

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Trainer, a prisoner at HMP Liverpool, on 23 November 2020

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*



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Summary

1. 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.
2. We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.
3. Mr Ian Trainer died in hospital on 23 November 2020, while a prisoner at HMP Liverpool. He was 83 years old. Mr Trainer's died from blood clots which had blocked his blood vessels, caused by COVID-19. He also had underlying chronic kidney disease. I offer my condolences to Mr Trainer's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Trainer received at Liverpool was of a high standard and equivalent to that he could have expected to receive in the community. She made no recommendations.
5. We do not know when or where Mr Trainer contracted COVID-19. However, we are satisfied that Liverpool followed national guidance on COVID-19 risk management and implemented the procedures advised to help prevent the spread of the infection. We found no non-clinical issues of concern and make no recommendations.

The Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Trainer's clinical care at HMP Liverpool.
7. The PPO investigator reviewed Mr Trainer's personal records, as well as HMPPS and local policy documents. She investigated non-clinical issues, including aspects of the prison's response to COVID-19 and shielding prisoners; Mr Trainer's location; the security arrangements for his journey and admission to hospital; liaison with his family; and whether early release was considered.
8. The PPO family liaison officer wrote to the solicitors acting on behalf of Mr Trainer's wife, to explain the investigation. They had no specific questions for us to consider.
9. We shared our initial report with HM Prison and Probation Service (HMPPS). They found one factual inaccuracy which has been amended in this report.
10. We sent a copy of our initial report to the solicitors acting on behalf of Mr Trainer's wife. They did not notify us of any factual inaccuracies.

Previous deaths at HMP Liverpool

11. Mr Trainer was the ninth prisoner to die at Liverpool since November 2018. Of the previous deaths, six were from natural causes (none with COVID-19), one was self-inflicted and the cause of one death was unknown. There are no similarities between our findings in the investigation into Mr Trainer's death and those of the previous deaths. There have since been six further deaths, four from natural causes (including two as a result of COVID-19), one self-inflicted and one that awaits classification.

COVID-19 (coronavirus)

12. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.
13. COVID-19 can make anyone seriously ill, but some people are at higher risk of severe illness and developing complications from the infection. People at high risk (clinically extremely vulnerable) include those who have had an organ transplant; have severe lung or kidney disease; or are having certain types of cancer or other treatment which significantly increases the risk of infection. Examples of those at moderate risk (clinically vulnerable) are people over 70; people under 70 with an underlying health condition, such as diabetes, or chronic respiratory, heart, liver or kidney disease; those with a weakened immune system; or who are very overweight. (These lists are not exhaustive.)
14. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy

is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly received prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

15. Mr Ian Trainer was remanded to HMP Altcourse on 6 May 2020, charged with threatening behaviour and breach of a restraining order.
16. Mr Trainer had been diagnosed with chronic kidney disease, as well as orthopaedic and rheumatology conditions, but he was otherwise fit and well. He was assessed for symptoms of COVID-19 and placed in isolation (reverse cohorting) for 14 days.
17. Following a healthcare review on 10 June, it was decided that in view of his age and medical history, Mr Trainer was at high risk of serious illness if he contracted COVID-19 and he was moved to the prison's dedicated shielding unit.
18. On 30 October, a COVID-19 swab taken from Mr Trainer two days previously was confirmed as negative.

Transfer to HMP Liverpool

19. On 2 November, Mr Trainer transferred to HMP Liverpool after a court appearance. During his initial health screen, Mr Trainer told the nurse that his cellmate at Altcourse had recently died from COVID-19. (Examination of prison records during the investigation showed that it was a friend on his wing, rather than someone with whom he shared a cell.) The health screen identified no concerns and Mr Trainer was placed in the reverse cohorting unit.
20. On 9 November, a prison officer told healthcare staff that Mr Trainer felt unwell. A nurse examined him and found that he was lethargic, with a poor appetite, hot/cold flushes and a raised temperature. She noted these were possible symptoms of COVID-19 and he was immediately placed in protective isolation in his cell. A swab was taken later that day (and returned as positive on 11 November).
21. The prison GP prescribed antibiotics and Mr Trainer was closely monitored. On 10 November, his condition deteriorated. Healthcare staff thought he would benefit from admission to hospital for rehydration and further assessment and requested an ambulance. Paramedics attended and decided against taking Mr Trainer to hospital as his clinical observations had returned to normal range. Therefore, with the approval of the prison's operational manager, he was relocated to the healthcare inpatient unit and a care plan was put in place.
22. Blood test results on 11 November were abnormal and suggested that Mr Trainer might have an infection. A prison GP discussed the findings with a hospital doctor, who agreed he should be taken to hospital. Mr Trainer returned to the prison in the early hours of 12 November, with a prescription for two types of antibiotics.
23. On 14 November, Mr Trainer had difficulty breathing and was again taken to hospital. He was given fluids and returned to the prison a few hours later.
24. Mr Trainer continued to deteriorate. On 17 November, his oxygen levels were low and a blood test indicated he might have a pulmonary embolism (blood clot blocking a blood vessel in the lungs). Healthcare staff urgently arranged for him

to be admitted to hospital and they obtained regular updates on his condition. Mr Trainer was escorted by two prison officers and no restraints were used.

25. The prison assigned a family liaison officer on 19 November. There had been no apparent family contact in prison and Mr Trainer had listed his solicitor as his next of kin. His solicitor agreed to act as the contact for Mr Trainer's family and to seek permission for their details to be shared, but all communication continued through the solicitor.
26. Mr Trainer died at 2.30pm on 23 November and his solicitor was notified the same day. His funeral was later arranged privately and held on 17 December, with no input required from the prison.
27. A prison manager debriefed the escort officers and other staff involved in Mr Trainer's care and offered support. Notices were issued to staff and prisoners.

Cause of death

28. The Coroner's inquest, held on 3 December 2020, concluded that Mr Trainer's death was due to multiple thromboemboli, caused by COVID-19. He also had chronic kidney disease, which did not cause, but contributed to his death.
29. Multiple thromboemboli are blood clots that break away from where they were formed, are carried away by the blood stream and block another blood vessel.

Findings

Clinical Findings

30. The clinical reviewer concluded that Mr Trainer received a high standard of clinical care, equivalent to that he could have expected to receive in the community. She considered that Mr Trainer's risk of contracting COVID-19 was well-managed by healthcare staff at Liverpool and that there were timely responses to changes in his health. The clinical reviewer made no recommendations.

Management of Mr Trainer's risk of infection from COVID-19

31. On reception to Liverpool, staff allocated Mr Trainer to the reverse cohorting unit, in line with the requirements to separate all new arrivals from existing residents. They had planned to move him to a shielding unit for high risk prisoners after the 14-day isolation period.
32. In response to apparent symptoms of COVID-19, Mr Trainer was immediately tested and isolated. When his condition deteriorated, he was admitted to the inpatient unit to allow better monitoring of his condition and healthcare staff referred him promptly to secondary care when they felt he needed further assessment, or additional treatment. Operational staff were instructed to allow nurses full access to Mr Trainer and to complete visual and welfare checks at the start of every shift and handover. All staff wore full PPE, comprising an apron, a mask and gloves. Mr Trainer was reviewed by a GP 15 times during his short stay at Liverpool.
33. We do not know how or when Mr Trainer contracted the infection. A test taken at Altcourse, 5 days before his transfer and 12 days before he became symptomatic, was negative. The incubation period from exposure to the onset of symptoms is thought to be around 14 days, so he could have been exposed at either Altcourse; during his attendance at court; or after his transfer to Liverpool.
34. The investigation found that Liverpool complied with the national cohorting and compartmentalising policy by creating local plans covering all areas of the regime. Prison managers assigned dedicated reverse cohorting and shielding units; implemented social distancing; and staff used PPE, in line with national requirements. We are satisfied that staff took all the appropriate steps to help protect Mr Trainer from infection, were responsive to signs of deterioration in his health and offered a high standard of care when he became ill.

Sue McAllister CB
Prisons and Probation Ombudsman

July 2021

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