Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Henry Heaton a prisoner at HMP Liverpool on 19 March 2019

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 Henry Heaton died on 19 March 2019 of pneumonia, acute kidney failure, abnormal heart rate, hypertension, a stroke and heart failure while a prisoner at HMP Liverpool. He was 91 years old. I offer my condolences to Mr Heaton's family and friends.

I am satisfied that the standard of care Mr Heaton received at 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 **November 2019**

Contents

Summary .... **Error! Bookmark not defined.**

The Investigation Process 2

Background Information 3

Findings 4

Summary

Events

1. On 30 April 2018, Mr Henry Heaton was remanded to HMP Liverpool charged with historic sexual offences. On 1 May, he was sentenced to 10 years in prison.

2. Mr Heaton arrived at Liverpool with a number of pre-existing medical conditions which needed regular reviews and monitoring by healthcare staff.

3. On 6 August 2018, a blood test indicated that Mr Heaton had a raised chance of developing prostate cancer. A GP referred Mr Heaton to hospital, where he was diagnosed with prostate cancer. Following his diagnosis, both healthcare staff and hospital staff monitored and reviewed Mr Heaton regularly. Comprehensive care plans were implemented to manage his condition.

4. On 18 February 2019, healthcare staff reviewed Mr Heaton after he became unsteady on his feet. It was noted that his legs were swollen and painful and he appeared to be confused. A prison GP reviewed him and sent him to hospital by emergency ambulance for review and he was admitted as an inpatient.

5. Mr Heaton’s condition continued to deteriorate and on 12 March, he told hospital staff he was refusing all food and fluids except for an intravenous drip. He signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. Hospital staff considered Mr Heaton had the mental capacity to make decisions about his care and treatment.

6. On 19 March, a nurse from the prison’s healthcare team visited Mr Heaton in hospital to get an update on his condition. Hospital staff told him that Mr Heaton was receiving palliative care and that his prognosis was one or two days at the most.

7. At 7.55pm on 19 March, it was confirmed that Mr Heaton had died.

8. The coroner gave the cause of death as pneumonia, acute kidney failure, abnormal heart rate, hypertension, a stroke and heart failure

Findings

9. The clinical reviewer found that Mr Heaton received a good standard of clinical care at Liverpool. Healthcare staff appropriately assessed his clinical needs and sought advice from hospital staff.

10. We are satisfied that the standard of care Mr Heaton received at Liverpool was equivalent to that which he could have expected to receive in the community.

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 him. No one responded.

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

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

15. We informed HM Coroner for Merseyside and Liverpool of the investigation. There was no post-mortem examination. The coroner gave us the cause of death. We have sent the coroner a copy of this report.

16. We wrote to Mr Heaton's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.

17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Liverpool

18. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 700 adult men. Merseycare NHS Foundation Trust and Spectrum provide healthcare services at the prison. There is a 24-hour inpatient unit.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Liverpool was in September 2017. Inspectors noted that despite consistent and challenging staffing pressures, and a limited leadership presence, the quality of clinical care was of a reasonable standard. They found good evidence of the use of comprehensive care plans and the regular monitoring of prisoners with complex healthcare needs.

20. They noted that prisoners who had been given a terminal diagnosis were well cared for. However, they considered the healthcare centre was not an environment conducive to palliative care. Links with local palliative care services were effective, but care pathways were underdeveloped.

Independent Monitoring Board

21. 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, despite difficulties caused by the environment they work in, the healthcare team had good morale.

22. However, the Board was concerned that areas of the healthcare unit were unable to be used due to damage. They were also concerned that repairs, and general cleaning, were not being carried out in a timely manner or to a satisfactory standard.

Previous deaths at HMP Liverpool

23. Mr Heaton was the thirteenth prisoner to die at Liverpool since March 2017. Six of the previous deaths were self-inflicted, five were from natural causes and one was from substance misuse. There have been three further deaths since Mr Heaton's, two from natural causes and one awaiting classification.

24. There are no significant similarities with those deaths.

Findings

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

25. On 30 April 2018, Mr Henry Heaton was remanded to HMP Liverpool charged with historic sexual offences. On 1 May, he was sentenced to 10 years in prison.

26. Mr Heaton had a complex medical history and a number of pre-existing medical conditions. He had been previously diagnosed with osteoporosis (a weakness in the bones leaving him susceptible to breaks and fractures), glaucoma (an eye condition which can lead to loss of vision), hydro-nephrosis (a build-up of fluid in the kidneys), retention of urine (for which he had a catheter inserted) and a stroke. In 2005, Mr Heaton had also been diagnosed with colorectal cancer, which had been treated successfully. Due to his poor health and mobility, Mr Heaton used a walking stick to move around.

27. Following his initial health screen at Liverpool he was admitted to the prison's inpatient unit for observation. Care plans were created for his various conditions, and he was referred to specialist older prisoner clinics at the prison for review. Mr Heaton was also referred for a social care assessment.

28. On 5 May, a prison GP reviewed Mr Heaton. He noted his pre-existing conditions and prescribed medications. He also noted that Mr Heaton had a catheter. Mr Heaton was reviewed regularly by healthcare staff over the weeks that followed.

29. On 22 May, Mr Heaton was discharged from the prison's inpatient unit and was moved to a cell on A wing, the induction unit. He was moved again on 20 June to K wing, a wing for vulnerable prisoners.

30. On 25 June, a nurse from the prison's healthcare unit, reviewed Mr Heaton after he complained of feeling short of breath. The nurse noted that he was breathing rapidly and gasping for air. He was also pale and felt very unwell. He told the nurse he had been experiencing chest pain, but that it had resolved itself prior to his arrival. The nurse took Mr Heaton's observations (measurements of temperature, respiratory rate, pulse, blood pressure and blood oxygen saturation, an indicator of a patient's state of health), and the results were normal. However, the nurse did note that the left side of Mr Heaton's face appeared to have dropped in comparison to the right. Mr Heaton also reported a feeling of weakness in his left arm and leg.

31. The nurse suspected Mr Heaton had had a stroke and asked, a prison GP to review him. The prison GP also suspected that Mr Heaton had had a stroke and sent him to hospital by emergency ambulance for review. Hospital staff carried out a number of tests, including a computerised tomography (CT) scan and confirmed the prison GP's diagnosis.

32. The next day, Mr Heaton was discharged from hospital and was transferred back to Liverpool. Healthcare staff advised him to move to the prison's inpatient unit for observation, but Mr Heaton told them he would rather be among his friends on his wing.

33. Healthcare staff reviewed Mr Heaton regularly. A stroke care plan was created, and his existing care plans were reviewed and updated. Following advice from hospital staff, Mr Heaton had ongoing routine blood and ECG tests and regular reviews by the prison GP's.

34. On 6 August, Mr Heaton was reviewed by a prison GP's after he noted a raised prostate specific antigen level which indicated a raised chance of developing prostate cancer. The prison GP's made a two week wait referral to the urology department of a hospital, which is a referral made for patients with suspected cancer.

35. On 13 August, a prison paramedic reviewed Mr Heaton after he complained of vomiting and feeling extremely lethargic. He took Mr Heaton's observations, which showed an irregular pulse and some crackling in his lungs. He considered that Mr Heaton could have had another stroke. He sent him to hospital by emergency ambulance for review. Mr Heaton was diagnosed with a urine infection and dehydration. He was given antibiotics and was transferred back to Liverpool later the same evening.

36. On 21 August, Mr Heaton was reviewed by the urology department at the hospital because of a prison GP's referral. They carried out a series of tests and the results showed that he had prostate cancer. Mr Heaton was prescribed appropriate medication and a review was planned for three months' time.

37. Following his diagnosis, Mr Heaton was reviewed by healthcare staff, and a cancer care plan was created.

38. We are satisfied that healthcare staff appropriately investigated Mr Heaton's symptoms, made timely referrals to hospital and discussed his diagnosis with him.

Mr Heaton's clinical care

39. On 29 August, following a review of the results of a routine ECG, hospital staff diagnosed Mr Heaton with pulmonic valvular regurgitation (a leak in the valve which controls the flow of blood travelling from the heart to the lungs) and mitral regurgitation (a leakage of blood backwards into the chamber of the heart).

40. The following day, a nurse reviewed Mr Heaton after he became unsteady on his feet and unable to support his own weight. The nurse took his observations and the results showed that Mr Heaton had developed an erratic pulse. The nurse also considered that he appeared confused and sent Mr Heaton to hospital by emergency ambulance for a further review. Hospital staff diagnosed him with a urine infection and prescribed antibiotics. Mr Heaton was discharged from hospital and was transferred back to Liverpool the following day.

41. Mr Heaton's care plans were updated and he was admitted to the prison's healthcare inpatient unit for 24 hours for observation. He was returned to K wing the following morning.

42. On 8 November, a prison GP reviewed Mr Heaton after he complained of difficulty swallowing for the previous two days. He took his observations but found nothing of note. He diagnosed Mr Heaton with severe oesophageal

dysphagia (the inability to swallow) and sent him to hospital by taxi for review. Mr Heaton was accompanied by two escort officers and was not restrained.

43. After reviewing Mr Heaton, hospital staff decided to admit him as an inpatient for a period of observation, during which time the oesophageal dysphagia resolved itself without further treatment. Tests carried out while Mr Heaton was in hospital showed that he had anaemia. Mr Heaton was referred to a hospital's haematology department for further review. He was discharged from hospital and was transferred back to Liverpool on 11 August.

44. On 24 December, Mr Heaton was reviewed by staff from the haematology department at a hospital. They considered Mr Heaton would benefit from a blood transfusion and he was admitted as an inpatient. However, during the first half of the transfusion Mr Heaton developed a pulmonary oedema (a collection of fluid in the lungs). As a result, he could not have the second half of the transfusion.

45. Hospital staff considered that due to Mr Heaton's age and condition, he would not be suitable for any further attempts at blood transfusions. They asked that a full blood count be carried out each week and that he be reviewed weekly by a prison GP to monitor his haemoglobin levels (to monitor his anaemia). Mr Heaton was discharged from hospital and was transferred back to Liverpool on 26 December.

46. On his return to Liverpool, healthcare staff regularly reviewed Mr Heaton. They updated his care plans to reflect his various medical conditions and carried out a full blood count as requested by hospital staff.

47. On 14 January 2019, a prison GP reviewed Mr Heaton after a routine blood test showed irregular and abnormal results. The prison GP telephoned the staff at the haematology department at the hospital for advice. They considered that although Mr Heaton's observations were normal, his blood test results showed that he had possibly developed internal bleeding. He was taken to hospital by emergency ambulance for review.

48. Hospital staff diagnosed Mr Heaton with chronic anaemia and he stayed in hospital as an inpatient. He successfully had a blood transfusion the same day. Mr Heaton was transferred back to Liverpool on 16 January.

49. Between 1 February and 15 February, Mr Heaton's routine blood tests showed a gradual reduction in his sodium levels (a reduction in sodium levels can cause confusion and seizures and can lead to coma and death.) A prison GP reviewed the results and adjusted Mr Heaton's prescribed medications to raise his sodium levels.

50. On 18 February, a nurse from the prison's healthcare team, reviewed Mr Heaton after he appeared to be confused and unsteady on his feet. She also noted his legs were swollen and painful. She referred him to a prison GP, for a further review. The prison GP suspected Mr Heaton had had another stroke. He was sent to hospital for further review and was admitted as an inpatient.

51. Healthcare staff kept in daily contact with hospital staff for updates on Mr Heaton's condition.

52. On 12 March, hospital staff told healthcare staff at the prison that Mr Heaton's condition had deteriorated, that he had taken the decision to refuse food and was only accepting intravenous fluids. Hospital staff had discussed the issue of resuscitation with Mr Heaton. He told them he did not wish to be resuscitated in the event of a cardiopulmonary arrest and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order to that effect. Hospital staff considered Mr Heaton had the mental capacity to make decisions about his care and treatment.

53. On 19 March, a nurse from the prison's healthcare team, visited Mr Heaton in hospital to get an update on his condition. Hospital staff told the nurse that Mr Heaton was receiving palliative care and that his prognosis was one or two days at the most.

54. Mr Heaton's condition continued to deteriorate and at 7.55pm on 19 March, Mr Heaton died. A hospital doctor confirmed Mr Heaton's death at 10.41pm.

55. We agree with the clinical reviewer that the standard of clinical care Mr Heaton received at Liverpool was equivalent to that which he could have expected to receive in the community.

56. The clinical reviewer noted that Mr Heaton arrived into custody with a number of pre-existing medical conditions. She considered healthcare staff appropriately reviewed and assessed his healthcare needs in line with NICE guidelines and sought advice from hospital staff where appropriate, and that Mr Heaton received appropriate screening and was referred to specialist clinics where necessary.

Mr Heaton's location

57. When Mr Heaton arrived at HMP Liverpool, healthcare staff noted his pre-existing medical conditions and reduced level of mobility, and appropriately located him in the prison's healthcare inpatient unit.

58. When Mr Heaton was discharged from the prison's inpatient unit on 22 May 2018, he was moved to a cell on A wing, the induction unit for prisoners arriving at Liverpool. He was moved again on 20 June to K wing, a wing for vulnerable prisoners.

59. As Mr Heaton's condition deteriorated, healthcare staff encouraged him to return to the inpatient unit, which he did. Following an improvement in his condition, Mr Heaton was moved back to K wing at his request to be among his friends where he continued to be monitored regularly by healthcare staff. Healthcare staff took his wishes into account while maintaining daily reviews of his condition.

60. We are satisfied that Mr Heaton was appropriately located throughout his illness and that his wishes were taken into account. We are also satisfied that he was quickly taken to hospital as his condition deteriorated.

Restraints, security and escorts

61. When prisoners must 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 must 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 considering factors such as the prisoner's health and mobility.

62. Following his diagnosis of prostate cancer, whenever Mr Heaton went to hospital he was escorted to hospital by two officers and was not restrained. We are satisfied that this was appropriate given his age and very poor health.

Liaison with Mr Heaton's family

63. On 15 March 2019, the Head of Safer Custody at Liverpool, telephoned Mr Heaton's next of kin, his sister, to inform her of his admission to hospital. She remained in contact with Mr Heaton's sister, who asked to be informed by telephone of any changes in his condition.

64. Following Mr Heaton's death on 19 March, the prison appointed the Head of Security and Intelligence at Liverpool, to act as family liaison officer (FLO). As agreed, he telephoned Mr Heaton's sister to inform her of Mr Heaton's death. However, she was unwell and her son, Mr Heaton's nephew, answered the phone and the FLO told him that Mr Heaton had died. He told the FLO he would ring him the following day.

65. Mr Heaton's nephew telephoned the FLO the following day. The FLO explained the FLO role to him and made arrangements to return Mr Heaton's property to the family. He remained in contact with the family over the days that followed. As arranged, the FLO visited Mr Heaton's sister on 23 April to return his property.

66. Mr Heaton's funeral was held on 1 May. The prison offered a financial contribution to the cost of the funeral in line with national policy.

Compassionate release

67. 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.

68. Although Mr Heaton was seriously ill on his last admission to hospital on 18 February 2019, it was not until the morning of 19 March that hospital staff said that Mr Heaton may not survive more than one or two days.

69. We are satisfied that there was not sufficient time for an application to be made on Mr Heaton's behalf.

70. We make no recommendations.

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