Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kenneth Glazebrook a prisoner at HMP Liverpool on 8 June 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 Kenneth Glazebrook died of pneumonia, in hospital, on 8 June 2016, while a prisoner at HMP Liverpool. He was 88 years old. I offer my condolences to Mr Glazebrook's family and friends.

Mr Glazebrook arrived at Liverpool with several chronic health problems and he lived in the healthcare department's inpatient unit throughout his time in the prison. I am satisfied that he received a good standard of care, equivalent to that he could have expected in the community.

However, it is a concern that, because of a shortage of staff, the prison was often unable to facilitate the clinical request to keep his cell door open and there was a delay in sending him to hospital. I am not satisfied that the use of restraints for some of Mr Glazebrook's journeys and hospital admissions was justified by fully considered risk assessments. I also consider that, in spite of the necessary restrictions on communication because of his offences, staff could have offered Mr Glazebrook more help to contact his family during his first few days in prison.

I have raised concerns over delays in sending prisoners to hospital, notification of families and the inappropriate use of restraints in relation to previous deaths at HMP Liverpool. It is troubling that I have to do so again and expect, these, and the other recommendations in this report, to be effectively addressed.

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 **January 2017**

Contents

Summary

Events

1. On 18 February 2016, Mr Kenneth Glazebrook was sentenced to five years in prison, for sexual offences, and sent to HMP Liverpool. He had several longstanding health problems, including advanced lung disease, asthma, type 2 diabetes, depression, cardiovascular disease, depression and chronic back pain. Mr Glazebrook used a walking stick and a wheelchair. Due to his frailty, Mr Glazebrook lived in the prison healthcare centre's inpatient unit.

2. Healthcare staff conducted specialist health assessments, created care plans to monitor his medical conditions and helped with Mr Glazebrook's personal care. Mr Glazebrook initially settled well. However, within a week, his health began to deteriorate. He had several falls and developed symptoms suggestive of dementia. From the end of March, he went to hospital as an emergency several times. Although assessed as a low risk of escape, prison managers often instructed escort staff to use restraints.

3. In the early hours of 1 June, a nurse decided to send Mr Glazebrook to hospital as he had difficulty breathing and low oxygen levels. Due to a shortage of staff to escort him, this was not arranged until almost three hours later. Two officers escorted him, without restraints. Mr Glazebrook remained in hospital, where he died of pneumonia on 8 June.

Findings

4. We are concerned that prison staff were unable to facilitate the open door policy requested by healthcare staff due to a shortage of staff. For the same reason, there was a delay in providing escort staff when Mr Glazebrook's condition deteriorated significantly and he needed to go to hospital.

5. We consider that restraints were used without proper justification, as it is improbable that an elderly and significantly debilitated man, escorted by two prison officers, was a risk of escape.

6. The investigation also found that Mr Glazebrook did not receive help to telephone his family after his arrival, contrary to national policy.

Recommendations

- The Governor should ensure that prisoners' cells in the inpatient unit remain open, where a clinical need has been identified.

- The Governor should ensure that requests for prisoners to go to hospital urgently are prioritised and arranged without delay.

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

- The Governor should ensure that, where appropriate, staff offer to make a telephone call on behalf of new prisoners subject to public protection procedures and provide appropriate support to allow older prisoners to contact their families.

The Investigation Process

7. 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.

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

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

10. 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.

11. One of the Ombudsman's family liaison officers contacted Mr Glazebrook's daughter, to explain the investigation. She had several questions about his care in prison, including:

    - What assessments took place when Mr Glazebrook arrived at Liverpool, and how did staff assist him, given it was his first time in prison and he had dementia?
    - How did healthcare staff manage his medical conditions?
    - What decisions were taken about resuscitating Mr Glazebrook?
    - There was a lack of communication from Mr Glazebrook when he first went into prison, was he assisted to contact his family?
    - Why did the healthcare department not update Mr Glazebrook's family on changes to his condition, or tell them promptly about his admission to hospital?
    - Did the prison record Mr Glazebrook's next of kin details, as staff seem to have been confused about who to contact?

12. We shared the initial report with the Prison Service and they found no factual inaccuracies.

13. Mr Glazebrook's daughter received a copy of the initial report. She did not make any comments.

Background Information

HMP Liverpool

14. 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

15. 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. The management of lifelong conditions needed to improve and some prisoners did not have all their needs assessed or met because social care assessments had not yet started. Inspectors also found that hospital appointments were often rescheduled because of a shortage of escort staff. Inspectors 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

16. 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 patients throughout their stay at the prison. All new prisoners were invited to a 72-hour comprehensive well man assessment. The primary care team had been increased to support patients receiving care and medication at any time of the day, and the inpatient unit was continually developing to meet the needs of a changing population.

Previous deaths at HMP Liverpool

17. Mr Glazebrook was the ninth prisoner to die from natural causes at HMP Liverpool since January 2014. We have previously made recommendations to the prison about delays in sending prisoners to hospital; notifying families when prisoners are seriously ill; and risk assessments and use of restraints.

Key Events

18. On 18 February 2016, Mr Kenneth Glazebrook was sentenced to five years in prison for sexual offences and sent to HMP Liverpool. It was his first time in prison.

19. At his initial health screen, a nurse noted that Mr Glazebrook had several chronic illnesses, including chronic obstructive pulmonary disease (COPD - the name for a collection of progressive lung diseases, including chronic bronchitis and emphysema), asthma, type 2 diabetes, depression, cardiovascular disease, depression and chronic back pain. The nurse found that he engaged well in conversation and said he was able to care for himself. He used a walking stick, but needed a wheelchair for longer distances.

20. The nurse noted that, due to Mr Glazebrook's age, limited mobility and medical conditions, he was not fit enough to live in a normal residential wing. She therefore allocated him to a shared cell in the inpatient unit, where he could be closely monitored. A prison GP re-prescribed his existing medications. At his first night interview (and subsequent induction meetings), Mr Glazebrook raised no concerns other than drawing attention to his reduced physical ability.

21. On 19 February, a nurse carried out detailed health assessments, including social care and falls risk assessments. Although Mr Glazebrook appeared to be well, he was unsteady on his feet and prone to falls. She created care plans to manage his diabetes, asthma and daily living activities and emailed a referral to the prison social care team. She noted Mr Glazebrook had no mental health problems. A prison doctor later examined Mr Glazebrook who had fallen from his bed the previous night. He noted no ill effects from the fall. Healthcare staff then gave Mr Glazebrook a hospital bed with side rails (to reduce the risk of further falls), a pressure relief mattress, and a reclining hospital chair, so that he could safely have naps during the day.

22. Due to the nature of his offences, there were restrictions on Mr Glazebrook's access to telephone calls, letters and visits. On 20 February, staff noted that he could not use the prisoner telephone system until his list of telephone numbers were processed and authorised. A prison manager approved the telephone monitoring form on 24 February. There is no evidence that anyone offered to telephone his family on his behalf, in the meantime. (The prisoner telephone records showed that Mr Glazebrook first attempted to make telephone calls in early March, but had dialled incorrectly several times. His first successful call was on 14 April.)

23. In his first few days, healthcare staff noted that Mr Glazebrook had settled satisfactorily. He ate and drank well, took his medication, he was bright in mood, independent and able to care for himself. Entries in his personal record showed that he received daily visits from members of the chaplaincy throughout his time in prison and raised no concerns.

24. From 24 February, healthcare staff noted that Mr Glazebrook often wandered around, apparently disorientated, and fell several times in his cell. Staff began to help him with his personal care.

25. On 26 February, one of Mr Glazebrook's daughters telephoned the prison, as she had been unable to book a visit and thought that Mr Glazebrook did not want to see his family. After enquiring with Mr Glazebrook, a prison chaplain found that he did not have the dates of birth for his family members. He obtained these details from Mr Glazebrook's daughter and healthcare staff asked prison staff to add his family to the visitors' list. His daughters subsequently visited him in the healthcare centre.

26. On 2 March, a multidisciplinary team meeting discussed Mr Glazebrook's care and management. They noted that he was too poorly to live on a normal residential wing and needed social care. They agreed to explore a move to HMP Wymott, a prison with dedicated facilities for older and vulnerable prisoners. (Mr Glazebrook was subsequently allocated a place at Wymott, but died before a transfer could be arranged.)

27. Mr Glazebrook's health deteriorated, he became increasingly confused, excessively tired and sleepy and incontinent. He had a personal alarm to call for help, later replaced with an alarm attached to his clothing, to alert staff to any movements that might lead to a fall. On 15 March, an assessment of his cognitive function indicated moderate impairment. Prison GPs requested blood tests to screen him for dementia, and a chest X-ray, as he had excess fluid in his legs, which can be suggestive of organ failure. On 17 March, a multidisciplinary team meeting, attended by a consultant psychiatrist, a doctor and a mental health nurse, commissioned various tests for suspected dementia, to be followed by a psychiatric assessment.

28. Healthcare staff closely monitored Mr Glazebrook. They reviewed his care plans, frequently assessed him using formal clinical assessment tools, and helped with his personal care. He remained in a shared cell due to the higher risk of falls. On 27 March, an officer noted that he had a lot of contact with his family, who visited frequently.

29. On 31 March, a doctor sent Mr Glazebrook to Aintree University Hospital to be checked for injury, after he fell twice within 12 hours. The Head of Security stipulated that staff should restrain him with single handcuffs, at all times. At the request of nurses, who cited Mr Glazebrook's limited mobility and the difficulty in getting him into bed while in handcuffs, the prison authorised the handcuffs to be replaced by an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Mr Glazebrook returned to the prison the same day.

30. On 4 April, Mr Glazebrook was admitted to hospital, with shortness of breath and low oxygen levels. He was restrained at all times with an escort chain. Doctors diagnosed a chest infection. On 6 April, the hospital telephoned the prison to advise that he was ready to be discharged, but would require 24-hour care and supervision, as he was at risk of falls if left unsupervised. Healthcare staff discussed his needs with prison managers, who agreed that his door should be kept open at all times, so that staff had easier access to monitor him. An officer would remain at his door to ensure his safety if he tried to get out of bed.

31. The hospital discharged Mr Glazebrook on 7 April. The next day, there were insufficient operational staff to watch him, so his door remained locked overnight.

(Several times over the next seven weeks, healthcare staff noted that Mr Glazebrook's cell door was locked throughout the night. On one occasion, the nurse in charge was permitted to hold a key to go into his cell.)

32. On 14 April, a multidisciplinary team meeting noted Mr Glazebrook was very poor physically and attended the memory clinic. On 18 April, a doctor completed a cognitive impairment test and found some memory impairment, but Mr Glazebrook declined dementia screening.

33. After another fall on 24 April, Mr Glazebrook was admitted to hospital. This time, no restraints were used. Doctors diagnosed pneumonia and said that he was very poorly. Healthcare staff sought daily updates and a prison nurse visited him. On 27 April, hospital staff consulted Mr Glazebrook's family about resuscitation and they agreed that he should not be resuscitated if his heart or breathing stopped. A hospital doctor signed an order to this effect. However, it was noted that he was not yet ready for end of life or palliative care.

34. Mr Glazebrook was discharged from hospital on 9 May. Healthcare staff reminded prison managers that his cell door should be left open 24 hours a day. (In spite of this, there were numerous occasions when this did not happen.) The next day, a multidisciplinary team meeting reviewed Mr Glazebrook and noted new family contact details, as his daughter was away on holiday.

35. On the morning of 13 May, a doctor diagnosed that Mr Glazebrook had pneumonia and sent him to hospital as an emergency. The security risk assessment noted that he was possibly nearing the end of his life and no restraints were used. He returned the next day and continued to receive antibiotics for a chest infection. He was admitted to hospital again on 22 May, after a fall in his cell. An initial security risk assessment indicated that escort staff should not use restraints. However, after a subsequent risk assessment on 23 May, a prison manager instructed staff to use an escort chain at all times, and handcuffs on the journey back to the prison.

36. On 23 May, a nurse and doctor had a meeting with Mr Glazebrook's daughter to discuss his treatment and resuscitation status. They agreed that, although the hospital had completed the form incorrectly, the medical decision not to resuscitate him was appropriate. The doctor completed a further form and circulated the information to staff. Staff noted that Mr Glazebrook's daughter had consented to this, as Mr Glazebrook did not have the mental capacity to make an informed decision. Mr Glazebrook returned to the prison on 25 May.

37. At 12.49am on 1 June, a nurse checked Mr Glazebrook and found that he had difficulty breathing, increasing confusion and low oxygen levels, despite receiving additional oxygen. The nurse decided to send him to hospital and telephoned the night manager to arrange escorts. The night manager went to the healthcare centre and told the nurse that no staff were available to escort Mr Glazebrook. In view of this, the nurse contacted the out-of-hours doctor, who prescribed medication to help his breathing and oxygen levels and authorised the nurses to administer this.

38. The Head of Security, told the investigator that there were three officers on duty out of a normal complement of six, and sending Mr Glazebrook to hospital would have reduced this by a further two.

39. As Mr Glazebrook's oxygen levels remained low, a nurse telephoned the hospital for advice. A doctor advised her to call an ambulance and she did so at 3.07am. The control room made a further call at 3.30am. The ambulance arrived at 3.44am and took Mr Glazebrook to hospital, where doctors again diagnosed pneumonia and admitted him as an inpatient.

40. Mr Glazebrook's daughters went to the prison to visit him on 2 June. When they arrived, prison staff told them that he was in hospital. During a management check at the hospital that afternoon, a prison manager met Mr Glazebrook's daughters and discussed the delay in notifying them. He said he would ensure that this did not happen again and authorised them to visit Mr Glazebrook freely. On 3 June, Mr Glazebrook's daughters informed the prison that, in view of his confusion and frequent hospital admissions, they had agreed with the hospital that he should not receive aggressive treatment.

41. The hospital planned to discharge Mr Glazebrook on 7 June. However, his condition deteriorated and he died on 8 June. Members of his family were with him.

Contact with Mr Glazebrook's family

42. The prison appointed a family liaison officer. On 8 June, he telephoned Mr Glazebrook's daughter to offer condolences and arranged to visit on 10 June. During the visit, Mr Glazebrook's daughter and her sister complained that the prison did not inform them promptly that Mr Glazebrook had been admitted to hospital on 1 June. The family liaison officer said they had notified the family immediately after previous admissions, but apologised that they had overlooked this when he went into hospital for the final time.

43. In line with national policy, the prison contributed to the costs of Mr Glazebrook's funeral, which was held on 16 June.

Support for prisoners and staff

44. After Mr Glazebrook's death, a prison manager debriefed the escort staff and offered his support and that of the staff care team.

45. The prison posted notices informing other prisoners of Mr Glazebrook's death, and offering support. Staff reviewed those considered to be at risk of suicide or self-harm, in case they had been adversely affected by his death.

Cause of death

46. The Coroner accepted Mr Glazebrook's cause of death as pneumonia, against a background of chronic obstructive airways disease, type 2 diabetes mellitus and ischaemic heart disease.

Findings

Clinical care

47. Mr Glazebrook was an elderly, chronically ill man. After reception health assessments, he was allocated a cell in the healthcare centre's inpatient unit, as he was too unwell to live on a residential wing. A multidisciplinary team oversaw his clinical management and healthcare staff implemented care plans and monitored him closely.

48. Shortly after his arrival at Liverpool, Mr Glazebrook's health began to deteriorate significantly and he was often sent to hospital for assessment and treatment. On the advice of hospital doctors, healthcare and prison staff agreed that his cell door should be left open at all times. However, the prison was frequently unable to provide staff to facilitate this at night. We are concerned that the prison could not support this element of Mr Glazebrook's care effectively and that staff shortages impaired his health provision. We make the following recommendation:

    The Governor should ensure that prisoners' cells in the inpatient unit remain open, where a clinical need has been identified.

49. In the early hours of 1 June, Mr Glazebrook had difficulty breathing and low oxygen levels. A nurse decided to send him to hospital, as an emergency, but there was a delay of nearly three hours in arranging this, due to a shortage of staff to escort him. As a contingency, the nurse consulted the out-of-hours doctor, who authorised her to give him medication, but this had little effect.

50. The Head of Security, said there would normally be six officers and eight operational support grade staff in the prison during the night. However, on that particular night, there had been a reduction of three officers and sending two out on escort would have reduced it to one. He also said that night managers could contact staff to volunteer to attend for duty.

51. Subject to a risk assessment, prison managers have the discretion to send one escort officer if a prisoner's medical condition or lack of mobility means that they cannot escape unaided, and there is no evidence that an escape attempt is likely. There is no evidence that staff considered this option. The clinical reviewer said that Mr Glazebrook's symptoms should have led to an immediate admission to hospital and was unacceptable. We consider that this was an avoidable delay. We make the following recommendation:

    The Governor should ensure that requests for prisoners to go to hospital urgently are prioritised and arranged without delay.

52. Despite the shortcomings resulting from the shortage of prison staff, we are satisfied that, generally, Mr Glazebrook received a good standard of care at Liverpool, at least equivalent to that he could have expected in the community.

Restraints, security and escorts

53. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

54. Mr Glazebrook had limited mobility; he used a walking stick, and a wheelchair for longer distances. Between the end of March and his death in June, he went to hospital eight times. The security risk assessments concluded that he was a low risk of escape, and low risk to hospital staff, but he was assessed as medium or high risk to the public, because of the nature of his offences. The medical section of some of the risk assessments mentioned his limited mobility. However, they contained scant information about how his medical condition affected his risk of escape, as the High Court judgment requires. With the exception of 24 April, 13 and 22 May, and his final admission on 1 June, escort officers used restraints for Mr Glazebrook's journeys and admissions to hospital. The prison provided extracts from the National Security Framework about the procedures for assessing risk, but was unable to explain the inconsistencies in Mr Glazebrook's risk assessments or the rationale for using restraints.

55. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. It is difficult to see how managers concluded that Mr Glazebrook, an 88 year old wheelchair user, with severely deteriorating health and chronic impairment of his breathing, had the ability to escape unaided from two officers. It seems that the judgements on the risk assessments and the decision to use restraints were mainly influenced by Mr Glazebrook's offences, rather than impartial consideration of his risk at the time.

56. We are not satisfied that staff appropriately assessed Mr Glazebrook's risk. However, we are pleased to note that, when Mr Glazebrook went into hospital for the final time on 1 June, prison managers appropriately took into account his age and poor health, and decided that he should not be restrained. We make the following recommendation:

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

Family liaison

57. Mr Glazebrook's daughter was concerned about the lack of contact from her father when he first went into prison and asked what assistance staff gave him to

contact his family. Prison Service Instruction (PSI) 07/2015, about early days in custody, specifies a mandatory requirement that newly arrived prisoners must be given access to a telephone to address urgent domestic issues, such as dependent care arrangements or to advise a family member where they are being held. If the prisoner is subject to public protection restrictions, a member of staff should make the call on his behalf. Another mandatory requirement in the instruction is for staff to advise prisoners that they are entitled to a social visit within 72 hours of their conviction.

58. The Head of Security explained that, as a prisoner subject to public protection measures, Mr Glazebrook would not have been allowed to receive a visit or make a call until his family's details were cleared, but that reception staff could telephone on the prisoner's behalf. He said that staff usually completed the form to clear such contact within 24 hours of the prisoner's arrival. There is no evidence that staff offered to call on Mr Glazebrook's behalf, or took active steps to facilitate a visit quickly. A week after his arrival, his daughter contacted the prison to ask about contact. She gave her personal details and those of other family members, and staff then authorised visits.

59. Mr Glazebrook had not been in prison before. The PSI states that those new to prison might find reception confusing and overwhelming. While we acknowledge that the nature of Mr Glazebrook's offences prevented him from directly contacting his family in reception, we consider that staff could have been more proactive in helping an elderly and frail man new to the prison system. We make the following recommendation:

The Governor should ensure that, where appropriate, staff offer to make a telephone call on behalf of new prisoners subject to public protection procedures and provide appropriate support to allow older prisoners to contact their families.

60. Mr Glazebrook's daughter was also concerned that prison staff had not promptly notified his family of Mr Glazebrook's admission to hospital on 1 June, although they had been informed of previous admissions. They found out when they arrived at the prison to visit him on 2 June. His family discussed this with a prison manager at the hospital and the family liaison officer, after his death. We have previously raised the issue of notifying prisoners' next of kin. However, we are satisfied that the prison has suitably acknowledged and apologised for the oversight. We therefore make no recommendation on this issue.

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