ensure clinical needs are not missed.

- good practice is established regarding the recording of an individual's condition when in local hospitals. There should be a system to ensure that dates of discharge are noted and the location of the prisoner on return made so that healthcare staff are able to monitor the progress of each individual.

- standards of clinical practice, record keeping and professional guidelines for all clinical staff are audited and met.

- the clinical record that has replaced the IMR is used for all new receptions into the establishment. This should be audited monthly.