Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ashley Gill a prisoner at HMP Liverpool on 29 April 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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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*

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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 Ashley Gill died of an acute asthma attack at HMP Liverpool on 29 April 2015. He was 25 years old. I offer my condolences to Mr Gill's family and friends.

Mr Gill had had severe asthma and had taken unprescribed medication and a new psychoactive substance, often known as 'spice', which contributed to his death. He often did not cooperate with his treatment or follow medical advice to give up smoking. His use of drugs exacerbated his condition. Nevertheless, the investigation found that Mr Gill did not receive a standard of healthcare equivalent to that he could have expected to receive in the community. There was no effective handover of care when Mr Gill transferred from HMP Forest Bank to Liverpool at the beginning of April, medical record keeping was poor and Mr Gill did not receive all the medication he had been prescribed for his asthma. I am concerned that there was no systematic management and active on-going monitoring of Mr Gill's chronic condition at Liverpool and signs that might have identified a need for an early transfer to hospital on the day he died were missed. We cannot know whether this would have altered the outcome, but it does not appear that Mr Gill would have survived this asthma attack.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **July 2016**

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Summary

Events

1. In July 2014, Mr Ashley Gill was released on licence from HMP Forest Back. He breached his licence conditions and went back to Forest Bank in September 2014.

2. Mr Gill had suffered from asthma since he was a child. Healthcare staff at Forest Bank saw Mr Gill frequently to monitor his condition. In February and March 2015, Mr Gill was admitted to hospital when his asthma deteriorated and doctors prescribed additional medication.

3. On 1 April 2015, Mr Gill transferred to HMP Liverpool. When he arrived, a nurse referred him to a chronic disease management nurse and a doctor prescribed medication. However, healthcare staff at Forest Bank had not handed over his care effectively and staff at Liverpool did not have a clear and up to date summary of the medication he had been prescribed. A doctor asked staff to find this out. There is no record that this happened.

4. A week later, a nurse reviewed Mr Gill and noted that he did not appear to have the correct medication. She discussed this with a doctor, who prescribed steroid medication, but did not record this in Mr Gill's medical record. Mr Gill made a written complaint about not being given the correct medication. A nurse responded to say that his medication had been prescribed but he had not collected it. She did not address the issue that he had still not been prescribed all the correct medication.

5. On 24 April, Mr Gill was moved to another wing after threatening an officer. On 28 April, Mr Gill rang his cell bell and told an officer he was having an asthma attack. The officer noted he was aggressive and abusive. Officers checked that he had received his medication and he said he did not need medical assistance. His cellmate said that Mr Gill had been smoking spice and had threatened him, so officers moved his cellmate. An officer said he later took a nurse to Mr Gill's cell to check him, but there is no entry from a nurse in his medical record.

6. On the afternoon of 29 April, a doctor examined Mr Gill, and noted that his asthma had deteriorated since he had arrived at Liverpool. Mr Gill told the doctor that he had waited 40 minutes for officers to respond to his cell bell, during an asthma attack the previous day. She prescribed further medication to be delivered the next day, and gave Mr Gill some medication using a nebuliser, (a machine which delivers asthma medication by turning it into a mist which is inhaled through a mask or mouthpiece). Mr Gill went back to his wing at about 4.15pm.

7. The doctor wrote a letter for wing staff emphasising the importance of responding immediately to Mr Gill's cell bell, because of his condition. She went to deliver it but when she got to the wing, around 5.00pm, she saw that Mr Gill's cell bell was ringing. He was having an asthma attack and said the he had been ringing his bell for twenty minutes. The doctor found officers to unlock the cell. She examined Mr Gill and told the wing manager that he needed to go to hospital. Mr Gill said he preferred to try a nebuliser first. The doctor went to get one from the

wing treatment room where she asked a nurse to call an ambulance. At 5.08m, the control room requested an emergency ambulance.

8. Mr Gill's breathing got worse and his condition deteriorated further. An officer called a medical emergency and the control room called an ambulance again. Mr Gill stopped breathing and then his heart stopped. The prison made a further call to the ambulance service and healthcare staff tried to resuscitate him. At 5.35pm, paramedics arrived and took over emergency treatment. Mr Gill did not respond and at 6.00pm paramedics recorded his death.

9. A post-mortem examination found that Mr Gill had died of an acute exacerbation of poorly controlled asthma. He had used a beta-blocker which he had not been prescribed and a synthetic cannabinoid. These, and smoking, were listed as contributory factors to his death.

Findings

10. There was poor continuity of care when Mr Gill transferred from Forest Bank to Liverpool. This meant that healthcare staff at Liverpool did not know what medication he had been prescribed at Forest Bank.

11. Although Mr Gill was referred to a chronic disease management nurse at Liverpool, his serious condition was not managed proactively to ensure he received appropriate treatment. A GP made good attempts to rectify this on the day that Mr Gill died. She gave him treatment and prescribed a range of medication that would be delivered the next day. A specialist respiratory consultant report prepared for the coroner noted that there signs that Mr Gill had not responded to treatment and hospital admission should have been considered at the time. However, the consultant recognised that Mr Gill did not claim to be having an asthma attack and seemed unperturbed, which might have given false reassurance. Mr Gill was a difficult patient; he could be violent and threatening and did not comply with his treatment consistently. He smoked and took drugs which exacerbated his condition. However, we do not consider he received care at Liverpool, equivalent to that he would have received in the community.

12. The investigation found that staff did not have good knowledge of the expected emergency procedures, but we are satisfied that this did not cause a detriment in Mr Gill's care. The GP requested an emergency ambulance immediately when she found that Mr Gill was having a severe asthma attack and the prison chased this up twice. Healthcare staff began cardiopulmonary resuscitation immediately and to a good standard when Mr Gill had a cardiac arrest. However, we are concerned that there is some evidence that Mr Gill had used his emergency cell bell some time before the GP found him having an asthma attack. Officers had not attended and an earlier response might have led to quicker intervention.

Recommendations

To HMP Forest Bank

- The Head of Healthcare at Forest Bank should ensure that there are comprehensive and well recorded handovers to ensure continuity of care when prisoners with significant health issues transfer to other prisons.

To HMP Liverpool

- The Head of Healthcare should ensure that prisoners with chronic diseases are appropriately assessed and monitored by GPs or by trained nurses in regular chronic disease management clinics and have appropriate management plans that are communicated effectively to healthcare and relevant prison staff.
- The Head of Healthcare should ensure that all healthcare staff fully comply with professional requirements for accurate record keeping.
- The Governor should ensure that all cell bells are answered within five minutes
- The Governor and Head of Healthcare should ensure that all staff are clear about their responsibilities under PSI 03/2013 and the local emergency protocol, and that this is part of induction for all new staff.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. Two prisoners responded.

14. NHS England commissioned a clinical reviewer to review Mr Gill's clinical care at the prison.

15. The investigator visited the prison on 11 May. He obtained copies of relevant extracts from Mr Gill's prison and medical records and interviewed one member of staff.

16. The investigator and another investigator, and the clinical reviewer interviewed five members of staff at HMP Liverpool on 15 June.

17. We informed HM Coroner for Merseyside of the investigation who gave us the results of the toxicology and post-mortem examination. We suspended our investigation for one month for police enquiries and regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Gill's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to take into account. She had the following questions for the investigation to consider:

    - Did staff respond to Mr Gill's cell bell promptly?
    - Was the emergency response adequate?
    - Did the prison turn away the ambulance?
    - When the prison rang the ambulance service, did they tell the operator what this was for?
    - Did Mr Gill have all of his inhalers and how was his asthma managed?
    - Should Mr Gill have been an inpatient in the healthcare unit?

19. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and the action plan responding to our recommendations has been annexed to this report.

20. Mr Gill's mother received a copy of the initial report. The solicitor representing her did not make any comments.

21. Mr Gill's partner received a copy of the initial report. The solicitor representing her wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Liverpool

22. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. From January 2015 to June 2015, Lancashire Care NHS Foundation Trust provided primary care services and Mersey Care NHS Trust provided mental health and substance misuse services as an interim arrangement when NHS England ended its contact with the previous provide after significant concerns about the safety of the service. Lancashire Care NHS Foundation Trust now provides all healthcare services. The Lifeline team provides additional interventions and services for prisoners with drug and alcohol problems.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Liverpool was in May 2015. Inspectors reported that since the previous inspection, primary healthcare services had deteriorated. In late 2014, elements of the service had been judged unsafe. The new provider had inherited a failing service. Governance was improving but severe staffing shortages restricted provision. Waiting times for most primary care services were too long and management of lifelong conditions needed improving. The inpatient unit was not a sufficiently therapeutic environment.

24. There was evidence of increased use of new psychoactive substances (NPS) and examples of prisoners under the effects of these, including reported use of spice – synthetic cannabis that mimics the effects of cannabis but is much stronger and is difficult to detect. Inspectors noted that the prison was dealing with the issue robustly. This included education for prisoners and staff, and a clear protocol for dealing with prisoners suspected of using these substances.

25. There was no automated monitoring of cell call bell responses, and in the inspectorate's survey of prisoners only 12%, against 28% on other similar prisons, said that bells were answered within five minutes. Inspectors pressed a cell call bell but had still not obtained a response from staff after 15 minutes.

Independent Monitoring Board

26. 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, the IMB noted that Lancashire Care NHS Foundation Trust had made a number of improvements after taking over provision of healthcare at the prison. The IMB reported that drugs were an issue of constant concern and that significant efforts had been taken to address this, although more resources were needed.

Previous deaths at HMP Liverpool

27. Mr Gill was the third person to die of natural causes at Liverpool since January 2014. There were no similarities with the circumstances of the other deaths.

Key Events

28. On 6 September 2013, Mr Ashley Gill was sentenced to one year and eight months for burglary and theft and sent to HMP Forest Bank. He was released on licence on 4 July 2014, but was recalled to prison on 15 September, for breaching his licence conditions by committing further offences. He had seven days added to his existing sentence and returned to Forest Bank.

29. Mr Gill had suffered from asthma since he was a child. Healthcare staff at Forest Bank monitored his condition and prescribed medication. Mr Gill smoked cigarettes and ignored medical advice that it was harmful for his health, particularly because of his asthma. He refused help to give up smoking. Mr Gill's medical and prison records show that there times when Mr Gill was considered to be under the influence of new psychoactive substances (NPS).

30. Mr Gill often did not accept medical advice and occasionally refused to take his medication. Healthcare staff told him to stop misusing inhalers, which included overusing his own, using them to take other substances or using inhalers given to him by other people. Healthcare staff recorded that Mr Gill sometimes used his asthma inhaler as a pipe to smoke tobacco and illicit substances. They warned him against this and tried to limit his dosage or prescribe different inhalers. Sometimes he destroyed his inhalers in protest.

31. Doctors had diagnosed Mr Gill with Attention Deficit Hyperactivity Disorder (ADHD) in childhood and his difficult behaviour continued into adulthood. His records show he often behaved aggressively towards staff. In October 2014, Mr Gill destroying the furnishings of a cell in the healthcare centre when he was there for observation. He told Nurse A that he was protesting at being in the healthcare unit and said that he did not need to be there.

32. In 2014, Mr Gill's asthma deteriorated and he had a number of hospital admissions for unstable, brittle asthma (a form of asthma that is difficult to control and is characterised by sudden, unpredictable drops in lung function). Healthcare staff tried to explain to him the harmful consequences of not complying with his asthma treatment but he continued not to follow advice.

33. On 17 February 2015, consultant physician reviewed Mr Gill at an asthma clinic at the Royal Salford Hospital. He recorded that Mr Gill was taking various medications, which included a salbutamol inhaler (a short acting asthma treatment drug), serevant (for asthma), qvar (a steroid to prevent inflammation of the lungs), tiotropium bromide (for breathing difficulties), zafirlukast (an anti-allergy medication), beconase nasal spray (for hay fever), cetirizine (an antihistamine), and frequent courses of steroids. He referred Mr Gill to the Complex Breathing Unit at Preston Hospital.

34. On 27 February, Mr Gill was taken to the Royal Salford Hospital by emergency ambulance as his asthma had worsened. He discharged himself two days later, against medical advice and returned to the prison.

35. On 24 March, a prison GP, A, referred Mr Gill back to hospital, after another asthma attack. The hospital discharged him on 26 March. Nurse B assessed him when he returned Forest Bank and noted that the hospital had prescribed

medication including fostair (to prevent inflammation of the lungs and excess mucus formation). There is no record of a hospital discharge letter, detailing exactly what medication doctors had prescribed.

36. The next day, Mr Gill told Nurse C that he did not have all of his inhalers since he had got back from hospital. The nurse said he would give him all his prescribed medication if he came to the medication hatch, but Mr Gill refused. There is no record of a further prescription in his medical records after he was discharged from hospital.

HMP Liverpool

37. On 1 April, Mr Gill transferred to HMP Liverpool. At an initial health screen, Nurse D recorded that he was asthmatic. This triggered an automatic referral to the chronic disease management nurse to manage his condition. A prison GP, Dr B, prescribed tiotropium bromide, salbutamol and salmeterol inhaler medication for his asthma, but did not see him.

38. On 2 April, another prison GP, Dr C, received a message from Forest Bank advising that Mr Gill should be prescribed a reducing course of steroids, but gave no detail of the dose or any other prescriptions. The doctor recorded that she did not know his current dose or medications, which were not listed in his medical records. She asked staff to get this information. There is no record that this happened or that a doctor prescribed any steroid medication at the time.

39. On 9 April, Nurse E, the chronic disease management nurse, saw Mr Gill to review his asthma after the reception referral. She recorded that she was concerned Mr Gill was not receiving his medication or inhalers. The nurse told us she discussed this with Dr D, who prescribed a 14-day course of prednisolone (a steroid to reduced inflammation in the lungs). There is no record of this prescription in Mr Gill's medical record.

40. On 16 April, Mr Gill wrote a formal letter of complaint saying that he had not received the prednisolone, which he said had been prescribed when he was in hospital, a few days before he had arrived at Liverpool. Neither did he have a fostair or qvar inhaler, which he said staff had taken from him when he arrived at Liverpool. On 19 April, Nurse D responded to say that a prescription had been prepared but that he had not been to the medication hatch to collect this. However, his full medication had not been prescribed.

41. On 24 April, Mr Gill was moved to another wing, after he had threatened to harm an officer on his current wing. About 5.00pm on 28 April, Officer A responded to Mr Gill's cell bell and Mr Gill said he was having an asthma attack. The officer recorded that Mr Gill was verbally abusive and aggressive. He asked Mr Gill to calm down and said that he would not open the cell until he did. He went away for a short time and came back with Supervising Officer (SO). Mr Gill told the SO that he did not want any medical help. Mr Gill's cellmate told the SO that Mr Gill had been smoking spice, a type of NPS, and had threatened him. The SO moved his cellmate to another cell.

42. Officer B went to the medication hatch to check whether Mr Gill had collected his medication and a nurse confirmed that he had received it. The SO told the

investigator that about 6.00pm, he took Nurse F to Mr Gill's cell to check on him. There was no record of this in Mr Gill's medical record.

29 April

43. At 7.55am, SO A and Officer C went to check Mr Gill in his cell and Mr Gill told them that he was feeling fine. Around 9.00am, Mr Gill went to the medication hatch to collect his medication. He told Nurse G that he was missing an asthma inhaler and that his other inhaler was nearly finished. He said he was finishing a ventolin inhaler every two days. The nurse informed Dr C who reviewed Mr Gill's record. She recorded that Mr Gill's asthma had got worse and noted that there was a letter from the respiratory clinic at Salford Royal Hospital listing several medications that were not on Mr Gill's prescription chart. The doctor noted there was no way of knowing what medication Mr Gill should be on at the time based on the information in the medical records and decided to review his medication with him.

44. Around 3.30pm that day, Dr C and Nurse G assessed Mr Gill and reviewed his medication. Mr Gill told the doctor that his asthma had got worse since he had arrived at Liverpool and that he had not had all his usual medication. He told her that he did not have any pillows, which he needed due to his asthma. After a detailed assessment, the doctor prescribed salbutamol, samerterol, tiotropium bromide, zafirlukast, fostair and cetirizine. She gave Mr Gill a salbutamol inhaler to take with him and arranged for him to have extra pillows. The pharmacy was due to deliver the rest of the medication the next day.

45. The C found that Mr Gill had a moderate exacerbation of asthma. She noted he was breathing normally, able to talk in full sentences, had a pulse rate of 96 beats per minute (within normal limits), some wheezing from his chest and a normal oxygen saturation of 96%. She recorded that his peak flow (a measurement of lung capacity) was 350 l/min, a low score that could indicate an asthma attack. At around 4.00pm, she gave Mr Gill an oral dose of prednisolone and salbutamol though a nebuliser (a machine to deliver asthma medication by turning it into a mist to be inhaled though a face mask or mouthpiece). The Dr C suggested that he keep the nebuliser overnight, but he said he did not want it as it did not help.

46. Mr Gill told Dr C that, the previous day, he had waited 40 minutes before an officer responded to his cell bell when he was suffering from breathing problems. The doctor wrote a letter to the SO, the wing manager, about the severity of Mr Gill's condition. The letter said that wing staff needed to respond to Mr Gill's cell bell immediately to check whether his asthma had deteriorated and that he might have to be seen by a nurse or go hospital if this happened. At around 4.15pm, Mr Gill went back to his wing. He did not show any signs of distress at this time.

47. At approximately 4.50pm, Dr C went to Mr Gill's wing to give the SO the letter but could not find him immediately. She went to Mr Gill's cell and found that the cell bell light was on. (When a prisoner uses the cell bell, as well an audible ring, there is light outside the cell to indicate which cell it is.) Mr Gill told Dr C he was short of breath and had been ringing the cell bell for at least 20 minutes. The cell was locked. The doctor found the SO and said she needed to get in to see Mr Gill straight away.

48. The SO and Dr C went back to Mr Gill's cell with Officer C, around 5.00pm. The doctor went into the cell and examined Mr Gill, who was having difficulty breathing. The doctor noted his peak flow was now 130 l/min (significantly lower than an hour before) and said he urgently needed to go to hospital. Mr Gill said he did not want to go to hospital and asked to use the nebuliser instead. The doctor went to collect a nebuliser and an emergency bag from the wing clinic. She saw Nurse G there and asked her to call an ambulance. The nurse spoke to a custodial manager, who was the orderly officer that day (responsible for the routine operation of the prison) and asked him to arrange an ambulance. At 5.08pm, the custodial manager noted that the nurse had requested a "blue light" ambulance for Ashley Gill who was having a severe asthmatic attack.

49. Dr C went back to Mr Gill's cell with Nurse H and told the SO that Mr Gill needed to go to hospital. The SO went to find the duty custodial manager to arrange a hospital escort. The control room log showed that at 5.08pm, a member of staff called an ambulance because Mr Gill had breathing problems. Nurse G arrived at the cell and the healthcare staff gave Mr Gill salbutamol using a nebuliser. However, Mr Gill became agitated and tried to remove the nebuliser mask. As he struggled, the equipment fell to the floor and broke. Nurse G went to get another and came back with one two minutes later. In the meantime, the doctor and Nurse H gave Mr Gill oxygen using a mask.

50. Mr Gill was distressed and lashing about in his effort to breathe. (Dr C believed this was because of a lack of oxygen.) This made it difficult to keep the nebuliser and oxygen mask in position. Officer D tried to reassure Mr Gill and held his arm. The doctor asked the SO to hold Mr Gill still. The SO helped Mr Gill sit on the floor, supported his head between his knees and placed the palm of his hand on Mr Gill's head. After around a minute, Mr Gill became weak, his face went pale and he stopped breathing.

51. At 5.20pm, the control room log showed that the SO called a code blue. (An emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.) The log indicates that a member of staff in the control room called the ambulance service again at 5.21pm and 5.31pm to check when the ambulance would arrive. At 5.31pm, they told the operator that Mr Gill was in cardiac arrest. The ambulance service had despatched an ambulance at 5.08pm, but had not logged the original call as high priority. The ambulance had then been sent to another higher priority emergency. When the ambulance service operator learnt that Mr Gill was in cardiac arrest, they escalated the priority of the call and the ambulance headed back to the prison.

52. After Mr Gill stopped breathing, Dr C inserted an airway and used an ambubag to give him oxygen. Two minutes later, Mr Gill had a cardiac arrest and Nurse G began cardiopulmonary resuscitation. More nurses arrived and helped with the resuscitation attempt. They moved Mr Gill from the cell onto the landing, which allowed more space. Nurse D attached a defibrillator to Mr Gill, but this found no shockable rhythm.

53. At 5.35pm, two paramedics arrived at the cell, followed by another paramedic a few minutes later. The paramedics took control of the emergency treatment and

administered adrenalin. The resuscitation attempt continued but Mr Gill did not respond. At 6.00pm, a paramedic recorded that Mr Gill had died.

Contact with Mr Gill's family

54. That evening, the Governor and prison manager drove to Mr Gill's mother's house to inform her of Mr Gill's death. However, there was no one there. They then went to the address they had for Mr Gill's partner. The arrived around 11.00pm, but found that Mr Gill's partner no longer lived there.

55. The prison asked the police to help inform Mr Gill's family that he died. In the early hours of 30 April, the police informed Mr Gill's mother. Later that day, the prison manage telephoned Mr Gill's mother and offered condolences. She and the governor arranged to visit Mr Gill's mother that afternoon.

56. At Mr Gill's mother's request the prison manager A acted as the prison's family liaison officer. Prison manager remained in contact with Mr Gill's mother to support her and helped organise the funeral. Mr Gill's funeral was on 27 May. The prison offered a contribution to the cost, in line with national instructions.

Support for prisoners and staff

57. Prison manager A debriefed the staff involved in the emergency response and offered her support and that of the staff care team.

58. The prison posted notices informing staff and prisoners of Mr Gill's 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 Gill's death.

Post-mortem report

59. A post-mortem examination found that Mr Gill had died of an acute exacerbation of poorly controlled asthma. Ingestion of propranolol and smoking tobacco and a synthetic cannabinoid were listed as contributory factors.

60. Toxicology tests found that Mr Gill had taken propranolol (a beta-blocker) and a synthetic cannabinoid (new psychoactive substance). Further forensic evidence found that Mr Gill had used his asthma inhaler as a pipe for smoking spice. Propranolol is a prohibited medication for asthmatics as it can cause the airways to contract, leading to acute severe asthma. Mr Gill had never been prescribed propranolol in prison.

Findings

Clinical care

61. When Mr Gill arrived at HMP Liverpool on 1 April, healthcare staff did not have up to date information about what medication he had been prescribed t the time. Mr Gill had been in hospital a month earlier, and appears to have been prescribed medication while he was there but there is no record of a discharge letter listing his medication. Staff at Forest Bank said that the hospital rarely provided discharge letters. A Performance Delivery Unit manager at Forest Bank told the investigator that when Mr Gill went to Liverpool there had been no verbal handover as it was a security transfer. He said that all information about his medication, his medical history and any medication would have gone with him. This was not the case. On 2 April, Dr C received a message that Mr Gill should be receiving a reducing course of steroids, but the message gave no information about the required dose for the steroids of any other medication and this was not listed in his medical record.

62. Prison Service Order (PSO) 3050 states that when prisoner transfers between establishments good communication is essential for patient care and that this will vary depending on the patients needs. The PSO notes that an up to date patient summary card with significant events and problems, the clinical record and a sufficient supply of medication will often be all that is required. However, it says that in cases of patients with more complex health needs, more planning such as communicating directly with the receiving healthcare team before transferring may be required. Given the seriousness of Mr Gill's asthma and his recent hospital admission, we are not satisfied that Forest Bank took sufficient steps to ensure basic good continuity of care. The clinical reviewer commented that there was a lack of information in Mr Gill's records that confirmed his ongoing treatment. A summary from Forest Bank when Mr Gill transferred to Liverpool would have allowed the correct medication to be prescribed and highlighted the risk his unstable asthma presented. We are not satisfied that this happened. We make the following recommendation:

    The Head of Healthcare at Forest Bank should ensure that there are comprehensive and well recorded handovers to ensure continuity of care when prisoners with significant health issues transfer to other prisons.

63. On 2 April, Dr C noted that it was unclear what medication doctors had prescribed Mr Gill and asked that healthcare staff should find out more from Forest Bank. This did not happen. With incomplete information about Mr Gill's prescription history, we do not consider that Liverpool was able to manage his asthma appropriately when he arrived at the prison.

64. Mr Gill's asthma led to an automatic referral to a chronic disease management nurse. On 9 April, Nurse E, the chronic disease management nurse, reviewed his asthma and created a care plan using a template. However, the care plan did not highlight his risk of an acute asthma attack. The nurse told us she had not been able to carry her role properly, due to staffing pressures and had not run chronic disease clinics for over a year. We note that the recent inspection of Liverpool in May 2015, found that prisoners did not have consistent timely access

to the full range of primary care services such as chronic disease management, clinics and screening, because of severe staffing shortages.

65. Nurse E told us that after she had reviewed Mr Gill, Dr D prescribed steroid medication. However, Mr Gill did not receive it and there is no entry in the SystmOne medical record about this. Mr Gill complained that he had not received his full medication but the reply he received from Nurse D did not indicate that she reviewed his prescriptions to ensure he was receiving the correct medication.

66. On 28 April, Mr Gill was aggressive towards officers when he was having an asthma attack. (He later explained that this was because he thought staff were denying him appropriate medical treatment.) The SO said that he took a nurse to Mr Gill's cell to check him. However, there was no entry from a nurse at the time in Mr Gill's medical records, to show that he had been assessed.

67. On 29 April, Dr C systematically reviewed Mr Gill's SystmOne record and previously archived prescription charts after he had complained to Nurse G about his medication. The doctor noted that she was unable to understand Mr Gill's treatment regime for his asthma fully because the records were incomplete and fragmented. She arranged to see Mr Gill for a consultation that afternoon and took a detailed history when Mr Gill told her that he was becoming increasingly short of breath and he had not had his regular medication. After a full examination, the doctor prescribed a full range of appropriate medication, which was due to be delivered the next day. In the meantime, she administered medication through a nebuliser. She arranged that Mr Gill should have more pillows and wrote a note for his wing manager, stressing the importance of officers answering his cell bell immediately, in case of a life threatening asthma attack.

68. The clinical reviewer noted that Dr C's intervention on the 29 April, providing a full assessment and rectifying Mr Gill's prescription appears to have been very well delivered and an example of good practice.

69. In his report for the coroner, the respiratory consultant noted that Mr Gill had not responded to the nebuliser therapy on the afternoon of 29 April, yet Dr C allowed him to go back to his wing without further treatment. He noted that when this had happened previously, other prison doctors had administered a second and third dose of nebuliser therapy and arranged to have Mr Gill transferred to hospital. However, the respiratory consultant recognised that this episode was different as Mr Gill had not reported an asthma attack and did not seem concerned, which might have given healthcare staff false reassurance.

70. We now know that Mr Gill had taken propranolol, which would have lowered his heart rate and impeded the effectiveness of the nebuliser therapy. He had also used a cannabinoid, which might have impaired his judgment and led him to underestimate the severity of his asthma attack. The respiratory consultant considered Dr C should have kept him at the surgery and administered another dose of nebuliser therapy and if his condition did not improve, arrange for him to go to hospital. However, he noted that if his bronchial tubes were severely congested by mucus plugging, (the post-mortem examination subsequently

identified this was the case) then it would have been unlikely that Mr Gill would have survived the asthma attack.

71. The clinical reviewer concluded that Mr Gill's care at Liverpool was not equivalent to that he could have expected to receive in the community. There was a lack of information about his ongoing treatment at his reception screening and inconsistencies in the record keeping on SystmOne (the computerised prison medical record system). Apart from Nurse E's meeting on 9 April, which did not fully identify his risk, and until Dr C reviewed his care on 29 April, there was no proactive, assertive management of Mr Gill's asthma. Mr Gill did not receive all his prescribed medication. We do not consider that Mr Gill needed to be admitted to the inpatient unit at Liverpool, but there was a lack of active management of his asthma and a need for effective chronic disease management programmes at the prison. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with chronic diseases are appropriately assessed and monitored by GPs or by trained nurses in regular chronic disease management clinics and have appropriate management plans that are communicated effectively to healthcare and relevant prison staff.

The Head of Healthcare should ensure that all healthcare staff fully comply with professional requirements for accurate record keeping.

Answering cell bells

72. Liverpool does not have an automated system to monitor response times to cell bells so we cannot know for sure how long Mr Gill waited for officers to respond when he rang his cell bell. He told Dr C that he had waited around 40 minutes on 28 April for staff to respond. On 29 April, he said that he had been waiting 20 minutes when the doctor found his bell ringing when she arrived on his wing. His cellmate told the investigator that Mr Gill had been waiting some time for a response to the cell bell on 29 April. The doctor had come to the wing specifically to deliver a note to wing staff to reinforce the importance of responding to Mr Gill's cell bells urgently.

73. Her Majesty's Inspector of Prisons has an expectation that cell bells should be answered within five minutes and this is the standard we expect. Inspectors have noted at successive inspections that staff at Liverpool do not respond to cell bells as they should. At the most recent inspection in May 2015, an inspector tested a cell bell and 15 minutes later had not received a response. While some prisoners misuse cell bells, this problem has to be managed in other ways. Unless staff respond quickly, they cannot know whether or not it is a genuine emergency. In Mr Gill's case a quick response to his emergency bell on 29 April might have led to a swifter emergency response. We make the following recommendation:

The Governor should ensure that all cell bells are answered within five minutes

Emergency response

74. Dr C found Mr Gill having an asthma attack on 29 April when she went to his wing. The time appears to have been sometime around 5.00pm. She responded quickly and went to get a nebuliser and emergency equipment from a nearby wing treatment room. She asked Nurse G to request an emergency ambulance, who alerted the orderly officer. The doctor said that she wanted the reassurance that paramedics were on their way in case Mr Gill's condition deteriorated rapidly as can happen in severe asthma attacks. None of the staff present, including the SO, used a medical emergency code blue, which is usually called in such situations to alert healthcare staff to attend with emergency equipment and for the control room to call an ambulance. In this situation this did not cause any delay as healthcare staff were present, with emergency equipment and an ambulance had been called at 5.08pm in response to a request by the nurse.

75. Dr C did not consider the situation was immediately life threatening and believed that she would be able to control Mr Gill's asthma attack with nebuliser therapy. When he did not respond, the situation changed. Mr Gill stopped breathing and then went into cardiac arrest. At that point, the SO radioed a code blue emergency. This would normally require the control room to call an ambulance but one had already been called. Additional nurses arrived very quickly and administered cardiopulmonary resuscitation (CPR).

76. After Mr Gill went into cardiac arrest, the control room contacted the ambulance service again, which updated the priority of the call and paramedics reached Mr Gill's cell at 5.35pm. CPR was in progress when they arrived. Sadly, it was not possible to resuscitate Mr Gill.

77. We are satisfied that Mr Gill received appropriate and timely treatment. While it did not affect the outcome in the circumstances of Mr Gill's asthma attack, we were concerned that not all the staff we interviewed had a good knowledge of emergency medical code procedures, including Dr C and the SO. These procedures are set out in Prison Service Instruction (PSI) 03/2013 and Liverpool has an appropriate local protocol, which reflects the national instruction. Dr C said that she had never received a prison induction when she had started work at the prison in 2014 and was not fully aware of emergency code procedures. While GPs are not usually part of emergency response teams, which are nurse-led, we consider it is important that all staff working in prisons who have contact with prisoners are familiar with emergency response procedures. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that all staff are clear about their responsibilities under PSI 03/2013 and the local emergency protocol, and that this is part of induction for all new staff.

Use of new psychoactive substances at Liverpool

78. There is some evidence from Mr Gill's medical and prison records at Forest Bank that he smoked new psychoactive substances (NPS) including spice. Spice refers to a wide variety of herbal mixtures that produce experiences similar to cannabis. Spice contains dried, shredded plant material and chemical additives. It is known to cause breathing problems, rapid heart rate, vomiting, agitation,

confusion and hallucinations. It can also raise blood pressure and cause reduced blood supply to the heart.

79. Staff told us that the use of NPS was an ongoing problem at Liverpool. We note that HM Inspectorate of Prisons was very concerned about the prevalence of NPS at Liverpool when they inspected the prison in May 2015, just two weeks after Mr Gill's death. We too are concerned about the prevalence of NPS in prisons and the effect it has on the behaviours and health of those taking it.

80. The toxicology results showed the presence of a synthetic cannabinoid and the post-mortem examination identified this as a contributory factor in Mr Gill's death. The forensic scientist, who analysed the toxicology findings, found that it was not possible to say when Mr Gill had last used the substance. However, anecdotal evidence from Mr Gill's cellmate suggests he had used it the day before he died and his erratic behaviour that day appears to reflect this. Forensic evidence from Mr Gill's cell showed that an inhaler had been adapted to take NPS.

81. Apart from the incident on 28 April, there was no other evidence that staff suspected Mr Gill of using NPS while at Liverpool. HM Inspectorate of Prisons was satisfied that the prison has a specific strategy for dealing with this issue, which includes education and a clear protocol for dealing with prisoners suspected of taking these substances. We therefore make no recommendation.

Use of non-prescription medication

82. The toxicology results showed that Mr Gill had taken propranolol before he died and the post-mortem found that this was a contributory factor in his death.

83. The coroner instructed the respiratory consultant who specialised in chest medicine and asthma, to prepare a medical report into Mr Gill's asthma care in prison. The respiratory consultant commented that the propranolol would have lowered Mr Gill's heart rate during an asthma attack and prevented the effectiveness of the nebuliser, used to treat Mr Gill on the day he died.

84. The post-mortem showed Mr Gill's bronchial tubes were congested with mucus. The respiratory consultant commented that if Mr Gill's bronchial tubes were severely congested by mucus plugging, then "it would seem more than likely than not that the chain of events had already been set in place for him to undergo respiratory arrest and despite all local effort, it was inevitable he could stop breathing. The likelihood that this would take place was increased significantly by the presence of propranolol in his blood stream but would have occurred independently of any propranolol use."

85. Doctors did not prescribe propranalol to Mr Gill at any time during at Forest Bank or Liverpool. It seems likely he got this medication from another prisoner, but this investigation has been unable to find out the source.

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