PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man in April 2012 at Fazekerley Hospital, while in the custody of HMP Liverpool

Report by the Prisons and Probation Ombudsman for England and Wales

September 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Liverpool. He died of lung cancer in April 2012. I offer my condolences to those affected by his death.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a review of the clinical care the man received at Liverpool. HMP Liverpool co-operated fully with the investigation.

During a hospital admission for an emergency blood transfusion in February 2012, the man was diagnosed with inoperable lung cancer. He was admitted to a hospice for a course of radiotherapy and was then discharged to the prison's healthcare centre. His condition deteriorated and he was admitted to hospital in April. He was then moved to a hospice, where he stayed until his death three days later.

The clinical review found that the man's diagnosis was not timely and aspects of his care were below the standard we would expect. In particular, the clinical reviewer considers that the man's symptoms should have been investigated but this did not happen until he was admitted to hospital with a dangerously low blood count.

The investigation also indicates that the use of restraints during some of the man's hospital admissions was not justified by his risk assessment. However, during his final admission, restraints were not used and his family had unrestricted visits. Finally, while the man's family were complimentary about their treatment by the prison, we would encourage an earlier appointment of a family liaison officer once a terminal diagnosis is made, so that the family is provided with a regular, central point of contact.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2012**

CONTENTS

SUMMARY

1. The man arrived at HMP Liverpool in November 2011 a very frail man. He had been convicted and given a three year sentence. Following his reception screen, he was admitted to the healthcare centre but he was not fully examined by a doctor. He remained on the healthcare centre for three months where his weight loss was monitored, but never investigated. He was admitted to hospital in February with a dangerously low blood count. Following further tests, he was diagnosed with possible lung cancer and transferred back to prison.

2. After an oncology review, hospital staff told the man that he had cancer. Treatment options were discussed with him at hospital, but there is no evidence that prison staff offered support to the man following the diagnosis, or that he was involved in the care planning process while in the healthcare centre.

3. The man attended all hospital appointments for consultations and treatment, and there were no issues in arranging escorts. When he was in the healthcare centre, his medications and pain relief appear to have been managed appropriately.

4. The man was in regular contact with his daughter during his time in custody and she often visited him. A family liaison officer (FLO) was not appointed by the prison when the man was diagnosed. A FLO was only appointed two days after his death.

5. After the man's diagnosis, care plans and risk assessments were implemented to ensure his care needs were met. The prison does not use an end of life care pathway[1] and there is no "do not attempt resuscitation" (DNAR)[2] policy. This is not good practice and prevents healthcare staff from appropriately documenting the prisoner's end of life care needs and specific wishes.

6. The man was restrained using an escort chain[3] during his hospital admissions for investigative tests and treatment, despite being very weak and having limited mobility. The risk assessment acknowledged the man's condition, but this was not taken into account sufficiently in the decision to apply an escort chain. During his final admission to a hospice for end of life care, he was not cuffed at any time and bedwatch staff stood at a distance to afford him some privacy.

7. We concur with the findings of the clinical review that the care the man received while at Liverpool fell below that which he could have expected and the diagnosis of cancer was not made in an appropriate manner. In addition to the recommendations made in the clinical review, we make six recommendations.

[1] A guidance for medical professionals to help provide holistic care and support to a terminally ill patient and their family.
[2] DNAR procedures are implemented when resuscitation would either not be successful, or would not improve a patients quality of life. Medical professionals can make a decision to implement DNAR, but it is good practice for the patient to be involved in the decision.
[3] A six foot long chain with a cuff at both ends. One cuff is attached to the prisoner, and the other to an officer.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 15 April 2012. An investigator from this office visited Liverpool on 19 April 2012. She met the Deputy Governor and staff who had been involved in the man's care. The investigator was shown where the man lived in the healthcare centre and the facilities that were available to him.

9. The investigator issued notices informing staff and prisoners of the investigation and asking them to contact her with any relevant information. No one responded to these notices.

10. The HM Coroner for Liverpool, was informed of the investigation. A copy of the investigation report will be sent to him to assist with his enquiries.

11. A clinical reviewer was appointed to review the clinical care the man received in custody. The clinical reviewer received copies of all relevant medical and prison documentation relating to the man.

12. The investigator reviewed all of the documentation relating to the man's time in custody. The investigator and the clinical reviewer interviewed two members of healthcare staff in May. The investigator interviewed two more members of prison staff.

13. The investigator provided written feedback to the Governor on 25 April, 22 May and 13 June. The Governor responded to the feedback on 21 June.

14. One of the Ombudsman's family liaison officers contacted the man's daughter shortly after his death. He explained the investigation process and invited her to ask any questions about his care. The man's daughter did not raise any concerns and complimented the reverend from the prison chaplaincy, and added that the bedwatch officers were sensitive in performing their duties.

15. The man's family received a copy of the draft version of the report as part of the consultation period. The man's family told the Ombudsman's family liaison officer that they were unhappy to learn of the inappropriate level of restraints used on the man. However they were pleased to see that a recommendation had been made with this in mind. They were also pleased to see that a recommendation had been made in regard to the consideration of compassionate release applications. The family were unhappy that it had taken so long to diagnose the man and agreed with the findings of the clinical review, that the standard of care fell below an acceptable standard.

16. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, liaison with his family, his location and security arrangements, whether compassionate release was considered and whether appropriate palliative care was provided.

17. The report was also issued for consultation with the Prison Service. There were no factual inaccuracies and the responses to the recommendations have been added to the recommendations page.

HMP LIVERPOOL

18. HMP Liverpool is a local prison and is one of the largest in the country. It holds remanded, unsentenced, and category B and C prisoners. It has an operational capacity of 1,359. HMP Liverpool has eight residential wings and a purpose built hospital unit, which opened in 2007.

19. North Liverpool Primary Care Trust (PCT) provides the healthcare services. The healthcare unit delivers out-patient services, as well as 24 hour in-patient care. A doctor is on duty during normal working hours and nurses and healthcare assistants work shifts to cover the 24 hour in-patient service.

HM Inspectorate of Prisons (HMIP)

20. HMIP carried out an announced inspection in 2009, which commented that:

> "Access to healthcare services and the quality of care provided was good. The resources available were very good, except in reception, with a new healthcare centre and refurbished treatment areas on wings. A large team of well qualified and enthusiastic staff was well led. Pharmacy services were adequate, but a number of issues relating to the administration and storage of medicines needed attention."

21. The Inspectorate also commented that prisoners with acute mobility issues lived in the healthcare centre, which has the only cells suitable for wheelchair access. There is no central database of prisoners with disabilities, no care plans or clear evacuation plans for prisoners who need them. In regard to older prisoners, there is no clear strategic approach to identifying and meeting their specific needs.

Previous deaths at Liverpool

22. In the last two years, there were three deaths through natural causes at Liverpool before the man died. There are no similarities between the previous investigations and this report.

ISSUES

The diagnosis of the man's terminal illness

23. The man arrived at HMP Liverpool in November 2011. During his first reception health screen[4], prison Dr A noted that he was "in poor general condition". The man was frail and used a walking stick. He gave a brief past medical history that included intermittent claudication[5], arthritis and a stroke that had affected his left side. There is no evidence that the doctor examined the man or took basic observations. This is not in accordance with Prison Service Instruction (PSI) 74/2011[6], early days in custody, which instructs that:

> *"All incoming prisoners must be medically examined by a qualified member of the healthcare team."*

The doctor no longer works for HMP Liverpool and was not available for interview.

24. The man was admitted to the healthcare centre. Although no reason was recorded for his admission, prisoners are only admitted to healthcare if there are mobility issues or they need access to 24 hour healthcare facilities.

25. The man's medical history was requested from his community general practitioner (GP). It was faxed to the prison the next day and scanned into his medical record. A summary of his medical history was not made in his ongoing clinical record. According to his GP's notes, his weight in 2009 was 86 kilograms (kg). The clinical reviewer suggests that once the medical records are received they should be summarised in the prison's electronic medical information system to ensure that all needs are identified and to allow appropriate continuation of medical care.

26. Prison doctor B reviewed the man in his cell on 7 November. The doctor told the investigator that she had asked the man how he was and he said he was fine. His cell mate told the doctor that the man was not fine and had painful feet. On examination his foot was blue, which suggested that he had poor circulation. He was admitted to hospital for further assessment. He was diagnosed with ischaemia[7] of his left leg and had an operation on both legs on 11 November, to help relieve the symptoms.

27. The doctor reviewed the man in his cell on 28 November, during her weekly ward round. The man was "very unwell" and was in severe pain with gangrenous[8], bleeding toes and was sent back to hospital for treatment.

---

[4] A full assessment of a prisoner's immediate needs and health concerns.
[5] Narrowing and hardening of the arteries that supply blood to the legs and feet, which causes decreased blood flow.
[6] Prison guidelines containing mandatory instructions, which are written in italics.
[7] An inadequate blood supply due to blockage of blood vessels.
[8] A serious and potentially life-threatening condition that arises when a considerable mass of body tissue dies.

28. On 2 December, the man attended an appointment with a dietician. He was said to have looked “thin and malnourished”. There is no evidence that the man was weighed. He was not referred for investigative tests to establish a cause for his poor condition. The doctor told the investigator she did not think it was unusual for someone of the man’s age with multiple health problems to have been underweight.

29. The doctor reviewed the man on 5 December. She recommended that his weight needed to be monitored as he appeared “fragile”. There is no evidence of a detailed examination or health screen. Later that afternoon his weight was recorded as 48.6kg. This is the first time he had been weighed since arriving at Liverpool and if his GP records had been checked, it would have been noted that he had lost nearly 40kg (nearly six stones) in two years.

30. Prison Nurse A made an entry in the man’s medical record on 9 January 2012. She said that he had a “good appetite” and was drinking high calorie supplement drinks in addition to his meals. She recorded his weight as 46.7kg and noted that he was to continue having his weight monitored. The man had lost nearly two kilograms in a month, despite reportedly having a good appetite and drinking high calorie drinks, but still staff did not refer the man for investigative tests. The prison doctor said during interview with the investigator that:

> “If things don’t marry up and they’re not gaining weight or they’re having the Ensures [high calories drinks] and they’re still not gaining weight, then we will organise blood tests and further investigations.”

31. The doctor assessed the man in his cell on 17 January. The man was described as pale, although the doctor noted he was well and had a normal appetite. The man was constantly tired and slept a lot, so the doctor referred him for a non-urgent full blood test.

32. The following week, on 23 January, the doctor reviewed the man again as part of her weekly ward rounds. The man was still described as having a good appetite and he continued to drink the supplement drinks. His weight was recorded as 47.5kg, a slight increase in the two weeks since he had last been weighed. The man had not had a blood test and was re-referred. The man eventually had a blood test on 27 January.

33. On 30 January, the man was examined by the doctor. He was experiencing pain in his legs and had lost his appetite. His weight was recorded as 46.6kg and he was said to be tired, breathless and pale. The doctor recommended that he was to have a full blood test weekly. The man’s blood test results from 27 January were entered into his on-going clinical record on this day, although they were not reviewed.

34. The doctor assessed the man two days later on 1 February. She noted that since December, he was tired and would spend most of his time in bed, unless he was encouraged to move around by staff. The results of his blood test were reviewed.

The results showed that he had a dangerously low blood count and was acutely anaemic[9]. He was admitted to hospital for an emergency blood transfusion. The clinical reviewer considers that the two day delay from the blood test results being entered in the man's clinical record to them being reviewed was unacceptable. The delay could have been life threatening.

The Head of Healthcare should ensure that blood test results are always reviewed within 24 hours.

35. On 2 February, the man had several blood transfusions at the hospital. He then waited to have a blood test and to be reviewed by a doctor before a decision could be made about discharging him.

36. The following day, 3 February, bedwatch officers telephoned the healthcare centre and spoke with Nurse B. The nurse was told that the man had had a chest x-ray, the results of which had shown a shadow on his lung. His red blood cell count was dropping, despite the blood transfusions. It was thought this could be due to cancer or an internal bleed. Further tests were needed to confirm a diagnosis.

37. On 8 February, the man was diagnosed with possible metastatic lung cancer[10]. The results of a bronchoscopy[11] and biopsies[12] that had been done in hospital were still to be reviewed. He was discharged from hospital. The diagnosis was confirmed on 27 February.

38. The clinical reviewer writes that good medical practice requires that a patient in poor general health (such as the man) should have had an in-depth medical history taken. The clinical reviewer notes that when the man arrived at Liverpool, he was frail and weak, yet he was not thoroughly examined and was not referred for investigative tests to establish if he had an underlying illness, despite staff being concerned enough about his health to admit him to healthcare. His weight loss was not managed or investigated with any urgency. There was an unacceptable delay in the blood test results being documented and reviewed, which could have been life threatening. The clinical reviewer concludes that:

> "It is very likely that the man suffered from lung cancer when he arrived at HMP Liverpool. In my opinion it is therefore a significant omission of the medical staff at HMP Liverpool to have not pursued the causes of these symptoms."

[9] A decreased level of red blood cells. The blood is unable to carry sufficient oxygen to meet the body's needs.
[10] A cancer that has spread from the part of the body where it started (the primary site) to other parts of the body.
[11] A procedure used to view the inside of the airways. A bronchoscope is a tube and can be flexible or rigid. The scope is passed through your mouth or nose, through your windpipe, and then into your lungs.
[12] A medical procedure during which a small sample of tissue is taken for examination to identify abnormal cells and to help diagnose health conditions.

39. If the man's care had been more proactively managed, an earlier diagnosis could have been made. The clinical reviewer makes the following recommendation in the clinical review, which we repeat (with minor modifications for house style):

The PCT should review, assess and manage the performance of the doctors involved in the healthcare provision for the man.

Informing the man about his condition and treatment

40. On 20 February, the man became unwell and was admitted to hospital for further assessment. During the admission he had another chest x-ray and a review by the oncology[13] team. According to the man's bedwatch log, his oncology results were discussed with him by hospital staff, during the evening of 28 February. It was confirmed that he had lung cancer, which was inoperable. He had a blockage in a vein and was to have a stent[14] fitted the following morning. He would then be taken to the local hospice for a course of radiotherapy[15].

41. The man's oncology consultant sent a fax to the prison doctor on 29 February. It said the man was frail and weak "with progressive non-definitively manageable cancer" and he had been reviewed by the hospital's palliative care team[16]. There is no evidence that this information was shared with healthcare staff and there is no summary of the fax in the man's clinical record.

42. On 11 April, the man's consultant told him that he had just days left to live, possibly weeks. The man was said to have been accepting of this and said that he was not worried about dying.

43. From reviewing the man's bedwatch logs it is apparent that he was informed appropriately of his condition and treatment by medical staff at the local hospital and hospice. The man's prison documentation does not show if he was offered support by prison staff after his diagnosis and there is no evidence that he was involved in the care planning meetings concerning his needs and how they could be met.

The Head of Healthcare should ensure that prisoners with terminal illnesses are involved in care planning and adequately supported following diagnosis.

The man's medical appointments and treatment

44. The man was diagnosed as being acutely anaemic and was admitted to hospital in February 2012. He was given many blood transfusions to help increase his red

[13] A team of specialists who deal with the diagnosis and treatment of cancer.
[14] A mesh tube that is inserted into the vein or artery. It is used to help relieve blockages.
[15] The controlled use of high energy X-rays to treat many different types of cancer.
[16] A palliative care team is a multidisciplinary service. They specialise in diagnosis, management and treatment of patients with advanced progressive illness (both cancer and non-cancer) and concentrate on quality of life issues for patients and their families, and provide expert guidance on end of life care.

blood cell count. During the admission, he underwent further investigative tests and was diagnosed with cancer.

45. The man was transferred to Woodlands Hospice and started a course of daily radiotherapy, which he completed at the end of March. The treatment and its side effects were discussed with the man by a consultant at the local hospice.

46. None of the man's hospital appointments were cancelled and there were no issues with arranging escorts. When the man was diagnosed with cancer, he was promptly treated with a course of radiotherapy and spent a lot of time in hospital and Woodlands Hospice. We agree with the clinical reviewer that the man's appointments and treatment following his diagnosis were timely and appropriate.

The man's pain relief and medication

47. The man was prescribed anti-sickness medication during his course of radiotherapy. He was also prescribed strong opiate based pain relief. There is no evidence of the man complaining of being in pain; it appears that the pain relief was adequate in managing his symptoms. The clinical reviewer concludes that the man was comfortable and pain free once he had been diagnosed.

48. The man was assessed by a palliative care nurse on 30 March. She requested that the doctor prescribe lidocaine patches[17] to use alongside his other pain relief. She said that healthcare staff were doing everything they could to keep the man comfortable and pain free.

49. The clinical reviewer concludes in the clinical review that the man was provided with appropriate pain relief and medication. The man's pain relief medication appears to have been given at the appropriate times and his prescriptions were amended according to changes in his condition.

The man's location

50. The man was admitted to the healthcare centre when he arrived at the prison, so that he could be observed and assisted with his care needs because he was in a weak condition. The man had many admissions to hospital, following which, he was discharged to the healthcare centre at HMP Liverpool.

51. After he was diagnosed with cancer, the man was transferred to a hospice for treatment and care. His prognosis was poor and it was said that he could deteriorate at any time. He stayed there for approximately four weeks while he completed a course of radiotherapy and was then discharged back to the healthcare centre. The man was accommodated in a cell that was opposite the nursing station for closer observation. An open door policy was authorised on 4 April, which enabled healthcare staff to have unrestricted access to administer medications and attend to his care needs.

[17] A form of pain relief

52. The man asked to die "anywhere he could be with his daughter". On 5 April, The man's condition was at a stage where healthcare staff were unable to meet his care needs and he was admitted to hospital. On 11 April, he was transferred Woodlands Hospice, where he remained until his death. His family visited him regularly and were with him when he passed away.

53. Healthcare staff enabled the man to stay in his cell as long as possible. When the man needed further treatment and care, he was transferred to Woodlands Hospice, which also gave his family the opportunity to have unrestricted visits. We agree with the clinical reviewer that appropriate decisions were made about the most suitable location for the man during his final days of his life. The man's location was appropriate at all times and relevant to his needs and wishes.

Liaison with the man's family

54. On 27 February, after the man's diagnosis was confirmed, the hospital consultant asked for his daughter's telephone number. For security reasons, her telephone number was risk assessed before she was contacted the following day and informed of her father's condition. A prison family liaison officer (FLO) was not appointed and there is no record of any regular contact with the man's daughter until he died. The prison FLO told the investigator that a FLO is not routinely appointed until after a prisoner has died. The man's daughter complimented the actions of the reverend from the prison chaplaincy and the bedwatch officers during the final days of her father's life. Despite the man's daughter being happy with the support she received, it would have been appropriate for a FLO to have been in place earlier, to offer support in line with PSI 64/2011, Safer Custody which states:

> "*Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or nominated person of prisoners who are either terminally or seriously ill.*"

55. There are three trained FLOs at Liverpool. The man died on a weekend and there was not a FLO on shift until the Monday. The Governor, head of operations and security, who is not a trained FLO, met the man's family at the hospice, along with the reverend. He explained to the investigator that, as he had spoken with the family before and the death was expected, he did not think that a FLO needed to be called in (if the death had been sudden and unexpected, he would have asked a FLO to attend). He told the family that they would be contacted by the FLO at the beginning of the week. The Governor offered his condolences on behalf of the prison and the man's property was returned.

56. Three days after the man's death, a FLO was appointed and he contacted the man's daughter. He explained the FLO process and offered a financial contribution towards the funeral. He visited the man's daughter. The FLO offered his condolences and checked that all of the man's property had been returned. The FLO provided a family liaison information booklet and his contact details to the man's daughter and explained the FLO role in further detail. They discussed the funeral arrangements and he said that he would keep in touch.

57. The man's funeral was held. The FLO and the reverend attended the funeral. A letter of thanks was sent to staff from the man's family the following week.

58. In response to our feedback to the Governor he wrote that the PSI does not require a trained prison FLO to be appointed when a prisoner is terminally or seriously ill. He was content that the head of operations and security had provided the man's family with appropriate support and advice. While the PSI does not explicitly require the appointment of a FLO for terminally ill prisoners, we still consider it best practice to ensure that a properly trained individual, who can act as a consistent and central point of contact for the family, is appointed at the earliest appropriate time.

    The Governor should ensure that a family liaison officer is appointed when a prisoner is seriously or terminally ill.

    Compassionate release

59. All prisoners who have not reached their automatic release date, conditional release date or parole eligibility date may apply for early release on compassionate grounds for medical reasons or due to tragic family circumstances. Prison Service Order (PSO) 6000, Parole, Release and Recall sets out the guidelines for early release on compassionate grounds. Early release can be considered when death is likely to occur soon. There are no set time limits, but in practice three months is often the timescale used. There also needs to be adequate arrangements for the prisoner's care and treatment outside prison.

60. There is no evidence in the man's prison documentation to suggest that he was told about compassionate release, or that compassionate release was considered. The head of operations and security said as far as he was aware it was considered, but he did not remember seeing an application.

61. The man could have been eligible for compassionate release but an application was not made. As soon as he was diagnosed with a terminal illness the application process should have begun, and certainly no later than 5 April when he was moved to the hospice for palliative care. On 11 April, the man was told he had just days to live, and yet there is no evidence that compassionate release was considered at this point. There is no evidence that an opinion was sought from a medical professional to confirm the man's life expectancy or his risk to others on release. There is no evidence that compassionate release was explained to the man or his family, and they were not given the opportunity to apply for compassionate release.

    The Governor should ensure that consideration of compassionate release is for all terminally ill prisoners, in accordance with PSO 6000.

Palliative Care

62. The hospital's palliative care team had regular involvement in the man's care. They were contacted for advice following his diagnosis and reviewed him while he was in hospital, as well as going to HMP Liverpool to review his medications and care.

63. When the man moved back to the healthcare centre on 27 March care plans, risk assessments and fluid charts were implemented. There is no specific end of life care plan for Liverpool and there is no evidence that the Gold Standards Framework[18] was implemented. "Do not attempt resuscitation" (DNAR) forms were not available to staff.

64. As part of the man's care plan, an airflow mattress[19] was ordered on 27 March. Community equipment services were contacted on 29 March to ask when the mattress would be delivered. Healthcare staff were told that there was a delay. Community equipment services were chased again on 2 April and staff were told that the mattress would be delivered within a few days. The man was transferred back to the hospice and the order was cancelled. Prison doctor B told the investigator that it is sometimes difficult to access resources from the community equipment services especially during weekends and on bank holidays.

65. Prison doctor B noted that, if the man's condition deteriorated and he needed a syringe driver[20], then he would need to be moved to an appropriate setting such as a hospice, as the healthcare centre could not facilitate that equipment. The nurses in the healthcare centre are not trained in palliative care and so are not able to administer a syringe driver.

66. The clinical reviewer comments that there is no documented evidence that an end of life care plan was followed. Liverpool does not have its own end of life care plan and DNAR forms are not available. Although care plans were implemented to ensure the man received appropriate care, end of life care plans are useful tools for staff to be able to see and record what care a patient needs, what their wishes are (including DNAR wishes) and how their condition should be managed. The clinical reviewer comments that there is insufficient written evidence in the man's medical record which suggests that although the man was comfortable and pain free, there is not enough evidence to show if his end of life treatment was within the standards set out in the Gold Standards Framework.

The Head of Healthcare should implement the Department of Health End of Life Care Pathway, the Gold Standards Framework and a DNAR policy.

[18] A systematic evidence based approach to optimising the care for patients nearing the end of life. It helps to improve the quality, coordination and organisation of care.

[19] An airflow mattress aims to ensure that patient's pressure areas do not bear a lot of weight, minimising the risk of pressure sores developing or worsening. This is alongside regular changes in position and helps to ensure their comfort.

[20] A small portable pump that can gives a continuous dose of pain relief and other medicines. It's often used if the patient is vomiting or unable to swallow. A syringe containing the pain relief is put into the driver and attached to a fine needle or cannula (fine, plastic tube) that is placed just under the skin. A small dose of the drug is then released at a constant rate for as long as needed.

Restraints, security and bed watch

67. A risk assessment is completed by security staff when a prisoner goes out of the prison, such as to court or hospital. The risk assessment should consider factors such as the prisoner's sentence length, how long he has left to serve, the offence he has committed, the risk of escape and the risk he presents to the public and staff. It should be based on an assessment of the prisoner's actual risk at the time, taking into account his health and physical condition. The duty governor should review the prisoner's level of risk and amend the risk assessment accordingly.

68. During the man's hospital appointments, such as for the fracture clinic, he was cuffed using an escort chain. He was considered a high risk to the public, but low risk of escape due to his wrist injury and his age. A member of healthcare staff did a medical assessment and concluded that due to his wrist fracture "may not be able to be double cuffed, nature of injury will prevent this. Has the ability to escape from custody". There were no objections to an escort chain being used. It is surprising that he was considered able to escape from custody given that he was elderly, weak and had limited mobility.

69. The man's physical condition deteriorated and he relied on crutches when walking. His health also deteriorated and he was admitted to hospital on 1 February. He was cuffed using an escort chain. The risk assessment shows that he was a low risk to the public, he was not an escape risk and had restricted mobility. The bedwatch logs show that the man spent the majority of his time in hospital asleep in bed and was not eating a lot.

70. The man was discharged back to healthcare on 8 February. He was re-admitted to hospital on 20 February, as his condition had deteriorated further. He was often reliant on a wheelchair. His risk assessment shows that despite very poor mobility, and a low risk of escape and danger to the public, he was again restrained using an escort chain. The risk assessment was reviewed five days later, on 25 February. His condition had not changed and it was recommended that he was to remain on the escort chain. Again, bedwatch log entries show that he was asleep the majority of the time he was in hospital.

71. The palliative care team reviewed the man on 29 February. His skin was very delicate and he was at high risk of developing sores. Bandages were applied to the man's wrists to help reduce the effects of the cuff on the escort chain rubbing. It was advised that the cuff was to be removed to minimise the risk of his skin breaking down and causing infection. (At one point the escort chain had become contaminated by the man becoming incontinent.)

72. Discussions were held between the hospital staff and managers at Liverpool about removing the escort chain. An entry in the bedwatch log five days later on 4 March says that the prison FLO confirmed that the escort chain remain in place, without explanation or a visit by a Governor. He explained to the investigator that he had not made this decision; he was feeding back from the Governor. He said

that in hindsight he does not think that it was appropriate for restraints to have been used and they should have been removed at an earlier stage.

73. On 5 March, the man transferred to a hospice for radiotherapy treatment as he was too weak to withstand the daily journey from prison to hospital. He had a private room. The head of operations and security reviewed the risk assessment. He noted that a doctor at the hospice raised concerns about the restraints being in place, but that the doctor had appreciated the need for a balance between the patient's welfare and maintaining security. Despite his assessment being low risk, the man's restraints remained in place while he was in the hospice. They were removed while he had radiotherapy treatment and were then replaced.

74. It is concerning that despite medical professionals asking for the restraints to be removed to minimise risk of infection, this was not authorised. Although the man was in prison for serious sexual offences, the assessment needs to represent the level of risk a prisoner presents at that time. It appears that the man's condition was not given sufficient weight during the risk assessment process. The man's serious ill health and the low level of risk he presented did not justify the need for him to be restrained using an escort chain.

    The Governor should ensure that a prisoner's medical condition is fully considered in a risk assessment for the level of escort and use of restraints needed, and that the level of restraint used corresponds with the assessed risk.

75. The man completed his treatment and was discharged back to the healthcare centre on 27 March. His condition continued to deteriorate and he was admitted to hospital on 5 April for further care and treatment. On 11 April he was transferred to a hospice. The man was noted to be seriously ill and was not able to move without assistance. Restraints were not used, as his condition was so poor and his level of risk was low. The decision not to restrain the man was appropriate and reflected that his medical condition had been adequately considered in the risk assessment.

Record keeping

76. The Nursing and Midwifery Council (NMC) is a regulatory body for England, Wales, Scotland and Northern Ireland. The NMC has clear guidelines relating to record keeping. Good record keeping is an integral part of nursing, and is essential to the provision of safe and effective care. A principle of good record keeping outlined by the NMC states:

    > "You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should also include details of information given about care and treatment."

77. The man was admitted to healthcare when he arrived at Liverpool. The investigator was told that when patients are admitted a 48 hour care plan is created and is logged on the computer system. There is no evidence of this in the man's medical record.

78. The man's past medical history was requested from his community GP when he arrived at Liverpool. The records were faxed over and scanned into his medical record. An entry was not made in the man's on-going clinical record summarising the man's medical history, which would have provided staff with relevant information and flag any issues, such as his significant weight loss.

    The Head of Healthcare should ensure that a patient's healthcare records are reviewed upon receipt.

79. An entry in the man's medical record shows that a DNAR form was completed while he was in the hospice. The man's DNAR form was not transferred with him from the hospice and they were contacted to see if they could send the DNAR form over, however it does not appear to have been done. There is no palliative care or end of life template on the computerised medical record system that would enable staff to make appropriate, comprehensive entries relating to a patient's condition and care needs. Prison doctor B explained that a template is being created and will be integrated into the medical computer record system in due course.

80. Entries in the man's on-going clinical record were basic. The entries do not always show what examinations were done. Without a comprehensive record of a patient's examinations and consultations, full assessments of a prisoner's condition cannot be made by medical professionals that are reviewing them.

81. The clinical reviewer concludes that the standard of record keeping was poor. The lack of written evidence in the medical record suggests that the man's end of life treatment could have been below the standards set out in the Gold Standards Framework. The record keeping at Liverpool needs to be detailed, accurate, and comprehensive.

    The Head of Healthcare should ensure that all nursing staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the Nursing and Midwifery Council.

CONCLUSION

82. The clinical reviewer concludes that it was likely the man was suffering from lung cancer when he arrived at HMP Liverpool, but it was not diagnosed for four months. He believes that the medical care the man received fell below the expected standard for general practice. He also considers that record keeping was poor and the management of investigation test results needs to be revised. As a result, on several occasions doctors did not appear to respond appropriately to medical symptoms.

83. Although restraints were appropriately removed before the man's death, their use during his earlier hospital and hospice admissions were not adequately justified by risk assessment. The compassionate release process was not started when the man was diagnosed with inoperable cancer of the lungs and the process was not discussed with the man or his family

84. While the man's family were complimentary about their treatment by the prison, we consider it would have been best practice for a family liaison officer to have been appointed when he was diagnosed as terminally ill with cancer. This would have enabled his family to have a trained, consistent and central point of contact.
.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that blood test results are always reviewed within 24 hours.

   Accepted - HMP Liverpool's lead GP will work with Aintree hospital to put in place a system that any abnormal bloods received at the prison will be followed with a phone call alerting staff so immediate action can be taken.

2. The PCT should review, assess and manage the performance of the doctors involved in the healthcare provision for the man.

   Accepted - This is already in place and all doctors are on the performers list and have regular Personal Development Plans. Following the man's death a review has been undertaken of GP records and there have been no issues highlighted.

3. The Head of Healthcare should ensure that prisoners with terminal illnesses are involved in care planning and adequately supported following diagnosis.

   Accepted - A lessons learnt review was held on the 17 July and a full action plan will be implemented. This highlighted that although the man was involved at all times in care planning and support given, this was not recorded on the Clinical System. This will form part of the lessons learnt action plan.

4. The Governor should ensure that a family liaison officer is appointed when a prisoner is seriously or terminally ill.

   Accepted - HMP Liverpool will ensure that a suitable and appropriate nominated person will be deployed to a prisoner's family when confirmation is received from a medical professional person that they are suffering from a serious, terminal or life threatening condition. In every possible situation this will be a person who has received family liaison officer training.

5. The Governor should ensure that consideration of compassionate release is for all terminally ill prisoners, in accordance with PSO 6000.

   Accepted - The death in custody/serious self-harm log will be amended to include matters of terminal illness and be updated with a check list for the family liaison officer to complete to ensure that compassionate release has been considered in all appropriate cases.

6. The Head of Healthcare should implement the Department of Health End of Life Care Pathway, the Gold Standards Framework and a DNAR policy.

   Accepted - Four nurses are to be trained in Palliative Care. Two Commencing in October 2012 and two in early 2013. Queens drive district nurses will support HMP Liverpool until this training is completed and LCH will be implementing a new DNR policy with specific reference to Offender Health.

7. The Governor should ensure that a prisoner's medical condition is fully considered in a risk assessment for the level of escort and use of restraints needed, and that the level of restraint used corresponds with the assessed risk.

   Accepted - The bedwatch booklet is to be reviewed to ensure it fully reflects medical condition and that a fulsome explanation of why restraints are applied or not is recorded and is balanced clearly on risk. HMP Liverpool has also initiated an Enhanced Case Review process where complex cases are discussed through a multi-disciplinary team. All terminally ill offenders are automatically referred to this. Key decisions on risk assessments, use of restraints and visiting rights are discussed and ratified within this forum. These reviews are chaired by the Deputy Governor.

8. The Head of Healthcare should ensure that a patient's healthcare records are reviewed upon receipt.

   Accepted - Records received from GPs will be scanned into the clinical system and summarised at the earliest opportunity. This will form part of the lessons learnt action plan.

9. The Head of Healthcare should ensure that all nursing staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the Nursing and Midwifery Council.

   Accepted - Training records for all staff will be reviewed to ensure all staff have attended the mandatory record keeping training. This will form part of the lessons learnt action plan.