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 in October 2014, while in the custody of HMP Liverpool

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 investigation report into the death of a man in October 2014, while a prisoner at HMP Liverpool. He died from liver failure. He was 43 years old. I offer my condolences to the man's family and friends.

One of my investigators carried out the investigation. A clinical reviewer reviewed the man's clinical care at Liverpool. The prison cooperated fully with the investigation.

The man received a three-month sentence of imprisonment on 17 September 2014 and was sent to Liverpool. A reception nurse noted that he was dependent on drugs and alcohol and appeared jaundiced and unwell. She referred him to the prison's drug service. Prison doctors prescribed medication for his drug and alcohol dependence. No immediate action was taken to investigate his jaundice.

On 29 September, the man told a prison doctor that he had abdominal pain and had passed blood. The doctor saw that he was jaundiced, and noted that his blood pressure was low and arranged for him to be taken to hospital. The man's condition deteriorated in hospital and he died during an afternoon in October.

The clinical reviewer considered that the man's care was not equivalent to that he could have expected in the community. Healthcare staff were aware that he was a heavy drinker, but did not investigate quickly the reasons for his jaundice, which can be a sign of liver disease and he did not receive a secondary health assessment. Although earlier diagnosis of his condition is unlikely to have changed the outcome, it might have helped make him more comfortable and reduced his pain.

When the man reported serious symptoms on 29 September, a doctor examined him and intended that he should go to hospital as an emergency. While it did not affect the outcome for the man, I am concerned that there was then a delay of some hours before he went, because of a confusion of messages. No one attempted to contact his next of kin until he had been in hospital for ten days. I am also concerned that he was subject to a high level of restraint in hospital, without appropriate and regularly reviewed risk assessments, which took account of his condition. I have raised similar concerns in several previous investigations at Liverpool.

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 **May 2015**

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SUMMARY

1. On 17 September 2014, the man was sentenced to three months imprisonment and was sent to HMP Liverpool. When he arrived, he told a nurse at an initial reception health screen that he was dependent on alcohol and drugs. The nurse noted he looked jaundiced and unwell. Prison doctors then assessed him to manage his drug treatment and prescribed medication. No one took action at the time to establish the cause of his jaundice, which can be a symptom of liver problems. He did not have a secondary health screen.

2. At 11.18am on 29 September, the man reported to a nurse that he was in pain and had been coughing up and passing blood. She arranged for the prison doctor to see him that day. Around four and a half hours later, the doctor referred him to hospital. The doctor had intended the man to be taken to hospital as an emergency, but there was some confusion about this and another two hours passed before he went to hospital by taxi, just after 6.00pm.

3. Staff completed a security risk assessment, which indicated that the man, a category C prisoner, was a low risk of escape. In spite of this, managers instructed escort officers to use double handcuffs for the journey and in hospital. These remained in place in hospital although he was bedridden and hospital staff had assessed him as very ill. No one informed his family at the time.

4. On 9 October, the hospital asked prison staff to notify the man's next of kin of his worsening condition. The next day, a prison manager reviewed his risk assessment and authorised the removal of the restraints. The man's condition deteriorated further and he died from liver failure on an afternoon in October.

5. The clinical reviewer concluded that the care the man received at Liverpool was not equivalent to that he could have expected to receive in the community. The prison did not offer him a full health assessment as part of the standard screening procedure to ensure continuity of care and healthcare staff did not address his immediate health needs when it was evident that he had jaundice. There was a delay taking him to hospital quickly on 29 September and we are concerned that the staff used handcuffs to restrain him in hospital, without a fully considered risk assessment to justify this. It took too long to notify his family that he was seriously ill. We make four recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.

7. NHS England commissioned a clinical reviewer to review the man's clinical care in prison.

8. The investigator obtained copies of the man's prison medical records and extracts from his prison record. On 27 November and 4 December, she interviewed four members of staff at Liverpool. She briefed the prison about her preliminary findings.

9. We informed HM Coroner for Merseyside, Liverpool District, of the investigation and have sent him a copy of this report. An inquest on 17 October, concluded that he had died from natural causes,

10. One of the Ombudsman's family liaison officers contacted the man's sister to explain the investigation. She did not have any specific issues for the investigation to consider.

11. The man's family received a copy of the draft report and had no comments to make. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP LIVERPOOL

12. HMP Liverpool is a local prison, which serves the courts in Merseyside. It holds up to 1,400 men. The prison has eight residential wings and a purpose-built healthcare unit. Liverpool Community Health Trust delivers healthcare services. A doctor is on duty during normal working hours and nurses and healthcare assistants provide 24-hour inpatient care.

HM Inspectorate of Prisons

13. The most recent inspection of Liverpool was in October 2013. The Inspectorate found that, overall, healthcare services were reasonable despite substantial staffing recruitment problems. Inspectors noted that each week the prison received over 70 new prisoners who staff screened for urgent medical problems but only 30% of them received a comprehensive health assessment in the following 72 hours. They recommended that all new prisoners should receive a comprehensive health needs assessment within 72 hours of arrival, with a triage system to ensure that prisoners received a standardised assessment.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recent published annual report for 2012 - 2013, the IMB noted that the prison had completed a full health needs assessment of prisoners. The number of GPs had increased to one part-time and three locums and there was a day centre for prisoners with complex needs. Attendance at outpatients had improved and the outcome of a patient survey had been positive.

Previous deaths at HMP Liverpool

15. The man's death was the fifth death by natural causes at Liverpool in the last two years. We have previously made recommendations about escort risk assessments and the inappropriate use of restraints.

KEY EVENTS

16. On 17 September 2014, the man was sentenced to three months imprisonment for several offences, including receiving stolen goods. He was sent to HMP Liverpool. He had been in prison several times before.

17. At a reception health screen, a nurse noted in the man's medical record that he had a history of alcohol and drug misuse. He told her that he used heroin, crack cocaine and illicit methadone (an opiate substitute for heroin used for drug treatment) and drank around 24 units of alcohol a day. He had received psychiatric treatment around 18 months before and doctors had prescribed antidepressants. He smoked cigarettes but did not want help to stop. The nurse recorded, in capital letters, "appeared unwell/skin pallor and slightly jaundiced" and referred him to the GP and the drug and alcohol service. He provided the contact details for his GP surgery in the community.

18. Shortly after the man's initial health screen, a nurse screened him for drugs and alcohol. He tested positive for opiates, methadone, cannabinoids and benzodiazepines. That evening, a prison GP saw the man and prescribed a dose of 10mls of methadone, as well as diazepam, thiamine and vitamin B to treat his alcohol dependence. He wrote that he had a 'double addiction' and no medical illnesses. There is no evidence that the doctor physically examined him, or noted the nurse's comments that he looked jaundiced and unwell.

19. The next day, 18 September, a consultant psychiatrist saw the man in the drug dependence unit and prescribed a continuation of methadone, initially for maintenance, with a view to detoxification after two weeks.

20. On 23 September, the man had blood tests for HIV and hepatitis B and C. (The results received on 3 October showed he had hepatitis C.) There is no record that healthcare staff conducted a general health assessment, which usually takes place within the first few days of imprisonment.

21. At 11.18am on 29 September, a nurse noted the man had reported having persistent pains in his lower abdomen and lower back and had been vomiting over the weekend. He said he had coughed up some bloodstained sputum. The nurse arranged for a GP to see him that day. At around 4.00pm, the man told a GP that he had passed blood in his urine and stools and had coughed up blood. The GP noted he had jaundice and low blood pressure. He consulted a gastric surgeon and they agreed he should go to hospital as an emergency.

22. The GP told the investigator that he had considered it an emergency, but because the hospital is nearby, he thought that the man should go by taxi, as this would be as quick as calling for an ambulance. However, the chronic disease manager had understood from the GP that this was not a medical emergency that required an ambulance. The prison booked a taxi to take him to hospital after the evening meal, when it would be easier to provide officers to escort him.

23. The chronic disease manager completed the medical section of the security risk assessment, indicating that there were no medical objections to restraints and that the man could be double cuffed. He had no mobility or disability issues or fractures. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs).

24. The man arrived at the accident and emergency department at outside hospital at 6.15pm and the hospital later admitted him as an inpatient. Hospital staff diagnosed liver cirrhosis, excess fluid in his abdomen and sepsis (inflammation of the body caused by an infection). They continued his prescription of methadone and conducted tests for suspected tuberculosis. Prison healthcare staff frequently contacted the hospital for updates on his condition.

Liaison with the man's family

25. On 9 October, the hospital told one of the prison's nurses that the man was very poorly and advised the prison to notify his next of kin. His partner had no fixed address, but later that day, healthcare staff learned that she was also in hospital and informed her that he was seriously ill. On 12 October, the prison's family liaison officer visited the man to try to obtain details of other family members, but was unable to get any information.

26. When the man's partner was well enough, she visited him shortly thereafter. However, by then he was unresponsive. The prison's family liaison officer visited the hospital that day and staff told him that the man appeared to be in his final hours. He spoke to the man's partner, who contacted his family who went to the hospital. At 12.50pm, a doctor certified his death.

27. On 17 October, the prison's family liaison officer visited members of the man's family at his sister's home. His funeral took place on 24 October and the prison contributed to the costs, in line with national guidance.

Support for staff and prisoners

28. A Governor's notice informed staff and prisoners of the man's death and offered support to anyone affected. Staff reviewed prisoners identified as at risk of suicide and self-harm, in case the news of his death had adversely affected them.

Cause of death

29. The Coroner's inquest took place on 17 October 2014 and concluded that the man died from natural causes caused by liver failure, liver cirrhosis, and hepatitis C.

ISSUES

Clinical care

30. The man had a history of drug and alcohol dependence. When he arrived at Liverpool, staff immediately referred him to the drug services and a doctor prescribed methadone for his opiate addiction and medication to treat the effects of his alcoholism. The clinical reviewer found that healthcare staff at Liverpool appropriately managed his drug and alcohol dependence.

Reception and secondary health assessments

31. Prison Service Order (PSO) 3050 Continuity of Healthcare for Prisoners, gives guidance on the clinical management of prisoners from reception through to discharge, with a focus on those with ongoing health needs. Prisons are required to carry out an initial assessment of the healthcare needs of all prisoners within 24 hours of first reception, to identify any existing health conditions and plan relevant care.

32. During his reception health screen, a nurse recorded that the man appeared unwell and looked slightly jaundiced. A doctor reviewed him shortly afterwards, but this was not followed up or subsequently. The clinical reviewer found that there was no evidence that doctors examined him or considered the reason for his jaundice, although it is a sign of liver disease and they knew he drank excess alcohol.

33. Another mandatory requirement of PSO 3050 is that :

> *"In the week following first reception, every prisoner must be offered a general health assessment. This assessment is equivalent to a primary care assessment when registering with a new practice in the community…"*

The secondary screen is an opportunity to gather and provide further information and check how the prisoner is settling in. The man was not offered and did not receive a secondary health assessment. Therefore, healthcare staff did not get a full understanding of any existing medical requirements or check his well-being as a new prisoner. We note that at the inspection in October 2013, inspectors were also concerned that few prisoners received a comprehensive health assessment after they arrived.

34. The clinical reviewer concluded this was significant because it would have been another opportunity to discuss the man's health problems and he had no assessment for physical health disorders linked to heavy alcohol use, such as liver disease. Blood or liver function tests might have identified abnormalities and should have informed decisions about his treatment for drug dependency.

35. The clinical reviewer noted that the man's liver failure was already beyond treatment when he was admitted to hospital and the outcome was unlikely to

have been different if his liver problems had been identified when he first arrived at Liverpool. However, she considered that earlier investigation and treatment might have helped avoid some discomfort and pain. For this reason, the clinical reviewer concluded that the man's care in prison was not equivalent to that he could have expected to receive in the community. We make the following recommendation:

The Head of Healthcare should ensure that significant medical issues identified at reception health screens are investigated quickly and that healthcare staff offer a full general health assessment to every prisoner within a week of their arrival.

Delay in assessing and sending the man to hospital

36. At 11.18am on 29 September, the man reported to a nurse that he had abdominal pain and had passed and coughed up blood. The GP assessed him at 3.57pm and instructed healthcare staff to send him to hospital as an emergency. Escort staff took him to hospital just after 6.00pm. The chronic disease manager, who arranged the transfer to hospital, said that she had checked with the GP and was under the impression that it was not a medical emergency.

37. The clinical reviewer considered it might have been more appropriate if staff had arranged for the man to see a GP urgently but we recognise that the GP saw him within a few hours. We are concerned that there was some confusion about whether he should have been sent to hospital as an emergency and two hours elapsed before he went to hospital after the doctor's assessment.

38. The prison GP and the chronic disease manager differ as to whether the doctor made it clear that the man needed an emergency admission. It seems that, although the GP did not necessarily expect staff to call an ambulance, he thought that the man should be taken to hospital immediately. This was not clear from the medical notes. While this did not affect the outcome for the man, it is important that there is clarity when a prisoner needs an emergency admission to hospital. We make the following recommendation:

The Head of Healthcare should ensure that clinicians make it clear when prisoners need to be taken to hospital as an emergency, that they note this in the clinical record and that staff arrange transport immediately.

Restraints, security and escorts

39. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between the prisoner's risk of

escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgement indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

40. When the man was taken to hospital on 29 September, an escort risk assessment indicated that he was a medium risk to hospital staff and the public. Staff assessed his level of risk for hostage taking, potential to escape and potential to receive outside assistance as low. The chronic disease manager completed the healthcare section. She said there were no medical objections to the use of restraints and that he could be double cuffed. She gave no specific information about his medical condition, but noted that he was going for treatment, and would then return to the prison. An operational manager authorised the escort officers to use double cuffs and two officers accompanied the man.

41. A prison manager and head of the offender management unit reviewed the use of restraints on 10 October. At that time, the man had been in hospital for twelve days and there is no record of any previous reviews of restraints. Escort records show that he was seriously ill, being treated for suspected tuberculosis and was being fed through a tube. He was confined to bed and not mobile. Taking into account his medical condition and his risk levels, she authorised the removal of restraints and they were not reapplied. Two officers remained outside his room during his final days in hospital.

42. We are concerned that staff authorised double cuffs for the man. He was serving a short sentence, due to be released from prison in around four weeks and the risk assessment indicated that he was a low risk. Double cuffing is usually used for moving category A or category B prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like this man, the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified. The unnecessary use of double cuffing is a matter we have raised with Liverpool several times before. The prison gave assurances that they would review the assessment process, but the man's case has shown that unnecessary double cuffing has continued.

43. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that staff took sufficient account of the man's physical health in assessing his risk, as the court judgement requires. The use of double cuffs in particular was not justified.

44. Ultimately, it is the Governor's responsibility to ensure that the process is managed properly, but the Head of Healthcare also needs to ensure that healthcare staff understand their responsibilities when assessing how health and mobility affects the risk of escape and any objections to the use of restraints. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed.

Liaison with the man's family

44. Prison Service Instruction (PSI) 64/2011, Safer Custody, requires that prisons should have arrangements to engage with the next of kin, or other nominated person, of prisoners who are either seriously or terminally ill. Prison Rule 22 also requires the governor to inform the prisoner's spouse or next of kin and "any person who the prisoner may reasonably have asked should be informed" when a prisoner is seriously ill.

45. The prison did not try to contact the man's next of kin until 9 October, by which time his condition was critical. We consider that the prison should have taken steps to inform his next of kin when he went into hospital on 29 September. We make the following recommendation:

The Governor should ensure that when a prisoner becomes seriously ill, staff notify their next of kin without undue delay.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that significant medical issues identified at reception health screens are investigated quickly and that healthcare staff offer a full general health assessment to every prisoner within a week of their arrival.

2. The Head of Healthcare should ensure that clinicians make it clear when prisoners need to be taken to hospital as an emergency, that they note this in the clinical record and that staff arrange transport immediately.

3. The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position that assessments fully take into account the health of a prisoner, are based on the actual risk the prisoner presents at the time and are frequently reviewed**.**

4. The Governor should ensure that when a prisoner becomes seriously ill, staff notify their next of kin without undue delay.

ACTION PLAN: [man's name] – HMP Liverpool

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible
1	The Head of Healthcare should ensure that significant medical issues identified at reception health screens are investigated quickly and that healthcare staff offer a full general health assessment to every prisoner within a week of their arrival.	Accepted	HMP Liverpool offers a first night health screen on a prisoner's initial reception to the prison. Every prisoner is then given a full "second day" health screen within 72 hours of their reception. Immediate GP referrals are made following these assessments where this appropriate. There is also now a comprehensive process in place to ensure that prisoners are taken from the wing they reside on to healthcare assessments via a "call up" system.	Completed Healthcare Department
2	The Head of Healthcare should ensure that clinicians make it clear when prisoners need to be taken to hospital as an emergency, that they note this in the clinical record and that staff arrange transport immediately.	Accepted	Healthcare Managers have briefed their staff about the requirement to inform orderly officers immediately if there are instances where prisoners require urgent treatment at outside hospital. In these circumstances, this action is recorded on SystmOne and Prison-NOMIS and the orderly officer will arrange appropriate transport and escorting officers.	Completed Healthcare and Operational Staff
3	The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position that assessments fully take into account the health of a prisoner, are based on the actual	Accepted	Healthcare Managers have briefed their staff about the importance of ensuring that risk assessments reflect each prisoner's condition/risk at the time of their transfer to outside hospital. A process is in place which ensures that a signed risk assessment is completed at the	Completed Healthcare and Operational Governor

	risk the prisoner presents at the time and are frequently reviewed**.**		time of a prisoner's discharge to hospital using up to date/real time information.	
4	The Governor should ensure that when a prisoner becomes seriously ill, staff notify their next of kin without undue delay.	Accepted	The prison now records prisoners' next of kin details on Prison-NOMIS, SystmOne and in wing files, and these details can be viewed by any member of staff. Following the deterioration in a prisoner's condition to the extent that they are considered to be seriously ill, the protocol is that Healthcare staff will inform the Duty Governor or Head of Safer Custody and they will deliver this news to the next of kin.	Completed Operational Managers