

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr James Knowles, a prisoner at HMP Liverpool, on 18 September 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 James Knowles died in the healthcare unit at HMP Liverpool on 18 September 2021, of heart failure. Mr Knowles was 78 years old. I offer my condolences to Mr Knowles' family and friends.
4. The clinical reviewer concluded that the clinical care Mr Knowles received at HMP Liverpool was of a high standard and equivalent to that which he could have expected to receive in the community. She noted good practice in clinical assessment, risk management and care planning. She made no recommendations.
5. We are concerned that once the prison correctly decided to appoint a family liaison officer (FLO) in July 2021, there was no FLO contact with Mr Knowles' family before his death. Although the prison did notify the family of his death in a timely fashion, there was then no further FLO support for nine days after his death. The FLO support was not in line with policy and did not fulfil the prison's duty of care to Mr Knowles and his family.
6. The prison could not locate the person escort record (PER) and the accompanying risk assessment for Mr Knowles' hospital escort on 30 August.

## Recommendations

- **The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously or terminally ill, in line with Prison Rule 22 and PSI 64/2011.**
- **The Governor should ensure that:**
  - **when a FLO is appointed, they fulfil the duties required in line with PSI 64/2011, and;**
  - **the prison has sufficient oversight of FLOs to enable timely reallocation of the role, to ensure that families are informed and supported, prior to and after a prisoner's death.**
- **The Governor should ensure that PERs and their accompanying risk assessments are retained and stored securely in line with retention policies and General Data Protection Regulation (GDPR) requirements.**

## The Investigation Process

7. NHS England and NHS Improvement (NHSE&I) commissioned an independent clinical reviewer to review Mr Knowles' clinical care at HMP Liverpool.
8. The PPO investigator has investigated the non-clinical issues, including Mr Knowles' 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 Knowles' next of kin, his ex-wife, to explain the investigation. She asked for a copy of this report, which we have sent to her.
10. Mr Knowles' family received a copy of the initial report. They raised one question that does not impact on the factual accuracy of this report and has been addressed through separate correspondence.
11. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.
12. The PPO found one factual inaccuracy, and this has been amended.

## Previous deaths at HMP Liverpool

13. Mr Knowles was the 11<sup>th</sup> prisoner to die at HMP Liverpool since September 2019. Of the previous deaths, six were from natural causes, three were self-inflicted and one was drug related. There are no similarities between our findings in the investigation into Mr Knowles' death and our investigation findings for the previous deaths.

## Key Events

14. On 26 July 2021, Mr James Knowles was sentenced at Liverpool Crown Court to an Extended Determinate Sentence (EDS) of 26 years for sexual offences. He was sent to HMP Liverpool.
15. Mr Knowles had many serious pre-existing medical conditions, including chronic kidney disease, ischaemic heart disease, heart failure, bronchiectasis (damage to the airways of the lungs), depressive disorder, a pulmonary oedema (where fluid leaks into the lining of the lungs) and colitis (inflammation of the colon and rectum). He had had several operations including a coronary artery bypass (in 1991), a coronary artery stent insertion (in 2004) and the insertion of a cardiac pacemaker.
16. Mr Knowles received a range of medication for his physical and mental health. He was under the care of doctors at two Liverpool hospitals. Mr Knowles had an active Do Not Attempt Cardio-Pulmonary Resuscitation (DNACPR) order in place, meaning that, in the event his heart or breathing stopped, he would not be resuscitated, which he had agreed with community doctors.
17. Healthcare staff saw Mr Knowles on reception at Liverpool, and he was located on the prison's healthcare unit as he needed oxygen therapy. Mr Knowles was highly dependent on healthcare staff who provided a high standard of physical and social care. Care plans for his health conditions and his social needs were created and followed throughout his time in prison. Healthcare staff monitored his health daily.
18. On 27 July, healthcare staff assessed Mr Knowles as being clinically extremely vulnerable to COVID-19. As he was located on the prison healthcare unit, he was effectively isolated from the rest of the prison population.
19. On 28 July, a prison GP saw Mr Knowles. They discussed his DNACPR order, and Mr Knowles confirmed that he still wanted the order to be in place.
20. On 30 July, a multi-disciplinary team (MDT) meeting was held with representatives from the prison, healthcare and social care. The minutes recorded that a named family liaison officer (FLO) was appointed. The FLO was appointed due to the severity of Mr Knowles' health conditions and his palliative care.
21. On 3 August, a nurse saw Mr Knowles after he complained of abdominal pain and impacted bowels. An emergency ambulance was called. When the ambulance arrived, the paramedic crew assessed that Mr Knowles could be treated in the prison's healthcare unit. The ambulance then left the prison. When a prison GP was informed of this, he called Aintree University Hospital (AUH). AUH advised that Mr Knowles needed to be admitted to hospital, and the prison called for another ambulance.
22. Mr Knowles was taken to hospital. He was escorted by two prison officers and he was not restrained. At hospital, Mr Knowles was treated for inflammation of the bowel.
23. On 12 August, Mr Knowles was discharged from hospital and went back to HMP Liverpool. He was located on the healthcare unit and subject to COVID-19 'reverse-cohorting' (a process of separating newly received or returning prisoners

from the main population), in line with HMPPS and Public Health England (PHE) policy.

24. On the afternoon of 17 August, a prison GP saw Mr Knowles. The GP carried out a clinical assessment and diagnosed Mr Knowles with potential dehydration or the return of an infection. He asked for blood tests to be taken and regular clinical observations for Mr Knowles. Nursing staff carried out observations throughout the night.
25. Around 6.30am on 18 August, a nurse saw Mr Knowles after he complained of pain in his lower back. He had a NEWS-2 (NEWS-2 is a tool to measure clinical deterioration in adult patients) score of six, which indicated he needed hourly observation and referral to a doctor. At around 1.45pm, a prison GP saw Mr Knowles. He diagnosed Mr Knowles with acute renal failure and an emergency ambulance was called.
26. There was a delay in the ambulance arriving at the prison, and healthcare staff continued to monitor him. At around 8.30pm, Mr Knowles was taken by ambulance to Liverpool University Hospital (LUH). On 19 August, Mr Knowles was discharged from LUH with a plan to manage his heart failure and renal impairment. He was subject to COVID-19 'reverse-cohorting' processes.
27. On 30 August, at around 4.30pm, a nurse saw Mr Knowles. Mr Knowles was struggling to breathe, and he had a NEWS-2 score of six. A prison GP saw Mr Knowles shortly after, and decided that Mr Knowles needed to go to hospital. At around 6.00pm, Mr Knowles was taken by ambulance to LUH. He was escorted by two prison officers and he was not restrained
28. While in hospital, Mr Knowles was assessed as reaching the end of life, with a prognosis of days to weeks. Hospital, prison healthcare and community palliative care staff worked together to devise and deliver appropriate end of life care. Mr Knowles was 'fast-tracked' for end of life care at HMP Liverpool.
29. On 8 September, Mr Knowles was discharged from hospital back to HMP Liverpool. He was again subject to COVID-19 'reverse-cohorting' processes. Healthcare staff followed Mr Knowles' palliative care plan and they provided a high standard of care to him, including pain relief and pain management medication.
30. On 9 September, the prison started an application for Mr Knowles' early release on compassionate grounds (ERCG). Mr Knowles died before the application could be completed.
31. At around 1.35am on 18 September, a nurse saw that Mr Knowles appeared restless. Mr Knowles refused pain medication. A Healthcare Assistant (HCA) sat with him. At around 3.00am, Mr Knowles began to gasp for breath, and a nurse and a HCA stayed with him until he died. An ambulance was then called, and paramedics attended. At 4.23am, they confirmed that Mr Knowles had died.
32. At 9.00am, the duty governor rang Mr Knowles' next of kin, his ex-wife, to inform her of Mr Knowles' death and to pass on the prisons' condolences. That day, the prison assigned a FLO to contact the family to provide advice and support, including

the funeral arrangements. No further contact was made with the family for around nine days.

33. On 27 September, the prison transferred the FLO duties to a prison manager. He contacted the family, and over the following days provided support and information. In line with policy, the prison contributed to the cost of the funeral.

### **Inquest**

34. The Coroner held an inquest on 6 October 2021 and concluded that Mr Knowles died of end stage heart failure, caused by ischaemic heart disease (heart problems caused by narrowed heart arteries).

## Non-Clinical Findings

### Liaison with Mr Knowles' family

35. Prison Rule 22 says that prisons should inform the next of kin immediately if a prisoner becomes seriously ill. Prison Service Instruction (PSI) 64/2011, about safer custody, says that if a prisoner suffers an unpredicted or rapid deterioration in their physical health, an appropriate member of prison staff should engage with their next of kin to provide information and support.
36. Chapter 11 of PSI 64/2011 covers the support and management of terminally or seriously ill prisoners. It says that prisoners who are terminally ill must be encouraged to engage with their families and prisons must have procedures in place for supporting the prisoner and engaging with their next of kin.
37. Chapters 12 and 13 of PSI 64/2011, covers family liaison following a death in custody. It says that after a death in custody, a FLO must be appointed to liaise with the family and a FLO log of all contacts should be opened.
38. Following a multi-disciplinary meeting between prison and prison healthcare staff on 30 July, a family liaison officer (FLO) was appointed. However, the first FLO told us that he did not start the FLO log. There is no record that the FLO spoke to Mr Knowles about his wishes or that the FLO contacted the family before Mr Knowles died on 18 September.
39. We were told that a second FLO had been appointed to liaise with Mr Knowles' family, although there is no information as to when this occurred. There is no evidence that the FLO contacted the family. When we contacted the second FLO, they said they had not been a FLO for Mr Knowles.
40. On 27 September, a third FLO was appointed. He contacted the family and helped arrange the return of Mr Knowles' property and support the funeral arrangements. The only FLO Log the prison could find was that opened by the third FLO.
41. Prison managers at HMP Liverpool were confused about when or if the first and second FLO was appointed. We were told that both the first and second FLO had to step back from their duties. However, we are concerned that the coordination and reallocation of the FLO role was not done in a timely way. We were also told by two members of staff, that they had to apologise to the family and try to build bridges with them.
42. We consider that the prison's duty of care to Mr Knowles and his family was not met and was not in line with policy. We have seen no evidence that any contact was made with Mr Knowles' family prior to his death, and there was no contact with Mr Knowles' family for nine days after his death. We make the following recommendation:

**The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously or terminally ill, in line with Prison Rule 22 and PSI 64/2011.**

**The Governor should ensure that:**

- when a FLO is appointed, they fulfil the duties required in line with PSI 64/2011, and;
- the prison has sufficient oversight of FLOs to enable timely reallocation of the role, to ensure that families are informed and supported, prior to and after a prisoner's death.

**Retention and storage of key documentation**

43. In line with all PPO investigations, we asked for all relevant escort records. We did not receive the person escort record (PER) or its accompanying risk assessment for the hospital escort of 30 August 2021. When we asked for a copy, the prison said that they could not locate either document.
44. We note that on previous hospital escorts, Mr Knowles was escorted and appropriately unrestrained. We were told by escorting officers for the hospital escort of 30 August, that Mr Knowles again went to hospital unrestrained. However, we consider that the prison should review their processes for the retention and storage of key documents, including escort records. We recommend:

**The Governor should ensure that PERs and their accompanying risk assessments are retained and stored securely in line with retention policies and General Data Protection Regulation (GDPR) requirements.**

**Lisa Burrell  
Assistant Ombudsman**

**July 2022**

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