Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Thompson a prisoner at HMP Liverpool on 11 November 2017

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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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 Paul Thompson died of pneumonia at HMP Liverpool on 11 November 2017. He also had chronic pancreatitis (inflammation of the pancreas), fatty liver disease and malnutrition. He was 44 years old. I offer my condolences to his family and friends.

While many areas of Mr Thompson's care at Liverpool were satisfactory, it was not equivalent to that which he could have expected to receive in the community. After his initial health screen, healthcare staff did not chase up his outstanding hospital appointment and tests, and he did not have a second health screen.

I am also concerned that despite his worsening condition, Mr Thompson was restrained from the time he went to hospital on 7 November until 11 November. When his restraints were finally removed, it was because staff considered that Mr Thompson was a risk of contamination and illness to the escorting officers, rather than through consideration of the prison's legal obligations.

I am also concerned that a family liaison officer was not appointed when Mr Thompson became seriously ill. This meant that his ex-partner did not have the opportunity to see him before he died.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **June 2018**

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Summary

Events

1. On 2 August 2017, Mr Paul Thompson was remanded to HMP Liverpool.

2. At his initial health screen, a nurse noted his history of self-harm and depression, excessive alcohol use, and that he had abdominal pain. Mr Thompson told the nurse that he was having tests for bowel cancer. There is no evidence in his electronic medical records that healthcare staff chased these, nor an outstanding hospital appointment for a hip replacement. The nurse noted that Mr Thompson's body mass index was too low.

3. There is no evidence that a second stage health assessment took place within seven days, as it should have done.

4. On 7 September, a prison GP saw Mr Thompson. He noted that he had had bloody diarrhoea for the past five months and referred him to the hospital gastroenterology department under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks.

5. On 20 September, Mr Thompson went to the gastroenterology department at a hospital, where hospital staff arranged for blood tests, a CT scan (an imaging procedure that uses x-rays to create detailed scans) of the chest, abdomen and pelvis and an endoscopy (an internal examination). On 29 September, Mr Thompson refused to have the endoscopy because he did not want bad news.

6. On 4 November, a prison GP saw Mr Thompson because he complained of vomiting, diarrhoea and abdominal pain. He had a high temperature. The GP asked for urgent blood tests. Mr Thomson's potassium levels were dangerously low and he went to hospital, where he had a potassium transfusion and further tests. He was returned to Liverpool the next day.

7. On 6 November, a nurse saw Mr Thompson who was very weak. Later that day, a prison GP saw him, and asked for further urgent blood tests. At 11.50pm, when healthcare staff received abnormal blood test results for Mr Thompson, they sent him to hospital for an urgent potassium transfusion. Staff did not complete a risk assessment before escorting him and did not restrain him on the way to the hospital.

8. The next day, a senior manager decided that Mr Thompson should be double cuffed (where the prisoner has his hands cuffed in front of him, with one wrist attached to a prison officer by an additional set of handcuffs) and escorted by two officers when going to hospital. She said that once admitted as an inpatient, Mr Thompson should be restrained 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). No one had completed the medical section of the bedwatch risk assessment; the senior manager had no medical information to inform her decision.

9. On 11 November, a custodial manager reviewed Mr Thompson's risk and concluded that staff were at risk of contamination and illness from Mr Thompson as some of his illnesses were contagious. He said that Mr Thompson had no control of his bodily functions, had pneumonia and gastroenteritis. A senior manager approved the removal of the restraints.

10. Mr Thompson's condition deteriorated. At 11.33pm that night, Mr Thompson died of pneumonia. He also had chronic pancreatitis (inflammation of the pancreas), fatty liver disease and malnutrition.

Findings

Clinical care

11. While there were many areas of satisfactory care, the care that Mr Thompson received at Liverpool was not, overall, equivalent to that which he could have expected to receive in the community. There is no evidence that healthcare staff chased outstanding bowel cancer tests nor a hip replacement appointment. A second health screen did not take place which meant that staff missed an opportunity to address a number of issues (not relating to Mr Thompson's death). Although a GP reviewed Mr Thompson's health, he was not monitored under a complex care or chronic conditions pathway.

Restraints, security and escorts

12. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Despite the fact that Mr Thompson was very frail, receiving intravenous antibiotics, undergoing tests and frequently soiling himself, he continued to be restrained with an escort chain until 11 November, the day he died, when a prison manager reviewed the level of restraints and told staff to remove them.

Contact with Mr Thompson's family

13. On 7 November, officers at the hospital were aware of Mr Thompson's critical and worsening condition. However, they failed to appoint a family liaison officer until 11 November, the day that he died, or tell Mr Thompson's ex-partner that he was seriously ill in hospital. This did not happen, and they broke the news of his death to her the next morning. This meant that Mr Thompson's ex-partner did not have the opportunity to see him before he died.

Recommendations

- The Head of Healthcare should ensure that:
  - prisoners consistently receive a first night reception screen, and that healthcare staff chase up any outstanding appointments; and
  - healthcare staff offer all new prisoners a second health screen, and that this is recorded.
- 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 a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

The Investigation Process

14. 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

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

16. NHS England commissioned a clinical reviewer to review Mr Thompson's clinical care at the prison. They jointly interviewed five members of staff at Liverpool on 22 January.

17. We informed HM Coroner for Merseyside of the investigation who gave us the cause of death. We have sent the Coroner a copy of this report.

18. One of the Ombudsman's family liaison officers, contacted Mr Thompson's partner to explain the investigation. Mr Thompson's partner had the following concerns:

- In October, she received a letter from Mr Thompson in which he expressed suicidal thoughts. She asked what provisions the prison put in place to support him.
- She was aware that Mr Thompson had been in and out of hospital. She asked for details of the appointments.
- She understood that Mr Thompson went to hospital on 3 November because he had harmed himself. She asked for details about what happened and what happened when he returned to prison.
- She understood that Mr Thompson went to hospital on 8 November after his condition deteriorated but said that she had not been contacted. (In fact, he had been transferred to hospital on 6 November.) She wanted to know why the prison had not contacted her because it would have allowed her to see Mr Thompson before his death. She said that the first time she was contacted was on 12 November, the day after Mr Thompson died.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.

20. Mr Thompson's partner received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Liverpool

21. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 994 men. Lancashire Care NHS Foundation Trust provides all healthcare services. There is a 24-hour inpatient unit.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Liverpool was in September 2017. Inspectors reported an abject failure of the prison to offer a safe, decent and purposeful environment. The inspection team could not recall having seen worse living conditions, which they described as squalid. Many cells were not fit to be used. Some had emergency cell bells that were not working but were still occupied, presenting a danger to prisoners. There were hundreds of unrepaired broken windows, with jagged glass left in the frames. Many toilets were filthy, blocked or leaking. There were infestations of cockroaches in some areas, broken furniture, graffiti, damp and dirt.

23. While primary health care had improved, staff shortages had a negative impact on all aspects of health services, especially mental healthcare. Inpatients had a very poor regime and were offered little therapeutic activity. The integrated mental health and substance misuse team did not have capacity to meet the needs of a complex population.

24. Inspectors found that there did not appear to be effective leadership or sufficiently rigorous oversight to drive the prison forward in a meaningful way.

Independent Monitoring Board

25. 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 2016, the IMB reported that under Lancashire Care Foundation Trust, mental health and substance misuse services were now integrated and they now aimed to complete well man assessments for newly arrived prisoners within 72 hours of admission. They said that six psychiatric sessions each week allowed patients to be reviewed.

Previous deaths at HMP Liverpool

26. There have been no other deaths from natural causes at Liverpool in the past 12 months.

Assessment, Care in Custody and Teamwork (ACCT)

27. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner’s main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

28. On 2 August 2017, Mr Paul Thompson was remanded to HMP Liverpool for possession of a controlled drug with intent to supply and breaching bail.

29. A nurse saw Mr Thompson for his initial health screen. He noted that Mr Thompson had a history of self-harm and depression, excessive alcohol use, arthritis in both hips, and had had pain in his abdomen for three days. Mr Thompson told him that he was having tests for bowel cancer.

30. Mr Thompson had an outstanding appointment for a hip replacement but there was no record in his electronic medical records that anyone chased up his appointment or the bowel cancer tests.

31. Mr Thompson was prescribed the following medication: mirtazapine for depression, dihydrocodeine for pain relief, omeprazole to reduce stomach acid, paracetamol, voltarol (an anti-inflammatory painkiller), multivitamin and mineral supplements, and nutritional calorific drinks.

32. Mr Thompson told a nurse that he had a history of drinking too much alcohol. The nurse saw that Mr Thompson had mild alcohol withdrawal and so referred him to a prison GP and the drug dependency unit.

33. A prison GP saw Mr Thompson because of his withdrawal symptoms. He noted that he wanted the Drug and Alcohol Recovery Service (DARS) to review him. He gave him diazepam for withdrawal seizures, and noted that he would check Mr Thompson's weight in four weeks.

34. On 3 August, a specialist in substance misus, saw Mr Thompson. He assessed his withdrawal symptoms and created an alcohol detoxification care plan. He assigned Mr Thompson to a DARS case officer.

35. A second stage health assessment, including a review of the actions and outcomes of the initial health screen, should have taken place within seven days. There is no evidence that this happened.

36. On 4 August, a nurse saw Mr Thompson at the medication hatch. He told her that he had bowel cancer and that everything he ate went through him. A prison GP, prescribed him loperamide for diarrhoea.

37. Mr Thompson saw the DARS team who monitored him for symptoms of alcohol withdrawal. He took part in the drug harm reduction programme and successfully withdrew from alcohol.

38. Although Mr Thompson's care plan said that his clinical observations should be recorded twice daily, healthcare staff recorded them once a day.

39. On 23 August, Mr Thompson saw a nurse. He said that he was passing blood clots through his back passage. She made an appointment for Mr Thompson to see a prison GP on 29 August. He did not attend and told a nurse that prison staff did not collect him. A nurse asked the administration team to rebook the appointment as soon as possible.

40. On 31 August, a nurse saw Mr Thompson. He noted Mr Thompson was underweight, having lost 4.1 kilograms over four weeks, and asked for his weight to be reviewed in another four weeks. The nurse said that Mr Thompson was at high risk of malnutrition.

41. A nurse, told a prison GP who asked him to book another urgent appointment to discuss Mr Thompson's weight and to continue with nutritional calorific drinks for one week, which he did.

42. On 7 September, a prison GP saw Mr Thompson. He noted that he had had bloody diarrhoea for the past five months. He referred Mr Thompson to the gastroenterology department under the NHS suspected cancer pathway, which requires patients with suspected cancer to be seen by a specialist within two weeks. Mr Thompson had not been seen by the gastroenterology department before being sent to Liverpool.

43. On 20 September, Mr Thompson went to the gastroenterology department at a hospital. Hospital staff arranged for blood tests, a CT scan of the chest, abdomen and pelvis and an endoscopy.

44. On 29 September, Mr Thompson refused to attend the appointment for the endoscopy. He told a nurse that he did not want bad news. A nurse spoke to Mr Thompson about how important it was to go and he agreed to have another appointment.

45. On 2 October, Mr Thompson went to hospital and had a CT scan of his chest, abdomen and pelvis.

46. On 3 October, Mr Thompson told a healthcare support worker, that he was stressed and depressed and had thoughts of self-harm. She referred Mr Thompson to the mental health team.

47. On 10 October, a mental health nurse, started suicide and self harm prevention procedures (known as ACCT). He noted that Mr Thompson was anxious about his cancer test results, that he was expecting a long prison sentence and that he could hear the voices of his two brothers who took their lives, telling him to kill himself. He assessed Mr Thompson's mental health. He prescribed a short course of sleeping tablets and asked prison staff to monitor Mr Thompson and assess his risks in more detail.

48. A nurse created a caremap which referred Mr Thompson to the mental health team, advised him to wait for the cancer results and asked for an appointment with a psychologist.

49. On 11 October, a nurse saw Mr Thompson because he had been sick in the night. She noted Mr Thompson's weight had decreased and that his weight should be monitored weekly.

50. At his ACCT review later that day, Mr Thompson said that he was stressed because of his health issues and because he had to wait for his cancer test results.

51. On 12 October, prison staff cancelled a gastroenterology appointment arranged for 16 October because they were unable to get him to the hospital. (The records do not explain why.) On 18 October, Mr Thompson refused to attend an endoscopy appointment because he said it was not necessary as he had had the procedure before and was waiting for his test results.

52. At an ACCT review on 20 October, Mr Thompson said that he was still anxious about the test results and had thoughts about suicide and self-harm.

53. On 31 October, a prison GP saw Mr Thompson who had swollen ankles and said it was painful to walk. Mr Thompson's weight had increased to 53.2 kilograms. He arranged for him to have blood tests and be reviewed in two weeks.

54. On 3 November, Mr Thompson had an ACCT review. He said that he did not have thoughts of suicide or self-harm. A mental health nurse, said that he felt Mr Thompson was concerned about his physical health and was anxious about his test results. Mr Thompson did not go to hospital that day.

55. On 4 November, a prison GP, saw Mr Thompson because he said he was vomiting, had diarrhoea and abdominal pain. He had a high temperature (37.6 degrees). He asked for urgent blood tests and for Mr Thompson to be monitored while waiting for the results.

56. Later that day, the blood test results showed Mr Thompson's potassium levels were dangerously low and he was sent to hospital. Hospital staff gave him a potassium transfusion and carried out further tests. He returned to Liverpool the next day.

57. On 5 November, a nurse saw Mr Thompson and noted that he should be observed daily. She gave him a chart to monitor his fluid intake. She asked for a GP to review him.

58. On 6 November, a nurse saw Mr Thompson who was very weak. She noted that he would probably have to go back to hospital because there was no GP available to see him and she was concerned about how weak he was. Later that day, a prison GP saw Mr Thompson. He asked for further urgent blood tests which, again, were abnormal and Mr Thompson was sent back to hospital for another urgent potassium transfusion.

59. No one assessed Mr Thompson's escort risk. The Head of Operations, said that it was not uncommon for the risk assessment not to be done during an emergency as priority was given to the preservation of life. She said that healthcare staff would not have assessed Mr Thompson as he had already been discharged to hospital and was in their care. Two officers escorted Mr Thompson to hospital and did not use restraints.

60. On 7 November, although Mr Thompson had already been taken to hospital, the head of operations noted on the escort risk assessment that in line with the local security strategy, Mr Thompson, as an unsentenced prisoner, should be treated as a category B prisoner. (The policy says that the highest levels of security are not considered necessary for Category B prisoners but escape should be made difficult.) She instructed retrospectively that Mr Thompson

should be double cuffed and escorted by two officers to go to hospital, and that he should be restrained by an escort chain once admitted to hospital. At this stage. Mr Thompson was restrained with an escort chain.

61. At 1.30am on 7 November, the officers at the hospital noted that hospital staff had inserted a drip in Mr Thompson. At 7.45am, the officers said that Mr Thompson had soiled himself and needed a nurse to clean him. At 10.00am, a hospital doctor told the officers that Mr Thompson's pancreas and liver were not working and that he had an infection. At 7.40pm, the officers said that Mr Thompson was very frail.

62. Between 7 and 11 November, Mr Thompson's condition worsened and officers reported that he was frail and constantly soiling himself. The officers removed the restraints for hospital procedures and to allow him to be cleaned after he soiled himself before re-applying the restraints.

63. The Head of Operations said that because of medical confidentiality, the practice was for the prison healthcare department to speak regularly to the hospital and update the Governor about prognosis and care. Based on that information, they would routinely review the prisoner's security arrangements. She said that during his time in hospital, Mr Thompson was escorted by two prison officers and custodial managers completed daily management checks.

64. On 11 November, a custodial manager updated Mr Thompson's risk assessment. He said that Mr Thompson had many illnesses, some of which were infectious. He said that Mr Thompson had had pneumonia, gastroenteritis and no control of his functions. He said that staff were at risk of contamination and of illness. He said that at 6.20am, Mr Thompson's restraints were removed and officers waited outside his room the ward until the risk was lowered.

65. The Head of Security, approved the removal of the restraints and instructed that officers should remain outside the room to minimise the risk of contamination.

66. Mr Thompson's condition deteriorated and at 11.33pm on 11 November, he died.

Contact with Mr Thompson's family

67. At 11.30pm on 11 November, The Head of Security appointed an officer as the family liaison officer (FLO). At 10.30am the next day, the FLO Officer and the duty governor, visited Mr Thompson's ex-partner to break the news of Mr Thompson's death. They offered their condolences. The FLO kept in contact with Mr Thompson's ex-partner.

68. A custodial manager, said that it was standard practice to allocate a family liaison officer (FLO) as soon as they became aware of any critical and potentially fatal illness. On 6 November, when Mr Thompson went to hospital, the custodial manager was not aware of the critical nature of Mr Thompson's condition or that it was life-threatening. He said that on 11 November, hospital staff considered the need for Mr Thompson to go to the intensive care unit but he died later that day.

69. Mr Thompson's funeral took place on 24 November, and the prison contributed to its cost in line with national instructions.

Support for prisoners and staff

70. After Mr Thompson's death, the head of security debriefed the staff who monitored Mr Thompson at hospital to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

71. The prison posted notices informing other prisoners of Mr Thompson's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Thompson's death.

Cause of death

72. There was no post-mortem examination after Mr Thompson's death. When Mr Thompson died in hospital, a hospital doctor, established that Mr Thompson died of pneumonia. He also had chronic pancreatitis, fatty liver disease and malnutrition.

Findings

Clinical care

73. Many areas of Mr Thompson's care at Liverpool were satisfactory, including access to a mental health assessment and support, appropriate use of the ACCT process, review by a substance misuse specialist doctor, monitoring of his weight loss and referral under the two-week rule for suspected cancer.

74. However, the clinical reviewer concluded that, overall, the care that Mr Thompson received was not equivalent to that which he could have expected to receive in the community.

75. When Mr Thompson arrived at Liverpool, healthcare staff should have chased up Mr Thompson's outstanding hospital appointment for a hip replacement and his bowel cancer tests. A second health screen did not take place which meant that staff missed the opportunity to address these issues.

While Mr Thompson was reviewed by a GP, he was not monitored under a complex care or chronic conditions pathway as he should have been. There was no process for staff to chase up results or communicate between teams, and no one considered Mr Thompson's anxiety while waiting for test results. The results of Mr Thompson's CT scan on 2 October were not chased and this was further hindered when prison staff were unable to take Mr Thompson to hospital on 16 October, where the test results would have been discussed. We make the following recommendations:

The Head of Healthcare should ensure that:

- **prisoners consistently receive a first night reception screen, and that healthcare staff chase up any outstanding appointments; and**
- **healthcare staff offer all new prisoners a second health screen, and that this is recorded.**

76. The Clinical Reviewer also made a number of recommendations. While these are not related to Mr Thompson's death, the Head of Healthcare will nevertheless need to address them.

Restraints, security and escorts

77. 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 a prisoner's health and mobility.

78. 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 he has 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. The judgement found that the using of handcuffs or other restraints on terminally ill or seriously ill prisoners was inhumane, unless justified by security considerations.

79. When Mr Thompson went to hospital on 6 November, staff should have assessed his escort risk. This did not happen. It was only the next day when Mr Thompson had already been admitted to hospital that the head of security and intelligence, assessed his risk retrospectively. Because he was an unconvicted prisoner, she decided that he should be treated as a Category B prisoner. She said that he should therefore be double cuffed and escorted by two officers to the hospital, and that once admitted to hospital, he should be restrained with an escort chain. While we recognise that this was in line with the local security strategy, she failed to take into account his medical condition, as required by the High Court judgement, because the medical section of the risk assessment had not been completed. Mr Thompson's medical records indicated that he was very weak and his health rapidly declined. We consider that she might have reached a different decision if all the available information about Mr Thompson's health and its impact on his risk had been taken into account, as it should have been.

80. This decision was never reviewed, as it should have been, despite the fact that Mr Thompson, already in very poor health and significantly debilitated, became increasingly frail, was receiving intravenous antibiotics, was undergoing tests and was frequently soiling himself.

81. On 11 November, the Head of Security and Intelligence, reviewed the level of restraints and told staff to remove them, but only on the basis that he considered the escorting officers were at risk of contamination and illness.

82. Public protection is fundamental but security measures must be proportionate to a prisoner's individual circumstances. The considerations to be applied are clearly set out in the High Court judgement and were not part of the prison's decision-making processes. We are concerned that despite prison officers noting in the bedwatch log that Mr Thompson was frail and soiling himself repeatedly, he continued to be restrained for four days, until the day he died. 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 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.

Contact with Mr Thompson's family

83. On 7 November, the officers at the hospital reported that Mr Thompson was unwell and were informed that his pancreas and liver were not working. They continued to report daily that Mr Thompson's condition worsened. We fail to understand therefore how a custodial manager, was not aware of Mr Thompson's critical and potentially fatal condition. No one, however, appointed

a family liaison officer or informed Mr Thompson's next of kin in a timely manner, as they should have. It was not until 11 November, the day that Mr Thompson died, that the prison appointed a family liaison officer, and it was not until the day after his death that they informed Mr Thompson's ex-partner that he had died. This meant that she did not have the opportunity to see Mr Thompson before he died. We make the following recommendation:

The Governor should ensure that a family liaison officer is appointed when a prisoner is assessed as seriously ill and that appropriate and timely arrangements are made for early contact with families.

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