PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Liverpool in March 2012

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the death of a man at HMP Liverpool. He died in March 2012, from an intra-ventricular haemorrhage (bleeding in the brain) with acute hydrocephalus (swelling due to excess fluid). He was 47 years old. I offer my condolences to his family and friends.

A clinical review was conducted on the care the man received whilst in prison. I apologise for the delay in issuing this report.

The man went into prison with a number of existing medical conditions, including a ventricular shunt in the base of his skull to drain excess fluid. Healthcare staff were initially unaware of the shunt. In May 2011, he began to experience bouts of dizziness and felt generally unwell. These incidents became more frequent and healthcare staff were often called to treat him in his cell.

No care plan was put in place to manage the man's condition and I consider that healthcare staff should have been more proactive in arranging hospital admissions for observation when he was unwell with symptoms apparently related to his shunt. While it is not possible to say whether this affected the outcome for him, in these respects I do not consider that his care at Liverpool was of a sufficient standard. As in a previous investigation at Liverpool, I consider that there is a need for the relevant healthcare commissioners to satisfy themselves of the quality of delivery of health services at the prison.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2013**

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SUMMARY

1. The man was remanded into custody at HMP Liverpool on 3 December 2010. He was sentenced to 5 years imprisonment on 16 September 2011, at Crown Court and returned to HMP Liverpool the same day. He was 46 years old.

2. The man had a number of existing medical conditions, including hydrocephalus, a condition which causes the body to produces excess cerebral and spinal fluid. To relieve this build up of fluid, a ventricular shunt had been fitted into the base of his skull to drain fluid away from his skull and disperse it into his body. Healthcare staff were unaware of this when he first arrived in prison. On 21 May 2011, he told a nurse that he had had the shunt fitted 21 years earlier. No care plan to manage his condition was implemented.

3. On 24 July 2011, the man reported dizziness. In the following months, the symptoms persisted and nurses frequently attended his cell to treat him. On some of those occasions, they administered oxygen therapy and his condition improved. The clinical reviewer considers that, on the majority of those occasions, he should have been admitted to hospital for observation. However, when he was referred to hospital on 24 February 2012 he discharged himself before being seen.

4. Towards the end of March, the man's cellmate reported that he was having difficulty breathing. After discussion with him, the nurse decided not to send him to hospital. The next morning his cellmate discovered him lifeless in his bed. The officer who had unlocked the cell earlier had not checked on his and his cellmate's wellbeing. Prison staff did not attempt resuscitation as rigor mortis had set in and it was clear that he had been dead for some time.

5. The clinical reviewer concluded that there were significant shortcomings in the care that the man received at Liverpool. We agree with his findings and recommend that the prison reviews his care to learn lessons. We also make recommendations about the quality of the record keeping by healthcare staff, availability of medical equipment, assessing those with complex care needs and facilitating hospital appointments. We make a further recommendation about unlock procedures.

THE INVESTIGATION PROCESS

6. Notices were issued announcing the investigation to staff and prisoners at HMP Liverpool, asking anyone with relevant information to contact the investigator. No one came forward.

7. The investigator examined documents relating to the man's time in custody. He visited Liverpool on 24 May 2012 and interviewed seven members of staff and one prisoner. He then gave feedback on the preliminary findings of the investigation to the liaison officer for Liverpool.

8. The local Primary Care Trust (PCT) asked a clinical reviewer to review the man's clinical care. A final version has not yet been agreed.

9. The investigation report has been sent to the Coroner to assist his enquiries into the man's death.

10. One of the Ombudsman's family liaison officers wrote to the man's mother to explain the investigation process and ask if there was anything that she wished to be considered. She said that she was impressed with the care her son had received at Liverpool and that she was grateful to the liaison officer for his care and consideration.

11. We regret the delay in issuing this report. This was partly due to the late receipt of the clinical review, and subsequent protracted correspondence with the PCT and clinical reviewer to seek additional information. The delay was further compounded by the absence of documents at the prison relating to external hospital visits.

HMP LIVERPOOL

12. HMP Liverpool is a local prison which serves the courts in Merseyside. It holds up to approximately 1,400 remanded and sentenced men. The prison has eight residential wings and a purpose built healthcare unit which opened in 2007.

13. At the time of the man's death, the local Primary Care Trust (PCT) commissioned healthcare services at the prison, which were provided by a Health Trust. The healthcare unit delivers outpatient services, as well as 24 hour inpatient care. A doctor is on duty during normal working hours and nurses and healthcare assistants cover the 24 hour in-patient service.

HM Inspectorate of Prisons (HMIP)

14. Her Majesty's Inspectorate of Prisons (HMIP) carried out a full unannounced inspection in December 2011. The inspection found some progress had been made at the prison since the last inspection, but it had been very slow. It was also noted that:

> "Health care was well managed, with appropriately qualified staff. Despite poor facilities the healthcare reception process was good. A wide range of clinics was provided, including a daily weekday GP session. Attendance had improved but there continued to be some problems with appointments".

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and humanely. In its most recent report, for the period January to December 2011, the IMB at Liverpool reported favourably on the healthcare provided. The Board also noted that plans to reduce the services in the inpatient unit would result in more serious health conditions being treated in hospital.

Previous deaths at HMP Liverpool

16. We have investigated a number of natural cause deaths at Liverpool. The investigation into the death of a man in 2011, found shortcomings in respect of record keeping and we identified deficiencies in clinical management in a more recent investigation. We recommended that the relevant PCT should commission a detailed review of clinical care at Liverpool prison to ensure that provision of healthcare was in line with the GMC Good Medical Practice guidance. There are similar concerns in this case and we have therefore repeated this recommendation to the newly established NHS Local Area Team.

KEY EVENTS

17. The man was born in December 1964. He was remanded into custody by Magistrates' Court on 3 December 2010, and taken to HMP Liverpool. He was subsequently sentenced to 5 years imprisonment on 16 September 2011.

18. A staff nurse carried out an initial reception healthscreen and recorded that he had a number of pre-existing medical conditions. These included kidney stones, scoliosis and Crohn's disease. She noted that he was fit for work and to live in a residential wing. On the same day one of the prison's GPs re-prescribed the man's existing medication.

19. On 6 December, three days after the man's arrival, wing staff reported that he was too ill to collect his medication. A staff nurse went to see him and found that due to his Crohn's disease, he found it difficult to be away from the toilet in his cell. She therefore asked the GP to authorise his medication to be held 'in-possession' in his cell.

20. On the same day, a healthcare administrator wrote in relation to the man's medical community records, "no paper records available-high priority". There is no evidence that his GP records were ever received or that a request was followed up.

21. On 16 December, the man told a nurse that he had a ventricular shunt fitted at the base of his brain for hydrocephalus (excess fluid in the brain). A ventricular shunt relieves hydrocephalus, where a set of structures in the brain called ventricles become enlarged by a build of spinal and cerebral fluid. The shunt relieves the build up of pressure caused by the fluid. This condition was not identified or recorded during the reception health screen. The nurse noted that he had an outstanding hospital appointment in respect of the shunt. There is no record that any action was taken about this appointment.

22. On 5 January 2011, a prison doctor examined the man after he had reported experiencing a tingling sensation in the fingers of his left hand (which can be associated with a failing shunt). She suspected that he might be suffering from cubital tunnel syndrome (a build up of pressure on the main nerve in the hand) and prescribed anti-inflammatory medication. She told him that if the symptoms persisted he would be referred to a specialist. By 24 January, there had been no improvement and staff referred him to an orthopaedic clinic.

23. A nurse saw the man on 2 February. She was concerned that he had suffered a blow to the head after a fall in his cell the previous day and whether this had affected his ventricular shunt. She noted that although he was alert and orientated he was very dehydrated. She told him that she would reassess him the next day. There is no record that the review took place.

24. On 25 March, a consultant orthopaedic surgeon at the hospital saw the man about the tingling sensation in his hand. He diagnosed neurapraxia (a temporary failure of nerve conduction) and arranged for a nerve conduction study, a test commonly used to evaluate the function of the motor and sensory nerves. He informed him that it might take up to 18 months for the nerve in his hand to recover fully. A follow up appointment was arranged for July.

25. The man's next recorded contact with healthcare staff was on 21 May, when he told a nurse that he felt unwell. He mentioned to the nurse that he had had a ventricular shunt fitted 21 years before. He said that up to that point it had not given him any cause for concern. The nurse carried out medical observations which were normal. No further action was taken.

26. Three days later on 24 May, the man again reported to a nurse that he felt unwell with headaches and ringing in his ears. The nurse gave him pain relief and arranged a further review that afternoon. Another nurse later examined him and his observations were normal.

27. A month later, on 27 June, a nurse examined the man, who complained of dizziness and feeling generally unwell. She noted on his medical records that he also appeared breathless. The nurse asked one of the GPs to examine him. The doctor noted that he:

> "has a shunt in situ which was fitted 20 years ago. Last been to neurosurgeon a few years ago and did have an appointment today which he was too unwell to attend (this appointment was in relation to nerve conduction study). He has an outpatients appointment for neurology and neurosurgery in July".

The doctor concluded that his symptoms were due to a combination of chiari malfunction (a malfunction in the area of the back of the head where the brain and spinal cord connect) and his chrohn's disease. He also noted that he should attend the appointment scheduled for July. (There is no record as to whether this appointment took place.)

28. During an examination for kidney stones on 1 July with a consultant urologist, the man said he was concerned about his shunt and complained of very painful headaches. The consultant advised Liverpool's healthcare department to arrange an appointment with a neurology specialist at Walton for a check on his shunt and discharged him from the urology clinic. No arrangements were made for the shunt to be checked but, as noted, he already had an existing neurology appointment there.

29. On 24 July, a nurse examined the man, who told her that he had bumped his head three days earlier and since then he had experienced dizziness and profuse sweating. He also said that approval had been given for him to use a fan in his cell but the security department had refused to allow this. She arranged for him to be examined by a GP.

30. On 28 July, another of the prison's GPs examined the man. She recorded that he:

> "Had a shunt in for the last 9 years - under the care of the neurologist and was seen 3 months ago at the hospital's neurology department".

This entry contradicted that of the nurse, which stated that the shunt had been fitted 21 years before. On 1 August, a doctor referred him to the neurology team at the hospital who had previously been responsible for his care.

31. The man had little significant further contact with healthcare staff until 9 October, when a nurse went to see him after he had complained of dizziness when attempting to stand up. He told her that sometimes the dizziness had caused him to fall over. He also had a buzzing sound in his left ear. After examining him, she referred him to a doctor.

32. The doctor saw the man the next day, 10 October. She wanted to examine his inner ears but was unable to do so until several days later as there were no disposable ear pieces to be used with the otoscope. After this examination, she referred him to the neurology department on the same day, 17 October.

33. On 23 October, the man told wing staff that he was unable to get out of bed and that he had difficulty moving. A nurse checked that his observations were normal but noted that, as she helped him to sit up, he began to feel dizzy. A doctor saw him on 5 November, when he said that he had been suffering from diarrhoea for several days, had lost some blood and had fainted while using the toilet in his cell. She recorded that she would keep him under observation until his neurology appointment on the 25 November.

34. A consultant neurologist at the hospital saw the man on 25 November. He found no significant neurological abnormalities but wrote on 1 December, that "it is possible that the shunt could be malfunctioning". To establish whether or not that was the case, he referred him for an MRI scan and, as a short term measure, prescribed tablets to ease the dizziness. The scan showed no evidence of any haemorrhage. However, the results referred to a "fluid filled structure", the appearance of which was in keeping with a meningcocle (a hernia like protrusion of the three membranes covering the brain and spinal cord through a defect in the skull). The consultant noted that another doctor at the hospital had previously managed the care of his shunt and decided to obtain his records from that doctor. There is no record of any further action.

35. Between 2 December and 21 February, nurses were called to the man's cell several times after he reported dizziness, fainting and profuse sweating. A nurse went to see him on 24 February, after he had complained of profuse sweating, slurred speech and weakness down his

right hand side. She believed that it was a transient ischaemic attack (a minor stroke) and called an ambulance to take him to hospital. Later that evening, after a series of tests, but before a consultation with a doctor, he discharged himself from hospital stating that he felt better. A nurse, who was on duty when he returned to the prison, advised him to ask for help if he felt unwell.

36. Three days later, in the early hours of 27 February, a nurse was again asked to go to the man's cell. He was sweating profusely and concerned about his recent episodes of ill health. His observations were normal. She arranged for him to attend the healthcare department for further examinations the next day. He did not attend the appointment but it is not clear from the medical records whether healthcare staff tried to find out the reasons.

37. At 2.00am the following morning, a nurse responded to a request to attend the man's cell as he again felt unwell and was unable to get out of bed. Once there was fresh air in his cell, he sat upright and his condition improved. The nurse asked for a GP to see him later that day. There is no evidence in his medical records that this happened.

38. In the early hours of 3 March, a nurse was again called to see the man. As the night staff were dealing with an urgent incident elsewhere in the prison, she was unable to see him in his cell and had to speak to him through his cell door. He said that he felt generally unwell, more breathless than usual and had a headache. She passed him painkillers under his cell door.

39. On 5 March, at 4.15am, a nurse again attended the man's cell. He reported pain all over his body and limited movement. The nurse noticed he was sweating profusely and she decided to administer oxygen therapy, which gives a concentrated dose of oxygen. She noted that after five minutes he was no longer in pain and had recovered well. She ensured that healthcare staff who came on duty later that day were aware of the incident and asked a GP to examine him as a follow up, as soon as possible. Later that day, a locum GP saw him, who informed him that he was "feeling fine now". The GP asked staff to check progress on the results of a recent CT scan at the hospital.

40. The next day at 2.04am, a nurse was called to the man's cell. She found him lying on his right hand side. His speech was slurred, he complained of a "fuzzy feeling" all over his body and of pain in his lower legs. She noted that he was sweating profusely but felt cold to the touch and thought oxygen therapy would be beneficial. She found that within 10 minutes of starting the therapy, his condition was much improved and he was in good humour. She told him that she would return to check up on him a little later. At 3.17am, a nurse reported that he was much better. His speech was not slurred and the feeling of fuzziness and pain had now gone.

41. On 7 March, a nurse was again called to the man's cell during the night. She noted that he was presenting the same symptoms as the previous

night but they were not as severe. She again gave him oxygen therapy and he responded well, as he had before. She told him that she would ask the day staff to see him later.

42. A doctor saw the man later the same day and noted that nurses had been to see him in the early hours on three successive nights. The doctor thought that the sweating was due to his chest infection. He suggested to him that he should consider moving to the healthcare unit but he declined, instead preferring to "see how things go". There is no evidence that healthcare staff spoke to him again about moving to the healthcare unit as an inpatient.

43. In the early hours of both 9 and 10 March, a nurse went to see the man. On the first occasion, he had breathing difficulties for which she gave him oxygen therapy and his condition improved quickly. On 10 March, he had a headache and said that he "couldn't take anymore". She gave him painkillers.

44. On 26 March at 10.23am, wing staff asked a nurse to attend the man's cell as he felt very unwell. He said he had the same symptoms that he had experienced a few weeks before. She arranged for him to be seen by a GP later that day. A doctor saw him in the afternoon but it is unclear from the notes what his conclusions were or what course of action the doctor planned to take.

45. Two days later, at 3.00am on 28 March, a nurse went to see the man, as night staff were concerned about his breathing. He was lying on his back on the bed and appeared to be frothing at the mouth. His speech was extremely slurred and he was sweaty but cold to the touch. She administered oxygen therapy and after ten minutes he was much improved. She returned to check on him later when he was sitting on a chair in good spirits and said that he felt much better. She told him and his cellmate to summon help immediately if he had any further problems. She said that she would refer him to be seen by the GP that day.

46. A doctor examined the man on 28 March and wrote to the consultant neurologist outlining her concerns. She gave a synopsis of the symptoms that he had been experiencing and concluded that:

> "Overall it is a very concerning clinical picture and I feel we are missing something in his diagnosis and management. In view of the above I would appreciate it if you could review him as a matter of urgency in your clinic and advise how best to proceed".

47. At 3.01am, the man's cellmate alerted staff that the man was having difficulty breathing and a nurse went to see him. He was fully conscious and told the nurse that he had a severe headache. She suggested that he keep a diary of how he felt during his episodes of illness to assist the neurologist with his diagnosis. They also discussed the possibility of referring him to hospital to be assessed. However, they both concluded

that it was unnecessary at that stage.

48. In the early hours of the following morning, between 2.00am and 3.00am, the man's cellmate said he got up to use the toilet. He heard the man snoring and saw him sleeping on his side. When he woke up in the morning, he was not snoring. This was unusual and as the cells had already been unlocked, at first he thought that the man had gone to collect his medication. He then noticed him lying in bed and shook him. He then realised something was wrong and called out to a Senior Officer (SO) who was opening the gate for prisoners to go to work.

49. At around 7.45am, the SO radioed a code blue emergency call (a code blue indicates an emergency of a respiratory nature). A nurse responded, taking with her a bag with emergency resuscitation equipment. The man was lying on his bed on his right hand side with no apparent signs of life. The nurse said that the primary care manager arrived at the cell approximately two minutes after her. The primary care manager examined him, checking his airway, breathing, pulse and pupil reaction and concluded that he had been dead for some time. She confirmed that there were no signs of life and decided that they should not attempt resuscitation as rigor mortis had set in. Paramedics arrived at 8.15 and confirmed his death at 8.20am.

50. The prison's family liaison officer went to the man's mother's home at 10 o'clock that morning and broke the news about her son's death. As it was sheltered accommodation, he spoke to the manager who contacted her granddaughter, who arrived within five minutes and, in turn, informed other members of the family.

51. The funeral took place on 12 April. The family liaison officer and a member of the chaplaincy team, attended on behalf of Liverpool. Funeral expenses were offered to the man's next of kin in line with national guidance.

52. The autopsy report states that the man's death was due to an Intra-ventricular haemorrhage with acute hydrocephalus, which was an underlying congenital issue.

ISSUES

Clinical care

53. The local Primary Care Trust (PCT) commissioned a clinical reviewer to review the man's clinical care at HMP Liverpool. He identifies a number of weaknesses in the man's care and makes a number of recommendations in his report. The main concerns are reflected below.

Reception healthscreen

54. When he arrived at Liverpool, the man had an initial health screen in which it was documented that he suffered from a number of existing conditions. The same day a doctor examined him, reviewed his medication and asked that his community medical records should be obtained. It is not clear when, or if, they were requested or received.

55. The clinical reviewer noted that neither the condition relating to the man's ventricular shunt, nor the full extent of his existing neurological condition were recorded during his healthscreen. This meant that healthcare staff were not in a position to monitor and assess any changes to his condition. No care plan was put in place to manage his identified conditions and staff did not gather full information about the care that he had received from secondary care providers. We accept that at reception healthscreens, staff are heavily reliant on the information given by individual prisoners, but it is surprising that questioning does not appear to have identified that he had a ventricular shunt. The staff do not appear to have sufficiently explored his outstanding medical needs.

56. On 16 December 2011, less than two weeks after his arrival at Liverpool, the man told a nurse that he had a ventricular shunt. The nurse referred to his hydrocephalus, noting that he had undergone a "procedure on his brain, ventricular shunt" and that he had an outstanding hospital appointment. No care plan was agreed at that stage to help manage this longstanding and serious condition. We make the following recommendations:

The Head of Healthcare should ensure that reception healthcare staff ask relevant questions to establish whether newly-arrived prisoners have ongoing medical conditions. Those with complex needs should undergo a full assessment as soon as possible after arrival with a clear and detailed management plan entered in the clinical record.

The Head of Healthcare should ensure that healthcare staff obtain community GP records and facilitate or rebook any outstanding hospital appointments prisoners have when they arrive.

Management of the man's health conditions

57. On 27 June 2011, the man was examined by a doctor. The clinical reviewer noted that at the time of this examination he had "new significant neurological signs" and believes the doctor should have considered an emergency admission. Instead, the doctor advised him to keep a forthcoming appointment arranged for July.

58. While attending an outpatient appointment in the urology clinic at hospital on 1 July, the man said he was concerned about his ventricular shunt. He informed the urologist that he had been experiencing some headaches and dizziness of late. The urologist wrote to the prison healthcare department, asking them to arrange for the shunt to be checked at hospital. It is unclear whether this was actioned but he was already scheduled to attend an appointment there later that month. However, there is no record of him attending that appointment.

59. After a fall on 28 July, a doctor noted that the man "has a shunt in the last 9 years-under the care of neurologist and seen 3m (3 months) ago - Hospital Neurology". There is no evidence in his medical records to suggest that he had attended such an appointment. The records show that he was due to attend an outpatient appointment on 27 June 2011, at the Neurology and Neurosurgery unit for a nerve conduction study. He was too unwell to do so and the records do not show whether healthcare staff followed this up.

60. On 25 November, the man was seen by a consultant neurologist at hospital. The consultant thought it possible that the shunt was malfunctioning. He referred him for an MRI scan, which showed no evidence of any haemorrhage but there appeared to be a "fluid filled structure" in his brain and spinal cord through a defect in the skull). It is not recorded whether the consultant pursued his intention to seek further information from a doctor at another hospital about the care of his shunt. Similarly, we do not know if anyone attempted to take forward the suggestion by the consultant to get the shunt checked.

61. On 2 February 2012, a nurse examined the man following a "bump to his head". She noted that he had "a cranial shunt in situ due to fluid retention, no past problems with shunt, never been checked for blockages". There is no evidence of follow up action to establish whether he had received the correct aftercare.

62. A nurse reviewed the man on 27 February, as he felt generally unwell and was sweating excessively. Although his observations were normal, the nurse told him that as a precaution he would be reviewed again later that day. He did not attend that appointment and there is nothing in the medical records to indicate if any action was taken to find out the reason or encourage him to attend the healthcare department after that missed appointment. We therefore make the following recommendation:

The Head of Healthcare should ensure that if prisoners miss appointments, the reasons are recorded and where they are not rebooked, the reasons are entered on the clinical record.

63. A doctor became increasingly concerned about the man's condition. On 28 March, she wrote to the consultant neurologist at hospital explaining the difficulties that she and the other healthcare staff were having with him and the regularity with which he required medical assistance and oxygen therapy. She feared that they were missing something in terms of his diagnosis and management and asked for him to be seen as a matter of urgency. He died before the consultant was able to reply.

64. The man experienced frequent episodes of abnormal symptoms such as dizziness and breathing difficulties. In particular, between 21 February and 29 March 2012, healthcare staff were frequently called to attend to him in his cell. On most of these occasions, he had a fast pulse, excessive sweating and his oxygen saturation was low. However, once oxygen therapy was administered, his condition improved greatly.

65. The clinical reviewer believes that on the first occasion the man should have been admitted to the healthcare centre and, given the frequency, on the subsequent occasions, staff should have sent him to hospital for observation. In summary, he considers that during his time at Liverpool, there were "significant shortcomings in the care that he received". In light of the poor management of his shunt, the clinical reviewer suggests that Liverpool should conduct a review of staff actions. Because of poor clinical care in relation to another death at Liverpool, we recommended in a report in October 2012 that the PCT should commission a detailed review of clinical care at Liverpool prison to ensure that provision of healthcare was in line with the GMC Good Medical Practice guidance. The PCT said this was under consideration. We believe there remains a need to review the provision in the light of care in this case. We make the following recommendations.

The Head of Healthcare should ensure that prisoners are referred to hospital whenever there are significant concerns about their health.

The NHS Local Area Team responsible for commissioning health services at HMP Liverpool should review the provision of healthcare at the prison to ensure it is of an appropriate standard and identify any training needs in the light of the care given to the man.

Stocks of equipment

66. On 10 October, a doctor examined the man as he was unsteady when standing or turning. She noted that the results appeared normal and thought that the dizziness was probably due to a viral infection. However, she was unable to fully examine him as there were no otoscope pieces available until 17 October.

The Head of Healthcare should ensure that sufficient stocks are held of all necessary equipment.

Morning unlock of prisoners

67. For their own safety, officers are supposed to look at and make contact with a prisoner through the observation hatch before opening a locked cell door. As well as a security precaution, it is also supposed to be a check on the prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

> "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

68. The man was found by his cell mate when he woke up that morning, after the cell had already been unlocked. Had staff carried out their duties properly, they might have discovered him sooner. However, it does not appear that it would have affected the outcome for him, as there were signs of rigor mortis, which suggests that he was likely to have died before the cell had been unlocked. Nevertheless, officers are required to get a response from prisoners when they open a cell and in another case, this might save a life. We make the following recommendation*.*

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Record keeping

69. The clinical reviewer points out that entries in the man's medical records were basic. Without a comprehensive record of a patient's examinations and consultations, medical professionals cannot fully assess and review a prisoner's condition. The record keeping at Liverpool needs to be detailed, accurate, and comprehensive.

The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.

Risk assessments for hospital visits

68. Before a prisoner is taken out of the prison for a hospital appointment, a risk assessment is carried out to determine the appropriate level of escort officers and restraint. The risk assessment should consider the risk of escape and the risk to the public posed by the prisoner concerned. The prisoner's health and

mobility should also be considered. Managers should conduct regular to review the risk assessment and ensure that the level of restraints used is proportionate.

69. The man went to hospital several times. Despite numerous requests, the prison did not provide any the risk assessment and escort documents. We are therefore unable to make a judgement as to whether his hospital visits were appropriately managed.

70. The Prison Service guidance on actions following a death in custody has a mandatory requirement for prisons to retain and securely store documents for the Ombudsman's investigations which the prison failed to comply with.

The Governor should ensure that after a death in custody, in line with national guidance, all relevant documents are passed to the PPO.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that reception healthcare staff ask relevant questions to establish whether newly-arrived prisoners have ongoing medical conditions. Those with complex needs should undergo a full assessment as soon as possible after arrival with a clear and detailed management plan entered in the clinical record.

   Accepted. "The Reception First Night process and Secondary healthcare screen within 48 hours identifies prisoners with on-going medical conditions. All prisoners are screened using an assessment template In the recent PHPQI audit, HMP Liverpool scored a Green on the requirements to complete both primary reception screening at reception and a secondary healthcare screen within 48hrs. Those with complex needs will receive a full assessment and care plan, which will be presented at the weekly Enhanced Care Review Meeting and entered onto clinical system.

   When first night processes are moved from reception to A wing in September 2013 this will afford the clinical staff easier access to newly arrived prisoners and allow for the assessments; care planning etc. to be completed in an even timelier manner and improve the services to prisoners.

   Furthermore, there is an upgrade to the clinical IT system (Systm1) that is due to be rolled out nationally over the next twelve months. The Prisons across Merseyside are the first Prisons nationally to be included in this upgrade which will allow clinical staff to access community GP records via Systm1 assuming the Prisoner consents. This is due to 'go live' in all the Merseyside Prisons by the end of July 2013."

2. The Head of Healthcare should ensure that healthcare staff obtain community GP records and facilitate or rebook any outstanding hospital appointments prisoners have when they arrive.

   Accepted. "Healthcare staff will obtain GP records, facilitate or rebook any outstanding hospital appointments that prisoner have when they arrive. This will be achieved via existing protocols.

   Healthcare staff to access EMIS community clinical system.

   There are existing protocols within the Providers portfolio include the requirement to access GP records. However, on this occasion, it is acknowledged that although the initial request was made to the GP, there are no recorded follow up requests on the man's clinical records. The Systm1 upgrade will assist greatly with this issue."

3. The Head of Healthcare should ensure that if prisoners miss appointments, the reasons are recorded and where they are not rebooked, the reasons are entered on the clinical record.

Accepted. "System is in place to risk assess the potential impact of not attending appointments. The incidence of DNAs is monitored and the reasons why are recorded. However, those Prisoners who choose not to attend appointments are within their right to do so as they are within the community. Those Prisoners who have complex needs and DNA are followed up and offered alternative appointments

Management audit to be robustly monitored."

4. The Head of Healthcare should ensure that prisoners are referred to hospital whenever there are significant concerns about their health.

Accepted. "When a patient is identified as needing referral to hospital, this is achieved by liaison with all local Healthcare facilities and appointments are scheduled.

Healthcare administration will diary the appointment and liaise with Prison Service security department to arrange escort.

All escorts & bed watches are determined on clinical need and triaged accordingly."

5. The NHS Local Area Team responsible for commissioning health services at HMP Liverpool should review the provision of healthcare at the prison to ensure it is of an appropriate standard and identify any training needs in the light of the care given to the man.

Accepted. "The PPO report will be made available to the NHS LAT Offender Health commissioning manager. A request for an assessment of provision and need will be made as requested.

A full service audit of HMP Liverpool was carried out scheduled on 19 June 2013.

The PHPQI audit was excellent for HMP Liverpool and resulted in Green ratings for Clinical Governance; Workforce Planning and Health Needs Assessment. Following the NHS transition to the new commissioning arrangements, the process of reviewing all the Service Specifications for Prison Clinical services, we anticipate that HMP Liverpool specifications will be reviewed and agreed by the end of 2013."

6. The Head of Healthcare should ensure that sufficient stocks are held of all necessary equipment.

Accepted. "There is a weekly stock list of levels of all equipment which then generates a weekly order list. The shortfalls in stock are then sent to our procurement department to ensure we have sufficient stock of all necessary equipment."

7. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Accepted. "A Governor's order is to be published to ensure staff are made aware of prisoner's safety and their needs are attended to. Furthermore, staff will receive briefings by line managers to remind them of their responsibility.

   Staff will also receive briefings Bi Annually via the daily briefing to remind them of this responsibility. This will be monitored via the safer Liverpool meeting."

8. The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.

   Accepted. "The Record Management Team at Liverpool Community Health retains annual 'record keeping' audits and we have weekly care plan audits which have management checks conducted.

   Record keeping is subject to random checks to provide quality assurance. Failure to adhere to the professional bodies' guidance will be addressed through disciplinary or capability procedures.

   Mandatory training is given to all staff on record keeping and Information Governance is provided annually for staff as part of the mandatory training."

9. The Governor should ensure that after a death in custody, in line with national guidance, all relevant documents are passed to the PPO.

   Accepted. "Collation of all relevant documents form part of our DIC contingency plans. All documents are brought together and copies made for all relevant parties. Initially the Silver commander is responsible for the collation of documentation. This responsibility passes to the Head of Safer Custody who co-ordinates duplication and safe storage."