

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Wilkinson, a prisoner at HMP Liverpool, on 21 January 2021

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 Raymond Wilkinson died in hospital on 21 January 2021 of multi-organ failure while a prisoner at HMP Liverpool. Mr Wilkinson was 50 years old. I offer my condolences to Mr Wilkinson's family and friends.
4. The clinical reviewer concluded that the clinical care Mr Wilkinson received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community. She made two recommendations about the location of care plans in the clinical record, and delays in completing social care assessments.
5. We found no non-clinical issues of concern. We make no recommendations.
6. This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Recommendations

- **The Head of Healthcare should ensure healthcare staff record care plans in the appropriate parts of the clinical record, following the identification of a health need.**
- **The Head of Healthcare should liaise with Liverpool Adult Social Care services to identify the cause of the delay by their service in completing the required social care assessments. This will help ensure that future social care assessments and interventions are implemented in a timely manner.**

The Investigation Process

7. NHS England commissioned an independent clinical reviewer to review Mr Wilkinson's clinical care at HMP Liverpool.
8. The PPO investigator investigated non-clinical issues, including Mr Wilkinson's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
9. The PPO family liaison officer wrote to Mr Wilkinson's next of kin, his brother, to explain the investigation. He did not respond to our letter.
10. The initial report was shared with the Prison Service. The Prison Service pointed out one factual inaccuracy, relating to the creation and storing of a care plan. This report has been amended accordingly.

Previous deaths at HMP Liverpool

11. Mr Wilkinson was the tenth prisoner to die at Liverpool since January 2019. Of the nine previous deaths, seven were from natural causes, one was a self-inflicted death, and one was drug related. There are no similarities between our findings in the investigation into Mr Wilkinson's death and findings for the previous deaths.

Key Events

12. In 2005, Mr Raymond Wilkinson was sentenced to four years imprisonment for robbery. In 2006, he received an Imprisonment for Public Protection (IPP) sentence with a tariff (minimum period to serve) of two years for arson committed in prison. The IPP sentence meant that he would only be released with the approval of the Parole Board.
13. On 8 March 2017, Mr Wilkinson transferred to HMP Liverpool. On 16 May 2018, he was sentenced to three years imprisonment for arson, committed in prison.
14. Before entering prison, Mr Wilkinson had suffered a head injury and a stroke. Throughout his time at HMP Liverpool, Mr Wilkinson had numerous appointments with healthcare staff. He did not always follow health advice given to him and repeatedly declined hospital admissions. In October 2019, Mr Wilkinson had a heart attack in prison but declined medical treatment.
15. In December 2019 and February 2020, he was referred to the local authority social services for an assessment as he was struggling to complete day-to-day tasks and care for himself.
16. In February 2020, Mr Wilkinson was twice admitted to hospital, initially for five days with pneumonia, and then for another week with sepsis.
17. In March, restrictions began to be imposed in response to the COVID-19 pandemic. On 26 March, Mr Wilkinson was given a letter advising him to shield in response to the COVID-19 pandemic. The prison offered him an alternative regime which included 12 weeks of shielding. On 9 April, he moved into the prison's shielding unit.
18. In July, Mr Wilkinson was diagnosed with Type 2 diabetes and a long-term condition review was completed.
19. In September, the prison received the assessment by social services after numerous requests, and a care plan was implemented.
20. On 23 November, healthcare staff noted that Mr Wilkinson's heart rate was slow, but he refused to have an electrocardiogram (ECG is a test that can be used to check the heart's rhythm and electrical activity). The following day he was admitted to hospital with pneumonia. On 27 November, he returned to the prison and was placed in isolation in line with the Prison Service's COVID-19 management policy.
21. On 10 January 2021, a nurse saw Mr Wilkinson due to concerns about his failing health. He diagnosed a lower chest infection and told Mr Wilkinson that he needed to go to hospital. Mr Wilkinson refused, and the healthcare staff therefore monitored him regularly.
22. On the morning of 11 January, the same nurse saw Mr Wilkinson again after he had a fall. The nurse completed a National Early Warning Score assessment (NEWS-2, a tool to measure clinical deterioration). Mr Wilkinson's NEWS-2 score was 12, indicating he needed urgent hospital care. At 8.10am, the nurse

called the prison Control Room who immediately called 999 for an emergency ambulance.

23. The ambulance arrived at the prison at 8.27am and Mr Wilkinson was taken to hospital, where he was admitted to the Critical Care Unit. He was treated for aspiration pneumonia (a chest infection caused by inhaling food, saliva or liquid) and was put on a ventilator to help him breathe.
24. On 20 January, Mr Wilkinson vomited faecal matter. A CT scan found an obstruction in his bowel. He had urgent surgery to untwist his bowel but that evening his condition deteriorated.
25. On 21 January, doctors assessed that Mr Wilkinson was not going to survive and treatment was withdrawn. He died at around 1.08pm.

Contact with Mr Wilkinson's family

26. When Mr Wilkinson was taken to hospital on 11 January, the prison appointed a Family Liaison Officer (FLO), who rang Mr Wilkinson's only listed next of kin, his mother. Calls to the number went unanswered. On 12 January, the FLO contacted HMP Birmingham, where Mr Wilkinson had previously been in custody, and asked staff there to try to contact Mr Wilkinson's family, who lived in the city. On 16 January, Mr Wilkinson's brother rang the FLO and they discussed Mr Wilkinson's condition.
27. At 3.20am on 21 January, the FLO rang Mr Wilkinson's brother to tell him that Mr Wilkinson had deteriorated. His brother travelled to the hospital and saw Mr Wilkinson.

Cause of death

28. The Coroner held an inquest on 1 February 2021 and concluded that Mr Wilkinson died of multi-organ failure caused by both small bowel volvulus (a twisted bowel causing an obstruction) and band adhesion (bands of scar tissue). He also had aspiration pneumonia which did not cause but contributed to his death.

Sue McAllister, CB
Prisons and Probation Ombudsman

November 2021

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