Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Greer a prisoner at HMP Liverpool on 27 March 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Robert Greer died on 27 March 2016 of a pulmonary embolism as a result of a deep vein thrombosis, while a prisoner at HMP Liverpool. He was 54 years old. I offer my condolences to Mr Greer's family and friends.

I am satisfied that, overall, Mr Greer received a good standard of clinical care for the short time he was at Liverpool. Mr Greer was already very unwell when he arrived; he was undergoing chemotherapy for cancer, and was mostly confined to his bed. Healthcare staff managed Mr Greer's conditions well and could not have prevented his death.

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 **October 2016**

Contents

Summary

Events

1. On 16 March 2016, Mr Greer was recalled to prison for breaching his licence conditions and sent to HMP Liverpool. He had previously spent time at HMP Thorn Cross for a violent offence.

2. During his time at HMP Thorn Cross, doctors diagnosed cancer in Mr Greer's right leg. In September 2013, surgeons amputated the leg and, in January 2014, Mr Greer was fitted with a prosthetic (artificial) leg.

3. When Mr Greer arrived at Liverpool, a nurse noted he had chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema), asthma and was undergoing treatment for cancer. The nurse allocated him a cell in the prison's inpatient unit and a prison GP prescribed his medications. The prison contacted the hospital to arrange for Mr Greer's chemotherapy to continue and for an update on his condition.

4. Mr Greer spent most of his time in bed and told healthcare staff that he could not bear any weight on his prosthesis and could not sit himself up. Healthcare staff implemented care plans to ensure Mr Greer's conditions were appropriately managed. Two healthcare assistants tended to his pressure areas, assisted him into comfortable positions in bed, changed his bedding and helped him to eat and drink.

5. At 1.14am on 26 March, a prison nurse checked on Mr Greer and found that he was struggling to breathe. The nurse found that his oxygen saturation levels were low and gave him a nebuliser until his oxygen levels increased. The nurse checked him regularly throughout the early hours. Just after 5.00am, the nurse noted his oxygen levels had decreased again and did not sufficiently increase using the nebuliser. The nurse asked for an emergency ambulance which took Mr Greer to hospital. A senior manager authorised an assessment that Mr Greer was an overall low risk and did not require restraints. Mr Greer's condition declined and he died in hospital the following day.

Findings

6. We are satisfied that, overall, Mr Greer received a good standard of care in the short time he was at Liverpool, equivalent to that he could have expected to receive in the community. Healthcare staff implemented appropriate care plans and cared for him well. However, the clinical reviewer considers that, on 26 March, the nurse should have used an appropriate assessment tool which would have resulted in Mr Greer being sent to hospital earlier. Although it would not have changed the outcome, it would have ensured Mr Greer received earlier treatment for his respiratory distress.

7. We are concerned there is no record that anyone from the prison informed Mr Greer's brother, his next of kin, that he was in hospital. A family liaison officer was not appointed until two days after Mr Greer died.

Recommendations

- The Head of Healthcare should ensure that staff understand and use the NEWS tool to assess a patient's condition and arrange an urgent transfer to hospital when indicated.
- The Governor should ensure that when a prisoner is taken to hospital seriously ill, their next of kin is informed without delay and, when a prisoner dies, there is no delay in informing and supporting their family, in line with Prison Service Instructions.

The Investigation Process

8. 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.

9. The investigator obtained copies of relevant extracts from Mr Greer's prison and medical records.

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

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

12. One of the Ombudsman's family liaison officers wrote to Mr Greer's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. He did not have any matters he wanted the investigation to consider.

13. Mr Greer's brother received a copy of the initial report and indicated that he was satisfied with the findings.

14. The initial report was shared with Prison Service. The Prison Service did not find any factual accuracies.

Background Information

HMP Liverpool

15. 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 a 24-hour inpatient unit.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Liverpool was in May 2015. Inspectors reported that the quality of healthcare provision had deteriorated considerably and the new provider had inherited a failing service. However, they found the prison and the healthcare provider were working effectively to address the deficiencies. Waiting times for most primary care services, including the GP, were too long and the management of lifelong conditions needed to improve. Inspectors also recommended that prisoners with palliative care and end-of-life needs should receive appropriate care developed in partnership with the patient and their family, relevant prison staff and community services.

Independent Monitoring Board

17. 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 Lancashire Care NHS Foundation Trust had implemented processes to support the patient's journey throughout their stay at HMP Liverpool. A nurse saw all new prisoners and all patients were invited to a 72 hour comprehensive well man assessment. The inpatient unit was continually developing to meet the needs of a changing population. The primary care team had also increased to support patients receiving care and medication at any time of the day, and to provide constant support to the main prison population.

Previous deaths at HMP Liverpool

18. Mr Greer was the sixth 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

19. On 11 November 2010, Mr Robert Greer was sentenced to eight years in prison for a violent offence. He spent time at HMP Thorn Cross before the prison released him on licence on 3 September 2014. On 16 March 2016, he was recalled to prison for breaching his licence conditions and was sent to HMP Liverpool.

20. In October 2011, while at Thorn Cross, Mr Greer sustained an ankle injury. In September 2013, following several months of further investigations, Mr Greer was diagnosed with a cancerous tumour, which resulted in surgeons amputating his right leg. In January 2014, Mr Greer was fitted with a prosthetic leg and he used a Zimmer frame and wheelchair to move around.

21. When Mr Greer arrived at Liverpool, clinical staff noted that Mr Greer had a history of chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and asthma. He also had an established diagnosis of metastatic synovial sarcoma (cancer that occurs near to the joints). Mr Greer said that he was attending hospital for chemotherapy each week as his cancer had progressed. A prison GP prescribed Mr Greer with his medications including pain relief and treatment for asthma. A healthcare administrator tried to contact the hospital for details of Mr Greer's chemotherapy appointments, but did not get a response.

22. Clinical staff noted that Mr Greer had been issued with a prison wheelchair and he had a prosthesis (artificial leg). Without his prosthesis, Mr Greer required assistance with activities of daily living so he was allocated to a shared cell on the inpatient unit. Healthcare staff implemented care plans to manage Mr Greer's conditions.

23. On 18 March, a mental health nurse noted that Mr Greer had been very angry during the night, waking his cellmate. Mr Greer was frustrated that his wheelchair did not allow him to access the toilet and there were no handrails to help him stand. Staff gave Mr Greer urine bottles to use overnight. The same day, healthcare staff began arrangements to move Mr Greer to a more suitable cell and measured him for a hoist (neither of which had been achieved before he died).

24. On 19 March, Mr Greer told a nurse that he could not bear any weight on his prosthesis and could not wear it. Mr Greer had told staff that he could not sit up in bed. The nurse carried out a social care assessment the same day. Following which, healthcare assistants worked with Mr Greer to assist him to sit up in bed, ensure he was comfortable and help him to eat and drink.

25. On 21 March, a healthcare administrator spoke to hospital staff at the hospital, confirmed that Mr Greer's chemotherapy treatments were every four weeks and arranged his next appointment for 29 March (sadly Mr Greer died before this appointment took place). The healthcare administrator requested a written update from the hospital about Mr Greer's condition and treatment.

26. On 22 March, a nurse noted that Mr Greer had developed a pressure sore. Healthcare staff implemented care plans to monitor and treat Mr Greer's

pressure sore and amputation site. Mr Greer continued to receive regular care from two healthcare assistants who treated his pressure areas, changed his bed linen and helped him to eat and drink, and remain comfortable.

27. On 22 March, staff provided an airflow mattress for Mr Greer to aid his comfort and to relieve his pressure sore.

28. Over the next three days, healthcare staff closely monitored Mr Greer. He had become incontinent, but said he was comfortable and had no concerns.

26 March 2016

29. At 1.14am on 26 March, Mr Greer told a nurse that he was having difficulty breathing. Mr Greer's blood pressure was normal, his oxygen saturation level, was low at 66%. The nurse helped Mr Greer to sit up in bed to ease his breathing and gave him saline via a nebuliser. Mr Greer's oxygen saturation levels increased to 88% and he said he felt better. The nurse noted that Mr Greer had been doubly incontinent and changed his bed linen.

30. At 2.36am, the nurse took Mr Greer's blood pressure and oxygen levels again. His blood pressure was still in the normal range, and his oxygen saturation level was 89% and he said he felt better. The nurse changed the bed linen again.

31. At 5.01am, the nurse checked Mr Greer's oxygen level which had dropped to 58%. The nurse gave him a saline nebuliser and his oxygen levels increased to 82% (still low). The nurse then requested an emergency ambulance which arrived at 5.17am.

32. The nurse assessed that there were no medical objections to Mr Greer being restrained. A senior manager assessed Mr Greer's overall risk as low and another senior manager authorised Mr Greer to be escorted without restraints. The manager further recommended that restraints were only to be applied to Mr Greer if his condition significantly improved.

33. The ambulance took Mr Greer to hospital where he was admitted. Mr Greer's condition declined and he died at 5.00am on 27 March.

Contact with Mr Greer's family

34. Mr Greer listed his brother, who lived in Scotland, as his next of kin. There are no prison records to show whether the prison told him that Mr Greer was in hospital. However, on 26 March at 3.50pm, he told hospital staff that he had booked a train to Liverpool to visit Mr Greer the following day. Sadly, Mr Greer died before his brother arrived. There are no prison records to show who told Mr Greer's brother of his death.

35. On 29 March, the prison appointed two family liaison officers. One family liaison officer telephoned Mr Greer's brother the same day to offer her condolences and support. After this date, both family liaison officers remained in contact with Mr Greer's brother and Mr Greer's son.

36. Mr Greer's funeral was on 26 April. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

37. After Mr Greer's death, a manager debriefed the staff involved in his care to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

38. The prison posted notices informing staff and prisoners of Mr Greer'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 Greer's death.

Post-mortem report

39. The post-mortem report concluded that Mr Greer died of a pulmonary embolism as a result of a deep vein thrombosis. The post mortem identified that bronchopneumonia, chronic obstructive pulmonary disease (COPD – the name for a collection of lung diseases including chronic bronchitis and emphysema) and metastatic synovial sarcoma (cancer of the joints) as contributing factors to Mr Greer's death.

Findings

Clinical care

40. Mr Greer was at Liverpool for just ten days. When he arrived at Liverpool, he had an established diagnosis of metastatic synovial sarcoma and was undergoing chemotherapy as his cancer had progressed. Healthcare staff made appropriate enquiries with the hospital so that Mr Greer could continue his treatment and arrangements were made for his next chemotherapy appointment (sadly he died before this took place). Mr Greer also suffered from COPD and asthma, which the clinical reviewer said healthcare staff treated appropriately in the short time Mr Greer was at Liverpool. Mr Greer was very ill and mostly confined to bed. We are satisfied that healthcare staff implemented appropriate plans ensuring he was seen several times a day. Healthcare assistants cared for his every day needs and ensured he was comfortable. We agree with the clinical reviewer that overall, Mr Greer's care in prison was equivalent to that he could have expected to receive in the community

41. However, on the night of 26 March, the clinical reviewer said that the nurse should have assessed Mr Greer as clinically unstable at the first opportunity, which was when he first presented with low oxygen at 1.14am. The clinical reviewer commented that the prison routinely used the National Early Warning Score (NEWS – a tool for the assessment and response to acute illness) and this should have been used to assess Mr Greer. A score of three of above in any of the parameters is a trigger for a critical and timely clinical response; the clinical reviewer states that Mr Greer's NEWS score would have definitely met this criterion so the nurse should have sent him to hospital immediately. The clinical reviewer also said that Mr Greer's medical history, diagnosis and possibility of metastasis, should also have indicated the need to send him to hospital earlier. Although this is unlikely to have changed the outcome for Mr Greer, it would have ensured earlier relief of the respiratory distress and given him more comfort. We make the following recommendation:

    The Head of Healthcare should ensure that staff understand and use the NEWS tool to assess a patient's condition and arrange an urgent transfer to hospital when indicated.

Family Liaison

42. Prison Rule 22 requires prisons to inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction 64/2011 states that prisons must ensure that a member of staff engages with the next of kin of prisoners who are either terminally or seriously ill.

43. We could find no record that anyone from the prison informed Mr Greer's brother that he had been taken to hospital on the morning of 26 March. However, he had clearly been informed relatively promptly about Mr Greer's situation, as he told the hospital on the afternoon of 26 March that he would be visiting on 27 March. We have not been able to speak to Mr Greer's brother so we do not know who informed him that his brother was in hospital or that he had died. The family liaison log does not start until 29 March and the escort records end at Mr Greer's death.

44. We draw this poor recording practice to the governor's attention, but recognise that Mr Greer's brother appears to have been kept appropriately informed. as the family liaison officer made contact with Mr Greer's brother on 29 March and remained in contact after this date.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141