

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Gordon Redfern a prisoner at HMP Liverpool on 6 April 2019

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Redfern died on 6 April 2019 of liver disease while a prisoner at HMP Liverpool. He was 57 years old. I offer my condolences to Mr Redfern's family and friends.

Mr Redfern had been diagnosed with end stage liver disease in the community nine months before he arrived at Liverpool, and received ongoing treatment and appointments with hospital specialists while he was in prison.

I am satisfied that the care Mr Redfern received at HMP Liverpool was equivalent to that which he could have expected to receive in the community. We have made no recommendations.

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

Sue McAllister CB
Prisons and Probation Ombudsman

October 2019

Contents

Summary	1
The Investigation Process	2
Background Information	3
Findings	4

Summary

Events

1. On 3 August 2018, Mr Gordon Redfern was sentenced to five years in prison for arson. He was sent to HMP Liverpool. Mr Redfern had been diagnosed with end stage liver disease prior to entering prison and had started receiving palliative care in November 2017.
2. In October 2018, Mr Redfern was moved to Liverpool's inpatient unit and a care plan was created to manage his health, which included reviewing his care at weekly multidisciplinary meetings.
3. In November, Mr Redfern was sent to hospital because a blood test showed he had an electrolyte imbalance. Mr Redfern's health deteriorated in hospital and end of life care began. However, before Mr Redfern could be transferred to a hospice, his health improved and on 14 January 2019, he was transferred back to Liverpool.
4. On 5 March, Mr Redfern was transferred to a hospice for blood transfusions and was then transferred back to Liverpool the following day.
5. On 27 March, Mr Redfern vomited a coffee ground like substance, a sign of internal bleeding. He was taken to hospital where he was admitted for treatment.
6. On 28 March, Mr Redfern was assessed to be at the end of life and the hospital tried to secure a bed at a hospice. The prison remained in regular contact with the hospital for updates on his condition.
7. At 4.40pm, on 6 April, it was confirmed that Mr Redfern had died in hospital.
8. The coroner gave the cause of death as decompensated (advanced) liver disease.

Findings

9. The clinical reviewer found that the care Mr Redfern received at Liverpool was equivalent to that which he could have expected to receive in the community. Mr Redfern's physical and mental wellbeing was supported by healthcare staff, prison staff, and peers.
10. The clinical reviewer made one recommendation about record keeping, which we do not repeat in this report but which the Head of Healthcare will wish to address.
11. We make no recommendations.

The Investigation Process

12. 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.
13. The investigator obtained copies of relevant extracts from Mr Redfern's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr Redfern's clinical care at the prison.
15. We informed HM Coroner for Liverpool and Wirral of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. We contacted Mr Redfern's sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not respond.
17. We shared our initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies.

Background Information

HMP Liverpool

18. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1,400 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. There is a 24-hour inpatient unit.
19. On 1 June 2018, Liverpool was placed in special measures by HM Prison and Probation Service (HMPPS), meaning HMPPS considers that it needs additional, specialist support to improve performance.

HM Inspectorate of Prisons

20. 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.
21. While primary health care had improved, inspectors found that staff shortages had had a negative impact on all aspects of health services, especially mental health care. 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.
22. 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

23. 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 2017, the IMB reported that many cells were in poor condition, with no electrics, running water and blocked toilets. The number of elderly and frail prisoners were increasing across the whole estate and the prison struggled to cope with older prisoners with significant health care needs and staff were not trained in social care. Also, the Victorian design of the prison was not suitable for those with mobility issues.

Previous deaths at HMP Liverpool

24. Mr Redfern was the fourteenth prisoner to die at Liverpool in the last two years, five from natural causes. There are no similarities between Mr Redfern's death and previous deaths at Liverpool.

Findings

The diagnosis of Mr Redfern's terminal illness and informing him of his condition

25. On 3 August 2018, Mr Redfern was sentenced to five years in prison for arson. He was sent to HMP Liverpool.
26. Mr Redfern had been diagnosed with end stage liver disease prior to entering prison and had been receiving palliative care since November 2017.
27. A nurse completed Mr Redfern's reception screening, his liver disease was recorded and he was referred to and saw a prison GP the same day. On 7 August, a second health screening was completed.

Mr Redfern's clinical care

28. On 22 August, Mr Redfern was seen by a prison GP because he reported increasing pain in his back and abdomen. Mr Redfern was taken to Aintree Hospital, he was admitted, and treated for decompensated (advanced) liver disease. Mr Redfern was discharged on 6 September and was transferred back to Liverpool.
29. On 8 September, a prison GP diagnosed Mr Redfern with peripheral oedema (swelling in both his legs due to fluid retention). Mr Redfern was already taking medication for fluid retention. This treatment was reviewed on 22 September by a prison GP and he prescribed codeine for pain relief.
30. On 24 September, Mr Redfern began vomiting and became jaundiced. He was taken to Aintree Hospital where he was treated for decompensated liver disease, alcoholic liver disease, cirrhosis (scarring of the liver) and neutropenic sepsis (a life-threatening infection). Mr Redfern's medications were amended and he was discharged back to Liverpool on 2 October 2018.
31. On 4 October, Mr Redfern was moved to Liverpool's inpatient unit. On 5 October, a prison GP reviewed Mr Redfern and a care plan was created to manage Mr Redfern's health, which included reviewing his care at weekly multidisciplinary meetings.
32. On 20 November Mr Redfern was sent to Aintree Hospital because a blood test showed he had an electrolyte imbalance. Mr Redfern's health deteriorated in hospital, and a Do Not Attempt Cardiopulmonary Resuscitation order (which means that no attempt at resuscitation will be made if the patient's heart or breathing stops) was put in place and end of life care began. However, before Mr Redfern could be transferred to a hospice, his health improved and on 14 January 2019, he was transferred back to Liverpool.
33. On 22 January 2019, blood tests showed that Mr Redfern had low potassium levels. He was taken to Aintree Hospital, treated, and was transferred back to Liverpool on 23 January. Later that day, Mr Redfern had a fall, so he was taken back to hospital, and later discharged with a diagnosis of pleural effusion (fluid between layers of tissue outside of the lungs). He was also referred to the respiratory pleural clinic.

34. On 11 February, at an advance care planning meeting, Mr Redfern said his preferred place of death would be a hospice.
35. On 23 February, a prison GP discussed Mr Redfern's care with a palliative care consultant because his blood test results showed he had anaemia. As a result, Mr Redfern was transferred to Woodhill Hospice on 5 March for blood transfusions and was returned to the prison the next day.
36. On 27 March, Mr Redfern vomited a coffee ground like substance, a sign of internal bleeding. He was taken to Aintree Hospital and was admitted for treatment.
37. On 28 March, Mr Redfern was assessed as being at the end of life and the hospital sought funding and a bed at a hospice. The prison remained in regular contact with the hospital for updates on his condition.
38. At 4.40pm, on 6 April, it was confirmed that Mr Redfern had died.

Mr Redfern's location

39. Mr Redfern was moved to the inpatient healthcare unit at Liverpool on 4 October 2018, because of his risk of falls and chronic illness. When necessary, he was transferred to hospital or a hospice for treatment.
40. Mr Redfern died in hospital. The prison liaised with the hospital and both made efforts to arrange for Mr Redfern to be moved to a hospice but he died before this could happen.
41. We are satisfied that Mr Redfern was suitably located throughout his illness.

Liaison with Mr Redfern's family

42. On 18 December 2018, the prison appointed a Family Liaison Officer (FLO) to support Mr Redfern and his sister (who was named as the next of kin). A deputy FLO was also appointed.
43. When Mr Redfern went to hospital on 27 March 2019, the deputy FLO contacted Mr Redfern's sister and explained why he was in hospital. On 4 April, his sister visited Mr Redfern and attend a multidisciplinary meeting to discuss his care.
44. When Mr Redfern died on 6 April, the FLO contacted Mr Redfern's sister by phone to offer support and guidance. His sister had already been informed by the hospital that Mr Redfern had died before the FLO could make contact. The FLO and her deputy arranged to visit her two days later, and they offered support.
45. Mr Redfern's funeral was held on 7 May. No one from the prison attended at the family's request. The prison contributed to the cost of the funeral in line with national instructions.

Restraints, security and escorts

46. When prisoners have to travel outside the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a

responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.

47. Mr Redfern was not restrained when he was taken to hospital on 27 March because of his ill health. He remained unrestrained until his death on 6 April. We are satisfied that this was appropriate.

Compassionate release

48. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months.
49. Two applications were completed to consider Mr Redfern's suitability for compassionate release. In December 2018, his application was refused because his risk of reoffending was considered too high.
50. A second application was made as Mr Redfern's health had declined further. This application was approved by the Governor and sent to the Public Protection Casework Section in HMPPS for consideration on 3 April 2019. Mr Redfern died before the application could be considered.
51. We are satisfied that the prison appropriately considered compassionate release.

**Prisons &
Probation**

Ombudsman
Independent Investigations