Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Guy, a prisoner at HMP Liverpool, on 6 April 2022

A report by the Prisons and Probation Ombudsman

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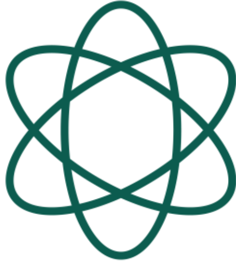
Our vision

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

OGL

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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 John Guy died in hospital of pneumonia on 6 April 2022, while a prisoner at HMP Liverpool. He was 64 years old. I offer my condolences to Mr Guy's family and friends.

The clinical reviewer found that the care Mr Guy received at Liverpool was equivalent to that which he could have expected to receive in the community.

I make no recommendations.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman **April 2023**

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Summary

Events

1. On 14 March 2022, Mr John Guy was remanded to prison for breaching a restraining order. He was sent to HMP Liverpool.

2. At his reception health screen, Mr Guy appeared to be under the influence of alcohol. No beds were available in the prison's Inpatient Unit (IPU), so the doctor requested overnight observations to check for withdrawal symptoms. A nurse checked on him three times during the night and there were no issues.

3. On 15 March, Mr Guy was moved to the IPU due to his continued disorientation, history of alcohol abuse, difficulty swallowing and diagnosis of bipolar disorder.

4. Mr Guy displayed challenging behaviour in the IPU, including verbal abuse, banging on his cell door and defecating in his cell. On 22 March, staff held a multidisciplinary team (MDT) meeting about how best to meet Mr Guy's needs. His sister had told them that Mr Guy had started drinking heavily, had a mass on his lung that he would not get assessed, and he thought he was dying. The MDT agreed several actions including a chest X-ray and social care assessment.

5. On the nights of 25, 26 and 27 March, Mr Guy was agitated and vomiting after eating. He refused to have his clinical observations taken.

6. On 30 March, Mr Guy told a nurse that he felt dizzy. The nurse asked a healthcare assistant to take Mr Guy's observations, but Mr Guy refused.

7. On the afternoon of 31 March, Mr Guy told officers that he had chest pain. Healthcare staff reviewed Mr Guy and arranged for him to go to hospital. In the early hours of 1 April, Mr Guy was discharged from hospital with no diagnosis as he had been abusive to hospital staff.

8. Prison healthcare staff were concerned about Mr Guy's discharge from hospital as they thought he might not have mental capacity. On 1 April, prison staff held an urgent MDT meeting to discuss Mr Guy's best interests. They concluded that Mr Guy did not have mental capacity and they sent him back to hospital. He was admitted and died in hospital five days later.

9. The post-mortem report concluded that Mr Guy died from klebsiella pneumoniae aspiration pneumonia (a bacterial lung infection).

Findings

10. The clinical reviewer found that the care Mr Guy received at Liverpool was equivalent to that which he could have expected to receive in the community.

11. The clinical reviewer was satisfied that Mr Guy had regular, timely and responsive reviews by members of the multidisciplinary team. She also found that while Mr Guy's behaviour could be challenging at times, he was managed holistically by competent, confident staff. She considered that the MDT meeting to discuss Mr

Guy’s best interests was held appropriately and that the decision to send Mr Guy back to hospital was the best one for him.

12. We make no recommendations.

The Investigation Process

13. 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.

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

15. NHS England commissioned an independent clinical reviewer to review Mr Guy's clinical care at the prison.

16. We informed HM Coroner for Liverpool of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Guy's wife and sisters to explain the investigation and to ask if they had any matters they wanted us to consider. They raised several issues which were outside the remit of this investigation, which we have addressed in separate correspondence.

18. We shared our initial report with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies.

19. We sent a copy of our initial report to Mr Guy's family. They did not notify us of any factual inaccuracies.

Background Information

HMP Liverpool

20. HMP Liverpool is a category B local prison holding up to 750 adult men. Spectrum Healthcare UK Trust provides physical healthcare services and Merseycare NHS Trust provides mental healthcare services.

21. There is a 26-bed inpatient wing to accommodate prisoners requiring extensive personal care packages with a wide range of clinicians to provide support.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Liverpool was in August and September 2019. Inspectors found that the 24-hour nursing team was stable, although not fully staffed, and had been supplemented by two social carers. Clinicians and officers knew their patients and offered a high quality of shared care while maintaining professional boundaries. Care plans and clinical records were clear and informed the support delivered.

Independent Monitoring Board

23. 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 31 December 2021, the IMB reported that healthcare services were maintained to an appropriate level. They found that nurses were responsive in dealing promptly with prisoner concerns and explaining their current medication to prisoners.

Previous deaths at HMP Liverpool

24. Mr Guy was the twelfth prisoner at Liverpool to die since April 2020. Of the previous deaths, one was self-inflicted, two were drug-related and the rest were from natural causes.

Key Events

25. On 14 March 2022, Mr John Guy was remanded in prison custody for breaching a restraining order. He was sent to HMP Liverpool.

26. When Mr Guy arrived at Liverpool, staff thought he was under the influence of alcohol. Mr Guy told the prison GP that he had been drinking earlier. The GP prescribed him a medication used to treat anxiety and alcohol withdrawal. Mr Guy told the GP that he had bipolar disorder and had recently been in hospital. No beds were available in the prison's inpatient unit (IPU), so the GP requested observations to be done overnight on Mr Guy to check for alcohol withdrawal symptoms.

27. A nurse reviewed Mr Guy at 11.30pm on 14 March, and at 2.45am and 5.15am on 15 March. There were no issues.

28. On 15 March, Mr Guy was moved to the IPU due to his continued disorientation, history of alcohol abuse, difficulty swallowing and diagnosis of bipolar disorder.

29. After discussion with a hospital doctor, a prison GP decided that Mr Guy needed to go to A&E. He was taken by ambulance in the early hours of 16 March. Mr Guy returned to Liverpool later that morning. He had been abusive to hospital staff, escort staff and other patients.

30. Mr Guy's behaviour was challenging in the IPU and included verbal abuse, being disruptive and noisy, and defecating in his cell. On 22 March, staff held a multidisciplinary team (MDT) meeting to discuss Mr Guy. Mr Guy's sister had told them that Mr Guy had a mass on his lungs and had declined to have it assessed further, had issues with his throat, and thought he was dying. The MDT agreed several actions including a chest X-ray and social care assessment.

31. On 24 March, a prison healthcare administrator chased up hospital referrals made by Mr Guy's community doctors for an endoscopy (when a long, thin tube with a small camera inside is inserted in your mouth to see inside your body) and a CT scan. The hospital did not have appointment dates for either.

32. On the nights of 25, 26 and 27 March, Mr Guy was agitated and was vomiting after eating. Mr Guy refused to have his clinical observations taken.

33. On 28 March, a second MDT meeting took place, where the attendees agreed to refer Mr Guy to the speech and language service because of his continued difficulty swallowing.

34. On 30 March, Mr Guy told a nurse that he felt dizzy. The nurse asked a healthcare assistant to take Mr Guy's observations, but Mr Guy refused.

35. On the afternoon of 31 March, staff asked for a nurse to see Mr Guy as he had chest pain. The nurse reviewed Mr Guy and then escalated this to the clinical lead.

36. A short time later, the clinical lead reviewed Mr Guy and took his observations and some blood samples. He conducted an electrocardiogram (ECG - a test to check the heart's rhythm and electrical activity) which showed abnormalities, so he called for an ambulance. Paramedics took Mr Guy to hospital. Hospital doctors took blood

samples and performed another ECG. Mr Guy returned to Liverpool at 1.00am on 1 April without the results of his blood test or ECG. He had been discharged due to being abusive to staff.

37. On 1 April, healthcare staff held an urgent MDT meeting to discuss Mr Guy's best interests as they were concerned that he had been discharged from hospital when he did not have mental capacity. A member of healthcare staff performed a mental capacity assessment on Mr Guy and found he did not have capacity. The MDT concluded that it was in Mr Guy's best interests to be sent back to hospital. They called an ambulance and Mr Guy was taken to hospital later that day.

38. Mr Guy's condition deteriorated over the next few days, and he died in hospital on 6 April.

Contact with Mr Guy's family

39. Mr Guy did not provide next of kin details when he arrived at Liverpool. However, his sister contacted the prison to ask about his welfare and was put in touch with the healthcare unit.

40. Healthcare staff at Liverpool contacted Mr Guy's family on 1 and 4 April to update them about his condition.

41. On 6 April, after Mr Guy's death, the prison appointed a family liaison officer. Initially, he tried to obtain next of kin details for Mr Guy from the police, but then healthcare staff provided him with contact details for Mr Guy's sister.

42. The family liaison officer contacted Mr Guy's sister by telephone and informed her of his death and offered his condolences. Mr Guy's sister said she would contact Mr Guy's estranged wife.

43. On 11 April, the family liaison officer and Deputy Governor visited Mr Guy's family and his wife.

Support for prisoners and staff

44. The prison posted notices informing other prisoners of Mr Guy's death and offering support. Staff reviewed all the prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Guy's death.

Post-mortem report

45. The post-mortem report concluded that Mr Guy died of klebsiella pneumoniae (a type of bacteria) aspiration pneumonia (a lung infection caused when food or liquid is breathed into the lungs). It also listed erosive oesophagitis (inflammation of the lining of oesophagus), pulmonary emphysema (a lung condition that causes breathing difficulties) and poor oral intake as contributory factors.

Findings

46. The clinical reviewer concluded that the care Mr Guy received at HMP Liverpool was equivalent to that which he could have expected to receive in the community.

47. The clinical reviewer found clear evidence of multidisciplinary working and was satisfied that Mr Guy had regular, timely and responsive reviews by members of the multidisciplinary team. She was impressed with the range of meetings undertaken by staff at Liverpool which ensured plans were put in place to appropriately manage Mr Guy.

48. She noted that while Mr Guy's behaviour was challenging at times, he was managed holistically (patient-centred care) and was cared for by confident, competent staff during his short time at Liverpool.

49. The clinical reviewer was satisfied that the best interests meeting was held appropriately and responsively, and that the decision to send Mr Guy back to hospital on 1 April was the best one for him.

50. We make no recommendations.

Inquest conclusion

51. The inquest, heard on 21 March 2023, concluded that Mr Guy died from natural causes.

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