

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Harrington, a prisoner at HMP Liverpool, on 13 April 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 John Harrington, who was 75 years old, died of aspiration pneumonia, Parkinson's disease and a pseudo obstruction (a blockage in the intestine or bowel which is caused by the nerves or muscles) on 13 April 2021, while a prisoner at HMP Liverpool. We offer our condolences to Mr Harrington's family and friends.
4. The clinical reviewer concluded that the care Mr Harrington received at HMP Liverpool was equivalent to that which he could have expected to receive in the community. She makes no recommendations.
5. We did not find any non-clinical issues of concern.

Investigation Process

6. NHS England commissioned an independent clinical reviewer to review Mr Harrington's clinical care at HMP Liverpool.
7. The PPO investigator has investigated non-clinical issues, including Mr Harrington's location, the security arrangements for his hospital escorts, liaison with his family and whether compassionate release was considered.
8. One of the PPO's family liaison officers wrote to Mr Harrington's next of kin, his sister, to explain the investigation. She did not respond to our letter.
9. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Previous deaths at Liverpool

10. Mr Harrington was the eleventh prisoner to die at Liverpool since April 2019. Of the previous deaths, seven were from natural causes and three were self-inflicted.
11. There are no similarities between our findings in the investigation of Mr Harrington's death and the previous deaths.

Key Events

12. On 11 January 2021, Mr John Harrington was sentenced to eight months in prison, after he breached a sexual risk order by indecently exposing himself on three separate occasions. He was sent to HMP Liverpool.
13. A nurse, part of the mental health inreach team (MHIRT) at the prison, carried out an initial health screen. She noted Mr Harrington was an elderly prisoner, who required a wheelchair to mobilise. She also noted he arrived into prison having been previously diagnosed with Parkinson's disease, Alzheimer's dementia, and hypertension.
14. Following the nurse's review, comprehensive care plans were put in place to manage Mr Harrington's pre-existing medical conditions and he was moved to the prison's inpatient unit for observation. Due to his increased risk of injuring himself from a fall, he was subject to an open-door policy. Healthcare assistants assisted him with daily tasks, and he received a high level of daily input from both healthcare and MHIRT staff.
15. Mr Harrington was reviewed by a prison GP later the same day. The GP noted Mr Harrington's pre-existing medical conditions. He noted Mr Harrington's chest was clear and without pain, he had no shortness of breath and was alert and engaged well. Following his review, Mr Harrington underwent a six item cognitive impairment test, he scored 15 (a brief test used in primary care settings to assess a patient's level of cognitive impairment, scored from zero to 28, the higher the score the more significant the impairment). The GP referred Mr Harrington to the specialist memory clinic at the prison for further review.
16. On 30 January, Mr Harrington was reviewed by a nurse after reporting a pain down the left side of his body, and an increased heart rate. The nurse noted Mr Harrington's body was hot to the touch and in an uncontrollable spasm, a symptom of his Parkinson's disease. She attempted to take a note of his observations but was unable to gain an accurate result. She considered he required a review by hospital staff and Mr Harrington was taken to Aintree University Hospital, Liverpool, by emergency ambulance. Following their review, hospital staff carried out a computerised tomography scan (CT, a series of X-rays taken from different angles simultaneously) which revealed nothing of note.
17. Following their review, hospital staff diagnosed Mr Harrington as suffering from dyskinesia (the spasms associated with Parkinson's) and prescribed him procyclidine in an attempt to lessen the severity of the spasms. He was discharged back to the prison in the early hours of the following day.
18. On 2 February, Mr Harrington became aggressive towards a female healthcare assistant. Prison officers intervened and secured Mr Harrington in his cell in the healthcare inpatient unit. Healthcare staff attempted to review him on several occasions throughout the day. However, each time they did, he became aggressive. It was not until the following day that he began to engage with healthcare staff.

19. Mr Harrington was aggressive towards staff on several occasions, often necessitating his open-door policy be suspended. However, on every occasion, the policy was reinstated later the same day.
20. On 10 February, Mr Harrington was reviewed by a visiting psychologist. However, he was unable to carry out a full assessment of his condition as Mr Harrington did not fully engage with him. He planned to review him further after consultation with the prison's mental health team.
21. On 21 February, Mr Harrington sustained a fall in his cell while standing up from his wheelchair and misjudging its position. While he did not sustain any injuries, his falls risk assessment was reviewed and updated.
22. On 10 March, when a suitable cell became available, Mr Harrington was moved to a smaller cell within the healthcare inpatient unit, to lessen the risk of him sustaining any further falls.
23. The following day, Mr Harrington was reviewed by a visiting psychiatrist. He considered that Mr Harrington understood some of what he was being asked but was unable to vocalise his responses. He noted that while Mr Harrington was calm and softly spoken, he was prone to becoming aggressive without reason. He also noted that Mr Harrington appeared to be suffering from visual hallucinations.
24. Following his review, he discussed his concerns with healthcare staff who confirmed they were enquiring into the possibility of a transfer to an elderly mental health unit or a nursing home.
25. On 29 March, Mr Harrington was reviewed by a visiting consultant old age psychiatrist and part of the memory clinic at the prison. Following his review, he prescribed Mr Harrington Trazadone 25mg (used to balance the chemicals in the brain) and referred him for a CT scan of his head.
26. Mr Harrington's condition continued to deteriorate steadily. He was the subject of regular inpatient multi-disciplinary meetings attended by the departments involved in his care. He also continued to receive a high level of input and support daily from healthcare staff, prison GP's and MHIRT staff.
27. On 9 April, Mr Harrington was reviewed by a nurse. The nurse noted Mr Harrington's abdomen was swollen and that he had vomited, the vomit had the consistency of coffee grounds (possible indicator of internal bleeding). The nurse considered he would benefit from a review by hospital staff, and Mr Harrington was taken to Fazakerley Hospital, Liverpool, by emergency ambulance. He was accompanied by two prison officers and was unrestrained.
28. Following a review, hospital staff diagnosed him as having an obstruction in his bowel. They also noted Mr Harrington had developed a raised potassium level (often associated with a weakening of the muscles within the heart). A CT scan was carried out and he was admitted as an inpatient for further observation.
29. On 12 April, hospital staff told the staff accompanying Mr Harrington that palliative care was the only treatment option open to him, and that he was not expected to survive the night.

30. His condition continued to deteriorate. At 3.47am on 13 April 2021, Mr Harrington died.
31. The Coroner accepted Mr Harrington's cause of death as given by hospital doctors which they concluded was due to aspiration pneumonia, Parkinson's disease and a pseudo obstruction (a blockage in the intestine or bowel which is caused by the nerves or muscles).

Lisa Burrell
Assistant Ombudsman

December 2021

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