Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Keith Harrison, a prisoner at HMP Liverpool, on 27 December 2022

A report by the Prisons and Probation Ombudsman

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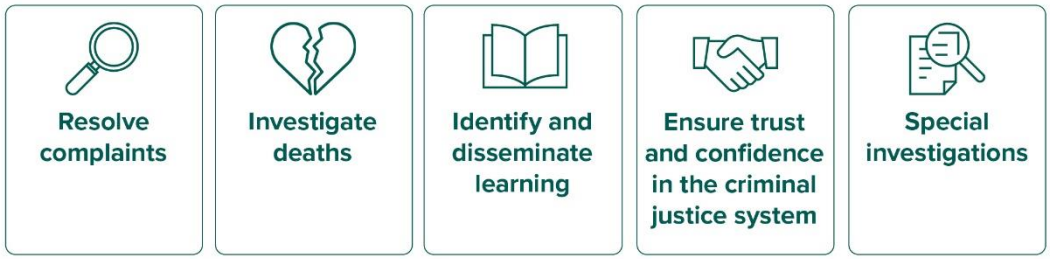
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Keith Harrison died of a ruptured abdominal aortic aneurysm (swelling in the aorta, the main artery in the body, that burst) on 27 December 2022 at HMP Liverpool. He was 81 years old. We offer our condolences to Mr Harrison's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Harrison received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community. She made several recommendations that were not related to Mr Harrison's death which the Head of Healthcare will wish to address.

5. We found no non-clinical issues of concern. We make no recommendations.

The Investigation Process

6. HMPPS notified us of Mr Harrison's death on 27 December 2022.

7. NHS England commissioned an independent clinical reviewer to review Mr Harrison's clinical care at Liverpool.

8. The PPO investigator investigated the non-clinical issues relating to Mr Harrison's care.

9. The PPO family liaison officer wrote to Mr Harrison's next of kin, his wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She had no questions but asked for a copy of our report.

10. We shared our initial report with HMPPS. They found no factual inaccuracies.

11. We sent a copy of our initial report to Mr Harrison's wife. She did not notify us of any factual inaccuracies.

Previous deaths at HMP Liverpool

12. Mr Harrison was the fourteenth prisoner to die at Liverpool since December 2019. Of the previous deaths, nine were from natural causes, two were drug related, one was self-inflicted, and one was from unknown causes.

Key Events

13. On 27 July 2020, Mr Keith Harrison was sentenced to six years imprisonment for sexual offences. He was taken to HMP Liverpool.

14. Mr Harrison had an abdominal aortic aneurysm (a swelling in the artery that carries blood from the heart to the abdomen) and had undergone surgery to try to repair the artery. He regularly saw doctors who monitored the size of the aneurysm to check if it was at risk of rupturing.

15. On 31 August 2022, a GP saw Mr Harrison as he had collapsed in his cell. He was complaining of pain in his left arm. The GP listened to Mr Harrison's heart and did an electrocardiogram (ECG - a test to check the heart's rhythm) which showed a normal result. She carried out some blood tests, which were abnormal, and called an ambulance. Mr Harrison was taken to hospital for further assessment.

16. On 3 September, the hospital doctors had a multidisciplinary team meeting as they found that Mr Harrison's aneurysm had grown. They agreed not to repair Mr Harrison's artery, even if it ruptured, due to a poor prognosis. Mr Harrison was discharged from hospital the same day.

17. On 27 December, at approximately 3.05pm, Mr Harrison pressed his cell bell. Two healthcare support workers attended his cell and found he had vomited on his bed and was complaining of back pain. He began to have a seizure at 3.15pm and one of the support workers went to get help from a nurse. (Neither of the two healthcare support workers were available for interview and the Head of Healthcare could not confirm whether either was carrying a radio on the day. We assume, from the timeline of events, that neither was.)

18. At 3.23pm, the healthcare support worker returned with a nurse, and they called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts staff to attend and the control room to call an ambulance). The nurse took Mr Harrison's clinical observations and put him in the recovery position. Two more nurses arrived and took over Mr Harrison's care.

19. At approximately 3.35pm, the ambulance crew arrived at Mr Harrison's cell. They did an ECG and took his blood pressure. At 3.45pm, Mr Harrison's heart stopped beating. The paramedics started CPR, however this was unsuccessful. At 4.22pm, the paramedics stopped CPR and confirmed with a GP that Mr Harrison had died.

Inquest

20. At the inquest, held on 17 January 2023, the coroner recorded that Mr Harrison died of a ruptured abdominal aortic aneurysm and concluded that he died from natural causes.

Adrian Usher
Prisons and Probation Ombudsman **February 2024**

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