

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Dean a prisoner at HMP Liverpool on 5 May 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 Gordon Dean died at HMP Liverpool on 5 May 2016 from an obstruction in his intestine. He was 80 years old. I offer my condolences to Mr Dean's family and friends.

Healthcare staff at Liverpool looked after Mr Dean well and could not have done anything to prevent his sudden death. I consider that Mr Dean received care in prison that was equivalent to that he could have expected to receive in the community. While unlikely to have affected the outcome for Mr Dean, there were deficiencies in the emergency response and emergency equipment which need to be rectified.

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

November 2016

Contents

Summary 1
The Investigation Process 3
Key Events 5
Findings..... 8

Summary

Events

1. On 21 December 2015, Mr Gordon Dean was remanded to HMP Liverpool. He told healthcare staff that he had not seen a doctor for several months and had no medical concerns. Over the next four months, Mr Dean had little contact with healthcare staff.
2. On 8 April, Mr Dean was sentenced to 20 years in prison for sexual offences.
3. On 1 May, Mr Dean told a nurse he had not felt well for several days, had stomach and lower back pain, and felt sick. The nurse referred him to a prison GP for a routine appointment. Later the same day, a different nurse examined him after he reported chest pain. His blood pressure was slightly elevated but all other readings were within the normal range. Mr Dean said he struggled to pass urine and the nurse arranged for him to provide a urine sample.
4. On 3 May, the results of a urine dip stick test showed raised glucose levels but were otherwise normal and a nurse advised Mr Dean to drink more. That evening a nurse gave him paracetamol for stomach pain. On 4 May, when the pain had not stopped, a nurse arranged for an urgent referral to see a prison GP the next day.
5. Just after 7.30am on 5 May, a prison officer told a nurse that Mr Dean was unwell. Neither the officer nor nurse considered it an emergency and the nurse went to see Mr Dean around 45 minutes later. He found Mr Dean unresponsive. The nurse left to get help and collect the emergency bag, but did not call an emergency code. Another nurse asked the control room to call an ambulance and both nurses returned to Mr Dean and commenced CPR.
6. Mr Dean had vomit and fluid in and around his mouth and nose, but the nurses could not use the suction machine as it was incomplete. They inserted an airway into Mr Dean's throat and attached a defibrillator to his chest, which showed no shockable rhythm. The nurses continued cardiopulmonary resuscitation (CPR) until paramedics arrived at 8.21am. Paramedics took over CPR but Mr Dean did not respond and a paramedic confirmed he had died at 8.46am.
7. A post mortem examination showed the cause of death was from an intestinal obstruction caused by a twisting of the bowel and small bowel adhesions.

Findings

8. We agree with the clinical reviewer that the care Mr Dean received at Liverpool was equivalent to that he could have expected to receive in the community.
9. The clinical reviewer said it was unlikely healthcare staff could have prevented Mr Dean's death, despite their best efforts. However, we share the clinical reviewer's concerns that essential emergency equipment was not in working order. We are also concerned that the nurse who found Mr Dean unresponsive did not call an emergency code, resulting in a slight delay in the control room

calling an ambulance. This delay is unlikely to have changed the outcome for Mr Dean, but could be crucial in other circumstances.

Recommendations

- The Head of Healthcare must ensure that all emergency equipment is kept in full working order and is checked regularly.
- The Governor and Head of Healthcare should ensure that all staff understand the circumstances where a medical emergency code should be called and that there is no delay in calling an ambulance in a life-threatening situation.

The Investigation Process

10. 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. No one responded.
11. The investigator visited Liverpool on 26 May 2016. He obtained copies of relevant extracts from Mr Dean's prison and medical records. He also interviewed Mr Dean's cellmate.
12. NHS England commissioned a clinical reviewer to review Mr Dean's clinical care at the prison. She conducted three telephone interviews with healthcare staff.
13. We informed HM Coroner for Merseyside, Liverpool District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Dean's daughter to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific concerns but asked to be kept informed about the circumstances of her father's death.
15. Mr Dean's family received a copy of the initial report and indicated that they were satisfied with the findings.
16. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Liverpool

17. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. Lancashire Care NHS Foundation Trust provides all healthcare services. There is 24-hour inpatient care.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Liverpool was in May 2015, when Inspectors returned to follow up a previous inspection because of concerns regarding the very poor state of health provision. During the previous inspection in 2014, Inspectors found the quality of health provision had deteriorated dramatically and was the subject of remedial interventions by the commissioners, the prison and a new primary care provider.
19. The new healthcare provision was inspected jointly with the Care Quality Commission. The overall assessment was that there were discernable improvements but a long way to go before outcomes were acceptable. Severe staff shortages restricted provision and waiting times for most primary care services, including the GP, were too long. Lifelong condition management needed to improve and medicines management was unsatisfactory. Health services staff had access to appropriate, well-checked emergency equipment throughout the prison but discipline staff had no access to defibrillators, and too few were trained in first aid. Ambulances were called promptly in emergencies.

Independent Monitoring Board

20. 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 2015, the IMB reported that the new healthcare provider had implemented many changes and redesigned the service to meet the needs assessment and service specification commissioned by NHS England.
21. A nurse screened all newly arrived prisoners and all were patients invited to a 72 hour comprehensive well-man assessment. The inpatient unit was developing to meet the needs of the changing population of patients and the primary care team had increased to provide care at the most appropriate times. The community based model of care included nurse triage, nurse practitioner clinics and a daily GP service.

Previous deaths at HMP Liverpool

22. Mr Dean was the eighth person to die from natural causes at Liverpool since January 2014. One person has died since. There are no similarities between this and other deaths.

Key Events

23. On 21 December 2015, Mr Gordon Dean was remanded to HMP Liverpool, charged with sexual offences. He shared a double cell on a wing for vulnerable prisoners.
24. At his initial health screen, Mr Dean told a nurse he had not seen a doctor in the previous months and could not remember which GP he was registered with in the community. He said he had no outstanding hospital or doctors appointments and did not take any medication.
25. On 18 January 2016, a nurse examined Mr Dean at the request of officers who had restrained him after he refused to allow them to search him before an appearance at court. Mr Dean told her he had existing back and arm pain and the use of restraints had made this worse. However, he said that he did not have any injuries and the nurse considered him fit to attend court.
26. On 30 March, a nurse examined Mr Dean after officers found him lying on his side in the holding room before his transfer to court. Other prisoners told her that Mr Dean had slipped from the sitting position to lying on his side. Mr Dean's observations were within the normal range and he told her he felt well enough to go to court. She confirmed that he was fit to attend.
27. On 8 April, at Crown Court, Mr Dean was convicted of sexual offences and sentenced him to 20 years in prison. He returned to Liverpool
28. Just after 6.00am on 1 May, a nurse saw Mr Dean at the request of wing staff. Mr Dean told her that he had felt unwell for the past couple of days. He said he had a pain that started in his lower back, he indicated to his kidney area, but it had moved to his lower stomach. He said he could pass urine and had regular, normal bowel movements but that he felt nauseous and wanted to make himself vomit. She agreed to put him on the waiting list to see the GP (an appointment was made for 5 May) and arranged for a nurse from the day team to review him.
29. At 11.21am the same day, an officer went to the medication hatch and told a nurse that Mr Dean had chest pain. Mr Dean's cellmate joined them and told the nurse that Mr Dean had been sick. She saw Mr Dean in his cell. She described him as calm. He did not have pain in his chest, arm or jaw (symptoms of a possible heart attack) but repeated that he had previously experienced pain in his back, which had moved to his lower stomach. He said the pain was less than earlier and he no longer felt sick. Mr Dean's observations were within the normal range except for his blood pressure, which was high at 148/86 (though considered satisfactory for a man of his age). Mr Dean said he struggled to pass urine and she recorded that he might have a urinary tract infection. She arranged for Mr Dean to give a sample of urine for testing.
30. On 3 May, the results from a urine dip stick test showed raised glucose levels but were otherwise normal. A nurse advised Mr Dean to drink more and to contact healthcare staff if he felt unwell. At 5.56pm that evening, Mr Dean went to the medication hatch and asked for pain relief for abdominal pain. The nurse gave him paracetamol and again advised him to tell healthcare staff if he did not feel better.

31. At approximately 4.00pm on 4 May, a nurse went to see Mr Dean in his cell when he complained of abdominal pain and sickness. She examined Mr Dean: she noted he was a good colour and talking in full sentences but complained that he had not opened his bowels for two days. She said she would get someone to arrange a GPs appointment for him the next morning. She told Mr Dean and his cellmate to alert the officers on the wing if they had any further concerns.
32. Around 7.30am on 5 May 2016, an officer responded to Mr Dean's cell bell. Mr Dean's cellmate said that Mr Dean was unwell and incoherent. The officer could see Mr Dean sitting on his bed and could hear him mumbling.
33. Nurses were attending the morning briefing at the nurses' station. The officer went to the nurse's station and told a nurse that Mr Dean was not well. The nurse said he would see Mr Dean once the briefing was over.
34. Around 8.15am, the nurse went to Mr Dean's cell, the door was open and Mr Dean was lying on his bed. He spoke to Mr Dean but he did not reply. He then shook Mr Dean's shoulders but he did not respond. The nurse saw vomit and fluid coming from Mr Dean's mouth and could hear him breathing but described it as laboured. He could not feel a pulse.
35. The nurse left the cell to get assistance and to collect the emergency medical bag. He did not radio a code blue emergency (which indicates that a prisoner is unconscious or not breathing). The nurse returned just over a minute later, accompanied by a colleague. They entered the cell but a nurse then went to the wing office and, at 8.18am, telephoned the control room and told staff to call an emergency ambulance. By this time, two more nurses were in the cell. While the nurse was speaking to control room staff, a nurse radioed a code blue emergency.
36. Two nurses began cardiopulmonary resuscitation (CPR) and when the nurse returned with a defibrillator, they attached it to Mr Dean's chest. It did not detect a shockable heart rhythm. A nurse asked for a suction device to clear vomit and fluid from Mr Dean's mouth and a nurse left to collect it. Unfortunately, when the nurse returned with the suction device they could not use it because it was incomplete. The nurses inserted an airway into Mr Dean's throat and continued CPR.
37. Paramedics arrived at 8.21am and took over from healthcare staff. Mr Dean did not respond and a paramedic confirmed his death at 8.46am.

Contact with Mr Dean's family

38. Mr Dean had named his wife as his next of kin, and after his death the prison appointed a senior manager as the family liaison officer. He went to the home address of Mr Dean's wife but there was no reply. A neighbour told him that she thought Mr Dean's wife might be living elsewhere.
39. The senior manager contacted Mr Dean's Offender Manager and obtained contact details for Mr Dean's daughter. He visited the address but got no reply, so he telephoned Mr Dean's daughter to inform her of her father's death and offer his condolences and support. Mr Dean's daughter explained that her mother was elderly and she would tell her that Mr Dean had died.

40. On 6 May, the senior manager and a custodial manager visited Mr Dean's wife and daughter. They offered their condolences and support. The senior manager stayed in contact with Mr Dean's family.
41. Mr Dean's funeral was on 25 May 2016. The prison contributed towards the costs in line with national policy.

Support for prisoners and staff

42. After Mr Dean's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
43. The prison posted notices informing staff and prisoners of Mr Dean's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide and self-harm in case they had been adversely affected by Mr Dean's death. Mr Dean's cellmate told the investigator that staff had supported him well.

Post-mortem report

44. A post-mortem examination indicated the cause of Mr Dean's death was from an intestinal obstruction/infarction caused by a small bowel volvulus (a twisting of the bowel causing obstruction to the flow of material through it) and small bowel adhesion (adhesions are bands of scar tissue that form between organs and tissues).

Findings

Clinical care

45. The clinical reviewer was satisfied that the care Mr Dean received at Liverpool was equivalent to that he could have expected to receive in the community. Mr Dean did not disclose any health problems and had little contact with healthcare staff at Liverpool. On 1 May 2016, when Mr Dean first reported stomach pains a nurse referred him to a GP as a non urgent case. When the pain continued healthcare staff took a sample of urine for examination, which showed nothing untoward apart from slightly raised glucose levels. When he continued to complain of pain on 4 May, a nurse arranged an urgent GP appointment for the next morning. Unfortunately, early the next morning Mr Dean collapsed and did not recover.
46. However, the clinical reviewer was critical of the emergency medical equipment available to the healthcare staff who responded to Mr Dean on 5 May. Nurses were not able to clear Mr Dean's airway because tubes needed for the suction machine were missing. The Head of Healthcare told us that because of staff sickness the need to order parts for the suction machine had been overlooked. She said that they had now been ordered and also that the suction equipment would be included as part of the emergency equipment and checked daily. The clinical reviewer says that the lack of a working suction machine did not affect the outcome for Mr Dean, and healthcare staff could not have saved him despite their best efforts. However, in other circumstances the lack of working emergency equipment could be vital. We make the following recommendation:

The Head of Healthcare must ensure that all emergency equipment is kept in full working order and is checked regularly.

47. The clinical reviewer makes some additional recommendations to improve emergency equipment at Liverpool which we do not repeat, but which the Head of Healthcare will need to address.

Emergency response

48. Prison Service Instruction (PSI) 03/2013 'Medical Emergency Response Codes', contains a mandatory instruction that all prison staff should use a code blue (or code one) for any emergency where a prisoner is unconscious. This should result in the control room calling an ambulance immediately. Liverpool has an appropriate local protocol.
49. It was around 45 minutes from the time Mr Dean's cellmate rang the cell bell to ask for assistance and a nurse attending. We accept that both the officer and the nurse were not aware of how serious Mr Dean's condition was at the time. However, having responded and found Mr Dean seriously unwell, the nurse did not call a code blue emergency. Consequently, there was a slight delay in the control room calling an emergency ambulance.
50. While it is unlikely that this delay would have affected the outcome for Mr Dean, in other circumstances it could be crucial. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff understand the circumstances where a medical emergency code should be called and that there is no delay in calling an ambulance in a life-threatening situation.

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