PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in a hospice in August 2012, whilst a prisoner at HMP Liverpool

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of the investigation into the death of a man at a hospice in August 2012 while in the custody of HMP Liverpool. He was 50 years old. He died as a result of oesophageal cancer (cancer of the gullet). I offer my condolences to his family and friends.

The investigation was carried out by an investigator. The local Primary Care Trust appointed a clinical reviewer to conduct a review of the clinical care the man received at Liverpool. Liverpool prison cooperated fully with the investigation.

The man had been in custody since February 2011, and moved to HMP Liverpool in March 2012. In May, he was diagnosed with cancer of the oesophagus which was treated palliatively. He did not want to die in prison and staff began an application for compassionate release. Unfortunately, his health rapidly deteriorated and there was insufficient time for it to be properly considered or completed. However, a hospice place was found for him and he travelled there by ambulance in August. Just six hours after his arrival, he died with his partner at his bedside.

Overall, I am satisfied that the man received a high standard of care from prison and healthcare staff. He and his family and friends were generally treated with compassion and sensitivity. His clinical care was equivalent to the care he might have expected in the community and he was allowed to die with dignity. However, I am concerned that the possibility of compassionate release was not considered earlier and that the use of restraints when he attended hospital was not always justified by a properly considered risk assessment.

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 **March 2013**

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SUMMARY

1. In February 2011, the man was convicted and sentenced to 30 months imprisonment. He was taken to HMP Altcourse. In January 2012 he was convicted of further offences and sentenced to 15 years 9 months. In March he moved to HMP Liverpool and began to experience a number of health problems shortly after arriving.

2. He was referred to hospital in April 2012 under the NHS rule which requires a patient with suspected cancer to be seen within two weeks. In May, he was diagnosed with advanced oesophageal cancer which was considered inoperable and curative treatment was unlikely. He was offered chemotherapy or radiotherapy as palliative care. He was told of his diagnosis, but did not appear to fully understand the prognosis until mid-June. He moved to the prison's healthcare centre but was still able to visit his friends on the wing until a week before his death.

3. On 19 June, a prison doctor asked the Governor to consider the man's release on medical grounds. His case was discussed during a weekly meeting about prisoners with complex issues and his clinical record made reference to compassionate release having been considered and declined. However, records show that an application was not made to the National Offender Management Service for early release on compassionate grounds until 29 August. He attended hospital for appointments and in-patient stays on a number of occasions after his diagnosis. Each time he was subject to restraints which we consider were not always properly justified by a risk assessment.

4. The man did not want to die in prison. Efforts were made by healthcare staff to secure a hospice bed and a family liaison officer was appointed to keep his partner informed. Arrangements were made for him to move to a hospice.

5. In August the man died at the hospice with his partner at his bedside. A post-mortem examination was not carried out as the Coroner was satisfied with documentation provided by the hospice that he died of metastatic oesophageal cancer.

6. We are satisfied that the care the man received from Liverpool was of a good standard. Both he and his family were kept fully informed of his diagnosis and treatment. However, we consider that the possibility of compassionate release should have been considered earlier and use of restraints when he attended hospital was not always justified by a risk assessment.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 30 August 2012. The investigator issued notices to staff and prisoners at HMP Liverpool to inform them of the investigation and asking anyone with relevant information to contact her. No responses were received.

8. The investigator visited Liverpool on 5 September and met members of the prison management team, staff and prisoners involved in the man's care, two members of the Independent Monitoring Board and a representative from the Prison Officers Association. She also visited K wing, where he had lived until his health deteriorated, and the healthcare centre.

9. The investigator obtained copies of the man's medical record and relevant prison records. The local Primary Care Trust appointed a clinical reviewer to review the medical care the man received at Liverpool. He was also given a copy of the man's medical record. The clinical review was received on 26 November.

10. The investigator returned to Liverpool in October to conduct interviews with staff and prisoners. The Governor was provided with verbal and written feedback after the interviews.

11. HM Coroner for the City Of Liverpool was informed of the investigation. The Coroner did not require a post-mortem, but provided the investigator with the cause of death. He will be provided with a copy of this investigation report for his information.

12. One of the Ombudsman's family liaison officers contacted the man's partner. She told her the purpose of the investigation and invited her to raise any matters which she wished the investigation to consider. The man's partner praised the care and consideration they had both been shown by staff at Liverpool, in particular from the prison's family liaison officer. She was grateful for the arrangements made for her partner to move to a hospice, if only for a few hours, and she spoke positively about the efforts to allow her partner to visit his friends on K wing. As part of the consultation process, she received the draft report. She commented that she still believed he should have been given early release as she did not think he was a danger to anybody and she would have wished to have him at home with her in his final days. The report was also sent in draft to the National Offender Management Service. Their response to the recommendations is included.

13. 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 arrangement, whether compassionate release was considered and whether appropriate palliative care was provided.

HMP LIVERPOOL

14. HMP Liverpool is a local prison which serves the courts in the Merseyside area. It holds up to 1,477 unconvicted, convicted and sentenced adult men. A purpose-built healthcare centre was opened in 2007 and is run as a joint venture with the local Primary Care Trust.

15. The healthcare centre provides 24 hour care and includes a 26 bed in patient unit. There are a number of nurse-led clinics and doctors, dentists and other specialists run regular clinics at the prison.

HM Inspectorate of Prisons (HMIP)

16. HMIP last carried out an inspection at Liverpool in December 2011. The inspection report noted that health services were good on the whole and the prison had made progress from previous inspections, albeit slowly. It described relationships between staff and prisoners on the vulnerable prisoner wing (K wing) as good but noted that the regime available to vulnerable prisoners was restricted and needed significant improvement. The healthcare centre was described as well managed and prisoners were generally satisfied with the quality of health services.

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for Liverpool covers the year 2010/2011.

18. The IMB reported that the recommendations of a full health service review (held from late 2009 to early 2010) were being implemented, with a service review implementation group meeting monthly to ensure the work was being carried out. A full health needs assessment of prisoners had been completed and Liverpool had a full time General Practitioner with two further posts due to be filled. Prisoners had more access to nurses who can prescribe medication which meant that some did not have to wait to see a GP. The report mentioned that Liverpool’s Community Health Nursing Team won the Team of the Year Award in 2009/10 which it saw as an acknowledgement of the work staff had done to develop services at Liverpool.

Previous deaths at Liverpool

19. This office has investigated seven deaths at Liverpool through natural causes in the last three years. In previous reports issued this year we have been concerned that restraints were used for hospital visits without an appropriate risk assessment, an issue we identify again in this report.

ISSUES

The diagnosis of the man's terminal illness

20. On 27 March 2012, the man moved from HMP Altcourse to HMP Liverpool. The records show no significant health concerns about him at this time, although he had a history of asthma and pneumonia.

21. On 25 April, a nurse examined the man as he was unwell and said he was feeling pains similar to when he had had pneumonia in the past. She noted that he was not unduly short of breath but felt hot and had been coughing up sputum for a couple of days. She gave him some paracetamol and examined him half an hour later. He told her that the medication had helped a little but he was still in pain. She referred him to be seen urgently by a doctor due to his history of asthma and pneumonia.

22. Liverpool's lead general practitioner (GP) saw the man that afternoon. She noted that he said he had been coughing phlegm with brown sputum for the last five weeks, was short of breath on exertion, was experiencing sharp and stabbing chest and back pains, had difficulty swallowing food, felt tired all the time for the last few weeks and had experienced indigestion for the last two months. When she examined him she noted that he was pale and, from his loose skin, had experienced obvious weight loss. He felt pain when she touched his abdomen. She arranged for an urgent chest X-ray, blood tests and for him to see a gastroenterologist under the two week rule. (The two-week rule is a means of GPs being able to fast track patients for hospital appointments if they have symptoms of cancer.)

23. The man had a chest X-ray on 1 May which revealed hardened areas in the lung (pleural calcification in the right hemithorax) but did not show definite evidence of active lung disease.

24. On 11 May, he had an endoscopy (an internal examination of his throat using a long, thin instrument with a video camera attached which shows pictures on a screen). This revealed a blockage in his oesophagus. On 17 May, the histopathology (microscopic examination of tissue) report said he had metastic oesophageal cancer (meaning the cancer had spread to other parts of the body).

25. We are satisfied that the man was appropriately referred to the hospital under the two week cancer rule and that the diagnosis of cancer was not delayed.

Informing the man about his condition and treatment

26. Following the test results, the man attended a gastroenterology clinic at the hospital on 31 May and saw a consultant. He was told that he had malignant cancer of the oesophagus which was inoperable but might respond to chemotherapy or radiotherapy. However this would be likely to ease the symptoms rather than provide a cure. Records show that support was offered

by staff and Listeners (prisoners selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress).

27. On 3 June, a staff nurse examined the man and explained to him that with chemotherapy and radiotherapy, the blockage in his throat might shrink so that he could eat and drink more comfortably. She liaised with the prison kitchen to provide him with soft food that he could manage, such as scrambled egg and white fish.

28. He attended an oncology appointment on 19 June. A doctor reviewed his case and provided a summary that he was to have radiotherapy which would potentially shrink the cancer and that he should be back to normal in 3-6 months. He returned to Liverpool with the apparent impression that his prognosis was good and that that there was a potential cure.

29. A staff nurse noted on 20 June that, from talking to him, she felt he was unaware of his prognosis. The Offender Health Service Manager saw him and explained his condition and that he had only about two months to live. He was described as being extremely upset. He was offered counselling and had several sessions with a counsellor who specialises in death and bereavement.

30. The lead GP discussed with the man several times whether he wished to be resuscitated if his heart stopped or he stopped breathing. After talking about this with his partner, he decided he did not wish to be resuscitated and told the doctor of his decision on 24 July. She made a record of this in his clinical record and ensured that the Offender Health Service Managers were aware and could make sure all staff caring for him were also aware.

31. The man was informed of his condition by a specialist at the hospital. It is clear that staff at Liverpool were supportive and ensured that he had access to a Listener. When it appeared he was not clear about his prognosis, it was carefully explained and he was offered appropriate support through counselling. His wish not to be resuscitated was properly documented and communicated.

The man's medical appointments and treatment

32. The man was appropriately referred to a specialist under the two week cancer rule. He had an X-ray on 1 May and further tests on 11 May.

33. On 21 May, the man was unable to swallow. He went to hospital to be treated for oesophageal stricture (narrowing of the oesophagus) and remained there until 24 May.

34. On 24 May, he complained of severe dyspepsia which was worse at night when he was lying down. A doctor diagnosed his discomfort as non-ulcer dyspepsia and was prescribed with omeprazole (a medication which reduces the amount of acid produced by the stomach). On the same day, he declined a counselling assessment as he said he was feeling okay and was sleeping better.

35. He attended the gastroenterology clinic on 31 May and was informed on the diagnosis of oesophageal cancer.

36. On 21 June, the man had PET scan (Positron Emission Tomography - which shows how the body tissues are working). The results were received on 2 July and showed that the cancer had spread to his iliac (pelvic) bone. The plan was changed to give palliative chemotherapy (to relieve his symptoms).

37. On 7 July, the man was admitted to hospital for retention of urine. He was discharged back to Liverpool on 10 July after being catheterised. On 13 July, an oesophageal stent (a tube inserted down the throat and through the blockage to make swallowing easier) was inserted.

38. He was admitted to the Coronary Care Unit at hospital with a suspected heart attack on 28 July. The next day this was diagnosed as symptoms related to his cancer and not a heart attack. He was discharged back to the prison on 2 August and admitted to the healthcare centre.

39. The man remained very poorly, but said that he was pain free. He was transferred to a hospice in August.

40. We are satisfied that he was appropriately referred to hospital and was able to attend all appointments and treatment.

The man's pain relief and medication

41. The man was prescribed metoclopramide (to stop sickness) and a nutritional supplement (fortijuice) in May and June 2012.

42. He took tramadol and nefopam (for moderate pain) throughout his illness and in late June oramorph (liquid morphine) was prescribed for breakthrough pain. He was also prescribed zopiclone (to aid sleep).

43. On 30 June, the man's pain relief was increased. On 16 July, the notes show that his pain was controlled and he was receiving a declining dose of oral morphine.

44. On 2 August, he was prescribed dexamethasone (a steroid to improve appetite) by the hospital, also folic acid (vitamin) and lactulose (for constipation).

45. Records show that on 18 August, he had no pain and had good food and fluid intake. By 23 August he was on an increased dose of long acting morphine.

46. The day before he died, it is noted that he was receiving medication through a syringe driver. He remained very poorly but appeared comfortable and pain free. He was aware that he could top up his pain relief with liquid morphine and that he could request this at any time.

47. We are satisfied that the man received appropriate pain relief and other medication to ensure he was as comfortable as possible throughout his illness.

Liaison with the man's family

48. On 10 July, a Principal Officer (PO) was appointed as the man's Family Liaison Officer and met him to explain his role. He remained in frequent contact with him throughout his illness. On 23 July, the PO contacted the man's partner to discuss possible hospice locations near to his home town. The PO remained in close contact with her, offered support and explained what would happen after her partner's death. She was able to spend time with him in the healthcare centre until he was admitted to the hospice where he died.

49. The man's partner was with him when he died. The PO remained in contact after the man's death and in line with national guidance; the prison offered appropriate financial contribution towards the funeral expenses.

The man's location

50. The man was living on K wing, in the prison when he became unwell. After returning to the prison on 24 May following a three-day stay in hospital, he was taken to the healthcare centre for observation. At his request he returned to K wing the following day. On 2 June, a nurse noted that she was asked to see him as an emergency by staff on K wing as he looked unwell and had vomited several times. After talking to him, she asked him to inform the wing staff if he felt worse and asked the evening duty nurse to review his progress.

51. It is not clear when he moved to the healthcare centre; however once there he asked to visit his friends on K wing as often as possible. This was arranged, and he was collected daily by K wing staff. He was given the use of a cell on K wing (known as the care suite), which would be left unlocked all day so his friends could visit him. Each evening he returned to the healthcare centre where there was full-time nurse care.

52. On 23 August, the man told the palliative care nurse from Macmillan that he was keen to go back to K wing permanently. However, on 24 August, another nurse noted that he was very lethargic and appeared low in mood. Over the next three days in was noted that he continued to be tired and lethargic. On 28 August, he appeared to be feeling pain and was unable to stand by himself. The Offender Health Service Manager liaised with the palliative care registrar to try to secure a hospice bed for him, but no beds were available. She contacted his partner and best friend and arranged for a taxi to collect them and bring them to the prison. His partner spent most of the day in the healthcare centre with him.

53. At 9.34am on 30 August, a nurse contacted the hospice, which offered the man a bed. A healthcare manager contacted the man's partner to say that he

had been taken to the hospice. This was followed by a telephone call with Family Liaison Officer.

54. We are satisfied that the man was appropriately located during his illness. The prison made good and sensitive efforts to allow him to spend time with others on his wing for as long as possible.

Compassionate release

55. Early release on compassionate grounds (ECR) is a means by which prisoners, who are seriously ill, usually with a life expectancy of less than three months, can be permanently released from custody before their sentence has expired. The criteria for early release for indeterminate sentenced prisoners are set out in Prison Service Order (PSO) 4700. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

56. The lead GP emailed the healthcare managers on 19 June to say that the man had oesophageal cancer which had spread to his aorta and lungs and his life expectancy was in months. She asked whether it would be possible for them to discuss his compassionate release with the Governor. It is not clear what action was taken following this request.

57. It was not until 16 July, when a Primary Care Graduate Mental Health Worker emailed the Deputy Governor asking for advice, that the man's case was put on the agenda of the enhanced case review meeting (this is a weekly meeting to discuss care planning for prisoners with complex needs). The Head of Operations and Security was asked to begin risk assessment procedures.

58. The next day, 17 July, the Head of Operations and Security asked a member of his staff to ensure that risk assessments were in place and for an officer in Liverpool's Offender Management Unit to look into the possibility of Release on Temporary Licence (ROTL).

59. On 20 July, the man's case was discussed at the enhanced case review meeting. The summary of the discussion says in part "Security are looking at the risk assessment. It is thought that he won't get it though because of his offences, however he is very poorly and we are looking at weeks/months to live".

60. The man's solicitor wrote to the Governor on 20 July with representations in support of his compassionate release. Records show that the letter was received on 31 July, although we were unable to find any evidence that it was responded to by the prison.

61. An entry in the man's clinical record by the lead GP on 6 August said "release from prison – not deemed to be an option … unfortunately release on compassionate grounds has been explored and is not possible".

62. On 29 August, the Health Service Manager and the lead GP completed a medical condition report as part of the application for early release on compassionate grounds. In addition there was correspondence between a Probation Officer and the Safer Custody Manager concerning whether the man would be accommodated at a hospice or his home address.

63. We are not satisfied with the length of time taken to consider compassionate release for the man. This issue was first raised on 19 June by the lead GP, yet it took until the day before the man died for the first active steps to be taken. References in his clinical record to compassionate release 'having been explored' and 'not possible' do not appear to be accurate as there is no record that appropriate consideration was given.

The Governor should ensure that when a prisoner has been given a diagnosis of a terminal illness, subject to his wishes, the possibility of early release on compassionate grounds should be considered at an early stage.

Palliative care plans and end of life pathway

64. The NHS document 'The route to success in end of life – achieving quality in prisons and for prisoners' sets out how an end of life care pathway might be implemented in prisons. Among the benefits of an end of life pathway are that it helps carers to plan when and how care will be delivered, and helps patients makes choices about how they are cared for towards the end of their lives. There are various examples of end of life care pathways, including the Liverpool Care Pathway (LCP) used by the prison. The LCP includes a template which staff involved caring for the dying person complete. The clinical review concludes that the man was treated appropriately under the end of life pathway.

65. The man was consulted and informed about his medical appointments. He was actively engaged in decisions with the palliative care team about resuscitation, where he lived and contact with his family.

Restraints, security and bed watch

66. The Prison Service has a duty to protect the public when escorting prisoners to hospital, and a responsibility to balance this by treating prisoners with humanity and maintaining their dignity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment which considers the risk of escape, the risk to the public, the prisoner's category and which also takes into account factors such as the prisoner's health and mobility.

67. A judgement in the High Court in 2007 made it clear that a distinction needs to be made between the risk of escape (and the risk to the public in the event of an escape) posed by a prisoner when fit and those risks posed by the same prisoner when suffering from a serious medical condition. The judgement indicated that medical opinion regarding the prisoner's ability to escape must be considered as part of the assessment process. It deemed that restraining by handcuffs of a prisoner receiving chemotherapy (and by implication, other life saving treatment) was degrading and that such restraint would be likely also to be regarded as inhumane unless justified by other relevant considerations.

68. After the man was told that his illness was terminal, he was escorted to hospital four times for out-patient appointments and was admitted four times as an in-patient. We are not satisfied that the risk assessments fully took into account his medical condition and how this affected his risk. For example, he went to hospital on 13 July 2012 and was subject to double handcuffing. (Double cuffing entails the prisoner having his hands cuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs.) Other than standard boxes being circled on the form, there was no indication of how his health condition affected his risk. On 25 July, in the medical information section it was noted that he 'mobilises with the aid of a wheelchair' His risk to hospital staff, risk of hostage taking, risk of escape and potential of outside assistance were all assessed as low. He was accompanied by two officers yet was still subject to double cuffs. The risk assessment noted 'to remain on cuffs at all times'. His appointment was for chemotherapy and a blood transfusion.

69. On 29 July, after the man had been taken to hospital with a suspected heart attack, the risks continued to be assessed as low except for risk of harm to the public, which was based on his offence, rather than his escape risk. There were no healthcare comments about his condition. This time an escort chain was used as a restraint. (An escort chain is approximately two metres long with a handcuff on each end. One end is attached to an officer and the other to the prisoner.) The risk assessment gave the reason for use of an escort chain as "He is terminally ill and poor mobility". It further noted "already has his end of life plan".

70. On 29 August, an escort and bed watch risk assessment decided that two officers should accompany the man to the hospice but that, as he was frail and terminally ill, he should not be handcuffed. The manager in charge wrote "The man is on his end of life pathway and is not expected to return to the prison … [he] is serving a 15 year sentence for a serious sexual offence but is now in the final stage of his terminal illness and completely bed bound. He is unable to offer any threat of escape or violence". We agree an appropriate decision was taken not to restrain him at the hospice for the final hours of his life, but it is difficult to see why two officers were required as an escort.

71. We are not satisfied that Liverpool always appropriately considered and balanced the actual risks the man posed, taking full consideration of his health at the time when making escort risk assessments.

The Governor should ensure that escort risk assessments accurately reflect the prisoner’s actual risk at the time and take account of a prisoner’s medical condition.

CONCLUSION

72. The man was diagnosed with advanced oesophageal cancer on 17 May. He did not wish to die in prison and died at a hospice in Warrington in August. The investigation found that overall Liverpool treated him with care and compassion and in line with national guidance. We conclude that he received a standard of healthcare, equivalent to what he might have expected in the community. However, we consider that the possibility of compassionate release should have been more actively considered and we are concerned that restraints were used for hospital escorts and stays which were not fully justified by risk assessments.

RECOMMENDATIONS

The National Offender Management Service's response is noted in italics below each recommendation.

1. The Governor should ensure that when a prisoner has been given a diagnosis of a terminal illness, subject to his wishes, the possibility of early release on compassionate grounds should be considered at an early stage.

This recommendation is accepted. The Enhanced Case Review process chaired by the Deputy Governor is now the vehicle used to consider and where appropriate, initiate applications for early release on compassionate grounds.

2. The Governor should ensure that escort risk assessments accurately reflect the prisoner's actual risk at the time and take account of a prisoner's medical condition.

This recommendation is accepted. All available information is taken into account and considered when making the appropriate decisions in relation to escorts and extended stays on outside hospital. Where cases become protracted or are of an end of life nature the enhanced case review meeting held weekly and chaired by the Deputy Governor will ensure assessments are informed and appropriate in respect of the prisoner's medical needs and security.