Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Holmes, a prisoner at HMP Liverpool, on 27 May 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Holmes died of cardio-respiratory failure, due to severe chronic obstructive pulmonary disease at HMP Liverpool, on 27 May 2015. He was 53 years old. I offer my condolences to Mr Holmes' family and friends.

Mr Holmes was found unresponsive in his cell on the morning of 27 May. The emergency response was prompt and appropriate but, sadly, staff could not resuscitate him. I am satisfied that Mr Holmes received a generally good standard of healthcare at the prison, equivalent to that he could have expected to receive in the community.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2015**

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Summary

Events

1. Mr Paul Holmes had been in prison since January 2012, serving a life sentence for murder with an 18-year minimum term. He had many long-term health problems, including heart, liver and lung diseases. Against advice, Mr Holmes continued to smoke and was aware of the negative consequences.

2. During the night and early hours of 26/27 May, Mr Holmes complained of vomiting and diarrhoea. A nurse checked him at 9.30pm, 11.50pm and 2.00am and found that his blood pressure, pulse and temperature were within the normal range. The nurse gave him some medication. At 2.00am, Mr Holmes said he felt better. The nurse and the wing officer told Mr Holmes to ring his cell bell to alert them if his condition worsened again during the night.

3. At about 5.10am, an officer checking prisoners could not see or get a response from Mr Holmes. The officer and the night manager went into his cell and found him lying in the toilet area, face down and unresponsive. At 5.15am, the night manager radioed an emergency medical code and the control room quickly requested an ambulance. Another officer arrived and they began cardiopulmonary resuscitation. Within minutes, two nurses arrived at the cell with emergency equipment and carried on the resuscitation attempt. Paramedics arrived at 5.26am and continued emergency treatment. Mr Holmes did not respond. At 5.55am, the paramedics pronounced him dead.

Findings

4. The clinical reviewer noted that the management of Mr Holmes' long term conditions would have benefitted from a multidisciplinary approach but considered that the clinical care Mr Holmes received at Liverpool was equivalent to that he could have expected to receive in the community. We are satisfied that Mr Holmes received an appropriate standard of care at the prison and that the emergency response when staff found him collapsed was well managed. We make no recommendations.

The Investigation Process

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

6. The investigator obtained copies of relevant extracts from Mr Holmes' prison and medical records.

7. NHS England commissioned a clinical reviewer to review Mr Holmes' clinical care at the prison. In his clinical review he made two recommendations about medicines management and record keeping, which the Head of Healthcare will need to address. We do not repeat them in this report as the issues were not directly related to Mr Holmes' death.

8. The investigator interviewed two members of staff at Liverpool on 29 July. On 4 August, she and the clinical reviewer jointly interviewed two further members of staff.

9. We informed HM Coroner for Merseyside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Holmes' daughter, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She said she was unhappy that the prison did not continue to support her actively after her father's funeral. She asked for more information about the events leading up to his death, including:

    - The action staff took and how often they checked him when he became unwell on the night of 26/27 May.
    - Why he was not monitored between 2.00am and 5.10am, or moved somewhere he could be watched more closely
    - Whether he received his medications as prescribed.

11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

12. Mr Holmes' daughter received a copy of the initial report. She did not make any comments.

Background Information

HMP Liverpool

13. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. At the time Mr Holmes was at Liverpool, Lancashire Care NHS Foundation Trust provided primary care services and Mersey Care NHS Trust provided mental health and substance misuse services. Lancashire Care NHS Foundation Trust now provides all healthcare services. There is 24-hour inpatient care.

HM Inspectorate of Prisons

14. The report of the most recent inspection of HMP Liverpool in May 2015 has not yet been published. In preliminary feedback, inspectors noted that in response to previous recommendations from the Prisons and Probation Ombudsman, the NHS Trust's Director of Nursing had written to NHS staff at the prison, reminding them of the requirement to adhere to Nursing and Midwifery Council (NMC) guidance when administering medication. The prison had also introduced a pharmacy medication management action plan, for storing and dispensing medication, in line with national professional guidelines. At the previous inspection in October 2013, the inspectorate reported that health services were generally good but staff recruitment problems had hampered the prison's ability to deliver a comprehensive service. Primary care services were sufficient to meet need but treatment for life-long conditions was underdeveloped.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2014, the IMB reported that staff provided a high standard of professional care for prisoners in sometimes very difficult circumstances. The IMB considered that the new healthcare provider had made a number of improvements to services.

Previous deaths at HMP Liverpool

16. Mr Holmes was the fourth prisoner to die of natural causes at HMP Liverpool since January 2014. There were no significant similarities with the finding of the investigations into the other deaths.

Key Events

17. On 7 January 2012, Mr Paul Holmes was remanded to HMP Liverpool and on 12 July 2012, he was convicted of murder. He received a mandatory life sentence with a minimum period to serve of 18 years before he could be considered for release.

18. Mr Holmes had several long term health problems, including chronic obstructive pulmonary disease (COPD – the name for a collection of long term progressive lung diseases including chronic bronchitis, emphysema and chronic obstructive airways disease); lung fibrosis (scarring of the lung, which causes breathing problems); ischaemic heart disease; and angina. He had a number of other conditions related to liver disease arising from alcoholism, including liver cirrhosis (scarring of the liver due to long-term damage) and gastric varices (blood vessels that are at risk of rupture).

19. Prison GPs and specialists at the hospital managed Mr Holmes' conditions and prescribed inhalers to help relieve his shortness of breath. Mr Holmes was a heavy smoker and healthcare staff frequently offered to help him stop smoking. Although he cut down, he refused to stop smoking.

20. Mr Holmes' last detailed, multidisciplinary review at the prison was in July 2014. It is not clear when his last medication review was held but there is nothing to indicate that he was not taking his prescribed medications. Although Mr Holmes had not had a recent review in the prison clinic, he had attended an appointment at the lung clinic at hospital on 19 February 2015. His consultant told him that his lung condition could be managed if he stopped smoking. Mr Holmes refused and said he understood his conditions would get worse if he did not stop. She prescribed inhalers and discharged him from the clinic, as there were no other treatment options.

26 and 27 May 2015

21. At about 9.30pm on 26 May, an officer asked a nurse to assess Mr Holmes as he had been vomiting. The nurse examined him and took his clinical observations, including blood pressure, oxygen saturation and temperature. They were all within the normal ranges. Mr Holmes was not sweating and had no chest pain or breathing problems, although he looked pale. The nurse gave Mr Holmes 10 milligrams (mg) of metoclopramide (to help control nausea and vomiting) and advised him to drink plenty of fluids. Mr Holmes said he would tell wing staff if his symptoms worsened or persisted.

22. At 11.50pm, the nurse went back to check Mr Holmes, who said he had diarrhoea. His observations were still normal. The nurse gave Mr Holmes three 2mg capsules of loperamide to treat the diarrhoea.

23. The nurse checked Mr Holmes again at 2.00am on 27 May. He said his symptoms had eased and he felt a little better, but he was worried the diarrhoea would return as he had vomited after taking the last dose of medication. The nurse said he did not look as pale as previously. He gave him another dose of loperamide and advised against going to work for 48 hours. He said that healthcare staff would check on him again in the morning. The nurse and the

officer both advised him to ring his cell bell to alert them if he had any further problems. Mr Holmes had plenty of water by his bedside and said he would try to get some sleep.

24. At about 5.10am, the officer began checking all prisoners were present in their cells. When he looked through the observation panel of Mr Holmes' cell door he could not see him. He called out to him, as he thought he might be using the toilet, but did not get a response. He ran to the wing centre (about 20 yards away) and shouted to the night manager. He asked the night manager to open Mr Holmes' cell door so they could check him. The night manager said it took him about 30 seconds to get to the cell.

25. When the night manager and officer went into the cell, they found Mr Holmes face down on the floor in the toilet area. At 5.15am, the night manager radioed a code blue (a medical code used to indicate a life-threatening emergency where a prisoner is unconscious, not breathing or is having breathing difficulties). The communications room log showed that staff called an ambulance immediately.

26. The officer turned Mr Holmes over and another colleague arrived. Mr Holmes was unresponsive and they immediately started cardiopulmonary resuscitation.

27. A nurse said that after hearing the code blue, he immediately went to Mr Holmes' cell with an emergency bag and defibrillator (a life-saving device that administers an electric shock to re-start the heart if it detects a rhythm). He arrived at about 5.18am. Another nurse got to the cell at around the same time and the nurse took over the resuscitation attempt.

28. The nurse gave Mr Holmes oxygen and attached the defibrillator. On the third cycle, the defibrillator advised a shock, but Mr Holmes did not respond so the nurses continued cardiopulmonary resuscitation. Paramedics arrived at Mr Holmes' cell at 5.26am and took over emergency treatment, assisted by the nurses. Mr Holmes did not respond. At 5.55am, the paramedics declared Mr Holmes dead.

Contact with the family

29. An operational manager at the prison acted as the prison's family liaison officer. She and the duty chaplain visited Mr Holmes' daughter at 9.50am to break the news of his death. They explained what would happen next and she gave them her contact details for ongoing support.

30. Mr Holmes' funeral was held on 10 June and the prison contributed towards the costs, in line with national policy. After the funeral, the family liaison officer told Mr Holmes' daughter to contact her if she had any questions or concerns.

Support for prisoners and staff

31. The night manager debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

32. The prison posted notices informing other prisoners of Mr Holmes' death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and

self-harm in case they had been adversely affected by Mr Holmes' death. The prison held a memorial service for Mr Holmes on 18 June.

Post-mortem report

33. The post-mortem report indicated that Mr Holmes died of cardio-respiratory failure, due to chronic obstructive pulmonary disease.

Findings

Clinical care

34. Mr Holmes had many long-term chronic conditions, including severe lung disease. Against the advice of prison healthcare and hospital staff, he continued to smoke, which is one of the main causes of COPD and makes the condition progressively worse. Healthcare staff appropriately referred him to prison GPs and secondary services, such as the lung clinic at the hospital.

35. Mr Holmes was unwell with vomiting and diarrhoea during the night and early hours of 26/27 May. A nurse assessed him three times between 9.30pm and 2.00am and his clinical observations were within normal limits. He gave him medication to ease his symptoms. At the last check, Mr Holmes said he felt a little better and his colour had improved. Staff advised him to alert them if he became worse.

36. As Mr Holmes' condition had improved when he was last checked, and the nurse had arranged for him to be seen in the morning, we consider it was reasonable that no further checks were made between 2.00am and 5.10am. There was nothing to indicate a serious deterioration in his condition and Mr Holmes did not use his cell bell again to indicate he was feeling worse.

37. The clinical reviewer concluded that Mr Holmes' care at HMP Liverpool was generally equivalent to that he could have expected to receive in the community. He considered that Mr Holmes received good ongoing medical care for his long term conditions but noted that there was no recent evidence of a multidisciplinary approach. However, National Institute for Health and Care Excellence (NICE) guidelines recommend annual reviews and Mr Holmes' last review was in July 2014, ten months previously. He had also been seen in the hospital lung clinic three months before his death, when a consultant considered that there were no additional treatment options. We are satisfied that Mr Holmes received an appropriate standard of care at Liverpool.

Emergency Response

38. Liverpool's local protocol states that, for security reasons, two officers should be present when opening a cell door during the night, unless it is a clear life-threatening emergency. An officer knew that Mr Holmes was unwell with vomiting and diarrhoea during the night, but that he had felt better when last checked at 2.00am. When he could not see or get a response from Mr Holmes during the early morning check, he initially thought he might be using the toilet. The night manager was approximately 20 yards from Mr Holmes' cell and it took him around 30 seconds to reach the cell and open the door when the officer called to him. We are satisfied that this was a quick response and there was nothing to indicate immediately that it was a life-threatening emergency. The emergency response was timely and appropriate.

Family Liaison

39. After Mr Holmes died, the family liaison officer quickly informed Mr Holmes' daughter of his death and supported her. After the funeral, on 10 June, she

asked Mr Holmes' daughter to contact her if she had any further questions or concerns. We understand that Mr Holmes' daughter did not consider that this was well timed, but we are satisfied that the family liaison officer reasonably offered further help and support if Mr Holmes' daughter needed it.

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