Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr James Reilly, a prisoner at HMP Liverpool, on 5 July 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*

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 James Reilly died on 5 July 2019 of heart failure and chronic obstructive pulmonary disease at HMP Liverpool. He was 85 years old. I offer my condolences to Mr Reilly's family and friends.

Mr Reilly had several long-term medical conditions when he arrived in prison. I am satisfied that the care Mr Reilly received at Liverpool overall, was of a satisfactory standard and equivalent to that which he could have expected to receive in the community.

I am concerned, however, that healthcare staff did not complete a secondary health screen within seven days of the first screen as they should have done and that healthcare staff did not discuss Mr Reilly's wishes about resuscitation with him.

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** **August 2020**

## Contents

# Summary

## Events

1. On 13 March 2018, Mr James Reilly was sentenced to 16 years in prison for sexual offences. He was sent to HMP Liverpool.

2. Mr Reilly arrived in prison with a number of pre-existing medical conditions including chronic obstructive pulmonary disease (COPD), atrial fibrillation peripheral vascular disease, anaemia and hypertension. He also had a prosthetic leg and used a wheelchair.

3. On 20 February 2019, Mr Reilly was admitted to hospital as an inpatient after having a heart attack. Hospital staff completed a do not attempt cardiopulmonary resuscitation (DNACPR) order on his behalf. Prison healthcare staff did not follow up or review the order with Mr Reilly when he returned to prison.

4. At 6.30am on 5 July, Mr Reilly was found unresponsive in his cell. Prison staff radioed an emergency code blue and an ambulance was called immediately. Nurses attended and began cardiopulmonary resuscitation (CPR).

5. At 6.45am, paramedics arrived and confirmed that Mr Reilly had died.

6. The coroner gave Mr Reilly's cause of death as heart failure and chronic obstructive pulmonary disease.

## Findings

7. The clinical reviewer concluded that the care Mr Reilly received at Liverpool was satisfactory and equivalent to that which he could have expected to receive in the community. Healthcare staff provided prompt and responsive primary care.

8. However, the clinical reviewer found that Mr Reilly did not have a secondary screen within seven days of receiving his first screen as he should have done, which is not in line with NICE guidelines.

9. Although the hospital discussed and completed a DNACPR order with Mr Reilly, prison staff did not follow up and review the order with him when he returned to prison. As a result, prison healthcare staff attempted resuscitation when Mr Reilly was found unresponsive in his cell, which was against his wishes.

10. The clinical reviewer also found that healthcare staff at Liverpool do not have a process in place that logs all DNACPR documentation and which identifies a designated place to store and locate them.

## Recommendations

- The Head of Healthcare should ensure that all new prisoners receive secondary health screens within seven days, in line with NICE guidelines and PSO 3050 *Continuity of Healthcare for Prisoners*.
- The Head of Healthcare should ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders are discussed promptly and where appropriate, implemented without delay.
- The Head of Healthcare should ensure that the presence of a DNACPR order is clearly communicated to all staff involved in the prisoner's care and that the DNACPR document is held in a designated and readily accessible place.

# The Investigation Process

11. 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.

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

13. NHS England commissioned an independent clinical reviewer to review Mr Reilly's clinical care at the prison. The investigation was suspended from 8 October 2019 until 10 January 2020, while we waited for the clinical review to be completed.

14. We informed HM Coroner for Liverpool and Wirral of the investigation. He shared the cause of Mr Reilly's death with us. We have sent him a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Reilly's nominated next of kin, his friend, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know whether healthcare staff had missed prescribing any medication to Mr Reilly. This has been addressed in the clinical review.

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

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 750 adult men. Spectrum Healthcare UK Trust provide healthcare services. There is a 24-hour inpatient unit.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Liverpool was in September 2019. Inspectors noted significant improvements since the last inspection that took place in 2017. The new healthcare providers worked well and the partnership arrangements were clear, strong and were driving service improvements. Oversight and governance processes were robust and effective collaboration in the prison was facilitated by a visible and committed leadership team. However, inspectors found that there were too many vacancies in the primary care nursing team. Inspectors also reported that the living conditions were now clean and decent.

### Independent Monitoring Board

20. 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 2018, the IMB reported that there had been significant improvements. Prisoners were no longer housed in inappropriate conditions. However, the Victorian design of the prison was not suitable for elderly, frail prisoners or those with mobility issues. The IMB also noted that with the change of healthcare providers, there was clear and accountable direction.

### Previous deaths at HMP Liverpool

21. Mr Reilly was the 15th prisoner to die at Liverpool since July 2017. Of the previous deaths, six were from natural causes, six were self-inflicted deaths, and two were drug related deaths. There are no similarities between our findings in the investigation of Mr Reilly's death and the other deaths.

# Key Events

22. On 13 March 2018, Mr James Reilly was sentenced to 16 years in prison for sexual offences and was sent to HMP Liverpool.

23. Mr Reilly had had poor health for several years and had a history of chronic obstructive pulmonary disease (COPD), atrial fibrillation (abnormal heart rhythm) peripheral vascular disease (restricted blood flow), anaemia and hypertension (high blood pressure). He also had a prosthetic leg, used a wheelchair and needed help with his personal care.

24. After his initial health screen, a nurse made an appointment for Mr Reilly to see a prison GP. A prison GP reviewed Mr Reilly and prescribed appropriate medication. Mr Reilly did not have a secondary health screen within the next seven days as he should have done.

25. On 6 April, a nurse completed a secondary reception screen. Mr Reilly said that he had regular check-ups for his muscular-skeletal problem and COPD. She scheduled regular COPD reviews. Mr Reilly frequently saw healthcare staff to monitor and treat his medical conditions. Prison GPs prescribed appropriate medications.

26. On 27 April 2018, a nurse completed Mr Reilly's first COPD review. He said that he had shortness of breath when moving around his wing. She asked administrative staff to check if he had any outstanding hospital appointments.

27. On 14 August, a nurse completed a long-term condition (LTC) review. Mr Reilly told her that he used two inhalers for his COPD and had stopped smoking approximately 18 months earlier. She gave him general advice about his inhalers and noted that he did not have shortness of breath and was able to mobilise using his wheelchair and walking sticks.

28. On 4 September, Mr Reilly told a prison GP that for some time he had chest pain at night. He arranged for an ECG and blood tests to be completed. The ECG test result was normal.

29. On 2 October, Mr Reilly told a prison GP, that he had pain in his leg. After examination, He suspected that Mr Reilly had some degree of vascular insufficiency (the valves in the leg veins were not working properly, making it difficult for blood to return to the heart from the legs) and likely dependent oedema (swelling in the lower body). He completed a referral to the hospital vascular service for further investigations.

30. On 5 October, a prison GP reviewed Mr Reilly's blood test results and noted that he was anaemic and was lacking in folic acid. He discussed this with Mr Reilly and suggested an improved diet and explained the benefits of taking folic acid.

31. On 20 November, a prison GP told Mr Reilly that the hospital vascular surgeon had diagnosed peripheral arterial disease and Mr Reilly needed to take an anticoagulant (to help to prevent blood clots) and a statin (to lower the level of cholesterol in the blood).

32. On 4 December, a prison GP reviewed Mr Reilly. Mr Reilly said that he was taking his medication but had a chesty cough with green sputum. He prescribed amoxicillin (an antibiotic) and recommended plenty of fluids. He reviewed Mr Reilly again on 18 December and prescribed more amoxicillin.

33. On 14 January 2019, wing staff asked a nurse to review Mr Reilly in his cell. Mr Reilly told her that he had a persistent chesty cough and shortness of breath. She referred him for an urgent GP review. A prison GP reviewed Mr Reilly and checked his observations. He noted that Mr Reilly's oxygen saturation level was 89% (low) and his heart rate was high. He diagnosed an infection of the lower respiratory tract and severe left sided pneumonia. He arranged for Mr Reilly to go to hospital for further review. Hospital staff diagnosed pneumonia and treated Mr Reilly with antibiotics until 17 January, when he was discharged from hospital and returned to Liverpool.

34. Mr Reilly's health was stable for a few weeks until 20 February. He a prison GP that he was short of breath, wheezing, coughing and had a sore throat. He arranged for an ECG to be completed and reviewed the results. He noted that the ECG showed a fast heart rate (126 beats per minute) and dips in the expected baseline and that Mr Reilly's temperature was very high. He suspected Mr Reilly had had a heart attack and arranged for an emergency ambulance to take him to hospital. He was not restrained.

35. Mr Reilly stayed in hospital for one week while hospital staff monitored his chest pain. He told hospital staff that he did not want anyone to resuscitate him if his heart or breathing stopped and signed a do not attempt cardiopulmonary resuscitation (DNACPR) order (which means that, in the event of cardiac or respiratory arrest, no attempt at resuscitation will be made; all other appropriate treatment and care will continue to be provided) to that effect. When Mr Reilly was discharged from hospital and returned to Liverpool, a prison GP noted the DNACPR order. However, healthcare staff did not follow up or review the DNACPR order regularly with Mr Reilly as they should have done.

36. Between March and June, healthcare staff continued to review Mr Reilly. He told healthcare staff that he did not have shortness of breath, chest pains or palpitations and was taking his medications with no side effects. Nurses checked his leg amputation and noted that there were no issues.

37. On 29 June, wing staff asked healthcare staff to see Mr Reilly in his cell. A nurse attended and Mr Reilly told her that he felt cold (when it was a warm day) but had no discomfort. She used the National Early Warning Score (NEWS) system (a tool devised by Royal College of Surgeons to assess the severity of a patient's condition, 0 being no symptoms 5 needing urgent clinical assessment) and noted that the score was "0" indicating no concerns. She reassured Mr Reilly and told wing staff to contact the healthcare unit if there were any further concerns.

38. On 2 July, wing staff called healthcare staff again to check on Mr Reilly because they were concerned for his well-being. Mr Reilly told a nurse that he thought he had pneumonia and that his inhalers had not helped. He also said that he had a dry cough with yellow sputum, had lost his appetite and was lethargic. The nurse arranged an emergency appointment with a prison GP. A prison GP. reviewed Mr Reilly and diagnosed a chest infection. He prescribed antibiotics and pain

relief and told Mr Reilly to ask for help if he had shortness of breath or a non-blanching rash (a rash that does not fade when pressed).

39. Mr Reilly was located in a ground floor double cell, on the bottom bunk. At 6.30am on 5 July, Mr Reilly's cell mate woke up and started talking to Mr Reilly. He realised that something was wrong and pressed the cell bell. An officer responded. He opened the cell observation panel and the cellmate said that something was wrong with Mr Reilly. The officer asked a nurse to come to the cell and they went into the cell together. The nurse immediately told the officer to radio an emergency code blue.

40. The officer helped the nurse lift Mr Reilly off the bunk and onto the floor. She began cardiopulmonary resuscitation with another nurse.

41. Paramedics arrived at 6.45am and confirmed that Mr Reilly had died.

### Contact with Mr Reilly's family

42. On 5 July, the prison appointed an officer as the prison's family liaison officer (FLO). The FLO visited Mr Reilly's family friend, as she was his named next of kin. He informed her of Mr Reilly's death and offered her condolences and support. He also arranged for prison staff at HMP Risley to break the news and offer condolences and support to Mr Reilly's son who was a prisoner there.

43. Mr Reilly's funeral was held on 5 August 2019. The prison paid for the cost of the funeral in line with national guidance.

### Support for prisoners and staff

44. After Mr Reilly's death, a prison manager debriefed the escort staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

45. The prison posted notices informing other prisoners of Mr Reilly'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 Reilly's death.

### Cause of death

46. The coroner gave Mr Reilly's cause of death as heart failure and chronic obstructive pulmonary disease (COPD).

# Findings

## Clinical care

47. The clinical reviewer concluded that the care Mr Reilly received at Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer found that healthcare staff created a comprehensive care package. They also provided a good standard of care and support, and provided prompt and responsive primary care.

48. The clinical reviewer did, however, identify some concerns, although these did not contribute to Mr Reilly's death.

## Continuity of care

49. National Institute for Health and Clinical Excellence (NICE) guidelines and PSO 3050 *Continuity of Healthcare for Prisoners* set out the expectation that prisons ensure continuity of care for prisoners on transfer. This includes considering relevant clinical information and carrying out a general health assessment, equivalent to a primary care assessment when registering with a new GP in the community. This should then be followed up with a secondary screen within seven days of arrival.

50. Although Mr Reilly did have a detailed second screening on 6 April, this did not take place within seven days of the first screening and was not in line with NICE guidelines. We make the following recommendation:

    **The Head of Healthcare should ensure that, in line with NICE guidelines and PSO 3050 *Continuity of Healthcare for Prisoners*, that all new prisoners receive secondary health screens within seven days.**

## Resuscitation

51. Following his admission to hospital on 20 February, Mr Reilly discussed his resuscitation wishes with hospital staff. The clinical reviewer found that the DNACPR order put in place by the hospital did not have a review date and did not say whether it was transferrable to cover Mr Reilly's care in prison. Although a prison GP noted the DNACPR order on Mr Reilly's return from hospital, prison healthcare staff did not follow this up or discuss and review the DNACPR order regularly with Mr Reilly. As a result, healthcare staff attempted to resuscitate him when he was found unresponsive in his cell and therefore did not take his wishes into account.

52. The clinical reviewer also found that there is no clear process in place at Liverpool that logs all DNACPR documentation and which identifies a designated place to store and locate them. We agree that there should have been recorded discussions about Mr Reilly's wishes and that all staff involved in his care should have been aware that a DNACPR order was in place for Mr Reilly and have known where to access it. We make the following recommendations:

**The Head of Healthcare should ensure that Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders are discussed promptly and, where appropriate, implemented without delay.**

**The Head of Healthcare should ensure that the presence of a DNACPR order is clearly communicated to all staff involved in the prisoner's care and that the DNACPR document is held in a designated and readily accessible place.**

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