



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in September
2013, 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 investigation report into the death of a prisoner at HMP Liverpool, who died of cancer of the oesophagus in September 2013, at Woodlands Hospice, Liverpool. He was 58 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at HMP Liverpool. The prison cooperated fully with this investigation.

The man had a number of health problems when he first arrived at the prison in September 2012. In November 2012, a doctor referred the man to hospital for a diagnostic scan after he complained of pain when swallowing. The scan was inconclusive and the radiographer requested that it was repeated in one week as a matter of urgency. Despite this, the hospital did not prioritise the scan and the prison did not chase it up although they had been informed it was urgent. A number of further rescheduled appointments were cancelled by the prison, due to the lack of available escort staff. The man eventually had the scan on 30 April 2013, when he was diagnosed with cancer which was too advanced to treat. The man was cared for at the prison but developed a gastric bleed and was admitted to Aintree Hospital on 15 September. He moved to Woodlands Hospice on 20 September and died a few days later.

There was a significant delay of several months before Aintree Hospital arranged an appointment for an urgent diagnostic scan which affected the man's treatment options. The actions of the hospital are outside the remit of this investigation and this was subject to a separate serious incident review. However, healthcare staff at the prison had been informed that the scan was urgent and should have actively chased up the appointment. I am very concerned that a number of subsequent appointments were cancelled by the prison which led to further unacceptable delays. After the diagnosis, the clinical reviewer was satisfied that the man received an appropriate standard of treatment and care at the prison. However, I do not consider that the use of restraints when the man attended hospital was justified by appropriate risk assessments which fully took into account his state of health. This repeats findings that have been made in previous investigations at the prison and I expect the governor to satisfy himself that lessons are being learned.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man was serving seven years and six months for violent offences and had been at HMP Liverpool since 21 September 2012. He was a heavy drinker and was prescribed medication for alcohol withdrawal when he arrived. He had suffered poor health for a number of years, was prescribed pain relief for chronic back problems and had Crohn's disease (inflammation of the digestive system) and kidney damage. The man smoked cigarettes and told nurses that he did not intend to stop.
2. In October 2012, the man reported experiencing pain when he swallowed. Medication did not ease the symptoms and a doctor referred him to the gastroenterology department of Aintree hospital. The doctor did not make an urgent referral for someone suspected of cancer, although the man was in a high risk group and met the referral criteria. An initial gastroscopy on 21 December was inconclusive and the hospital radiographer asked to repeat the procedure urgently in one week. A failure in the booking arrangements at Aintree Hospital resulted in significant delays in rearranging the appointment. The prison had been notified this was urgent but did not follow it up. Some further appointments were cancelled by the prison and the gastroscopy was not repeated until 30 April 2013. The man was then diagnosed with cancer which was too advanced to be treated.
3. The man received palliative radiotherapy and he lived mainly on G wing at Liverpool, which he preferred to the prison's inpatient unit. On 15 September, he developed a bleed in his stomach and was admitted to Aintree Hospital. The man moved to Woodlands Hospice on 20 September and died on 24 September. We are concerned that the man's family was not informed quickly of his move to hospital on 20 September and, as in some previous investigations into deaths at Liverpool, we found that restraints, including double handcuffs, were used without appropriate risk assessments to justify their use.
4. An investigation by Aintree Hospital after the man's death identified that there had been a significant delay in diagnosis, which impacted on his treatment options. This was regarded as a serious untoward incident. Hospital care is outside the Ombudsman's remit, but we are concerned that the delays were compounded by poor systems in the prison to follow up hospital appointments and that the prison was responsible for cancelling some appointments.
5. The clinical reviewer is satisfied that after he was diagnosed, the man received satisfactory care and support, although this was not always evidenced in the medical records. We make a number of recommendations about healthcare procedures, cancelling appointments, use of restraints and family liaison.

THE INVESTIGATION PROCESS

6. 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.
7. The investigator obtained copies of the man's prison and prison medical records. She interviewed six members of staff and one prisoner at HMP Liverpool on 6 November, and visited the healthcare inpatient unit and the wing where the man had lived. The investigator informed the Governor in writing of the preliminary findings of the investigation.
8. NHS England appointed a clinical reviewer to review the man's clinical care at the prison.
9. The investigator informed Her Majesty's Coroner for Merseyside - Liverpool District of the investigation and the Coroner provided the cause of death. We have sent the Coroner a copy of this investigation report.
10. One of the Ombudsman's family liaison officers contacted the man's daughter, to explain the investigation. The man's family was aware that hospital appointments had been cancelled and had no additional specific issues for the investigation to consider.
11. The investigation has assessed the main issues involved in the man's care including his diagnosis and treatment, whether palliative care was provided, liaison with his family, his location and security arrangements and whether compassionate release was considered.
12. The man's family received a copy of the draft report. They pointed out a factual inaccuracy and this report has been amended accordingly. The man's family also raised issues that did not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison considered our draft report and recommendations, which they have accepted. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP LIVERPOOL

13. HMP Liverpool is a local prison which serves the courts in Merseyside. It holds up to approximately 1,400 men. The prison has eight residential wings and a purpose-built healthcare unit, which opened in 2007.
14. Liverpool Community Health Trust is commissioned to provide healthcare. The prison healthcare centre provides outpatient services, as well as 24-hour inpatient care. A doctor is on duty during normal working hours and nurses and healthcare assistants provide a 24-hour inpatient service.

HM Inspectorate of Prisons

15. The most recent inspection of Liverpool was in December 2011. The Inspectorate found some progress had been made at the prison since the previous inspection, but it had been very slow. Inspectors noted that healthcare was well managed with a good range of nurse-led and specialist clinics. Patients could see staff trained in the care of older prisoners and those with life-long conditions. HMIP repeated a previous recommendation that prisoners should be allowed to smoke in an outside area when they were admitted to the inpatient unit and recommended that there should be sufficient escorts for hospital appointments, to avoid cancellation and delays in treatment.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In their most recent annual report for 2012, the IMB noted that recommendations from a service review held in 2009/10 were still being implemented, including increasing the number of GPs and the development of a day centre for prisoners with complex needs.

Previous deaths at HMP Liverpool

17. The man's death was the third death at Liverpool in the last year, two of whom also died of cancer. We have raised the issue of escort risk assessments and the use of restraints before.

ISSUES

The diagnosis of the man's terminal illness and informing him of his condition

18. When the man first arrived at Liverpool in September 2012, healthcare staff contacted his community GP to verify what medication he had been prescribed, but did not request his medical records or obtain any details about his health conditions. Healthcare staff told the investigator that they do not routinely request community medical records. Prison Service Order (PSO) 3050 - Continuity of Healthcare states that efforts should be made to retrieve any information required from the prison's GP or other relevant service. The man had a history of gastrointestinal disease and requesting the clinical records would have helped the prison doctor make a more informed assessment when he presented again with these symptoms.
19. On 25 October 2012 a prison GP examined the man who had complained of pain when swallowing food and drink. The GP noted that he had not lost any weight and had no difficulty swallowing. He prescribed gaviscon for heartburn and indigestion and told the man that he would review him in a week.
20. Another prison GP examined the man on 1 November, who told him the gaviscon was not helping. The man stomach was tender and the GP increased a prescription for omeprazole (which reduces stomach acid) and referred the man for a routine appointment to the gastroenterology department of Aintree hospital. There is no record that the man's history of gastrointestinal disease was discussed and the GP did not have the benefit of his community GP records. The clinical reviewer notes that the man smoked, had a history of excessive alcohol use, was over 55 and had a medical history of gastrointestinal disease. With these risk factors, he considers he should have been referred urgently under the NHS pathway which requires patients with suspected cancer to be seen by a relevant specialist within two weeks.
21. The electronic medical records show the GP's referral was actioned by an administrator the next day but according to Aintree Hospital was not received until 2 November. An appointment was made for the man to have a gastroscopy procedure (to examine the inside of the stomach) on 13 December. This appointment was cancelled by the prison and rescheduled for 21 December. There is nothing in the records to explain why this appointment was cancelled but we were told that the security department cancelled all non-urgent appointments that day.
22. On 21 December, the man attended Aintree Hospital for a gastroscopy. Patients are told not to drink tea with milk 2-3 hours before the procedure as it could compromise the images. The man seems not to have been told this and he had a cup of tea beforehand, which resulted in a poor scan image. The senior endoscopist recommended that the procedure was repeated urgently in one week. The hospital's booking system was poor and the appointment was scheduled for 4 March, despite the request for urgency. A discharge letter from Aintree Hospital dated 21 December, had stated that the repeat gastroscopy

was urgent and was scanned onto the man's prison medical record but healthcare staff at the prison did not follow this up.

23. In the meantime, the man had an appointment to attend the hospital's inflammatory bowel disease (IBD) clinic on 7 January, which was cancelled by the hospital on 5 December and rescheduled to 4 February. This rescheduled appointment was then cancelled by the prison and rearranged for 11 February. It was noted that the man had had symptoms of dyspepsia (indigestion) for some months, omeprazole medication had helped, and there was no weight loss. Due to the poor images from the gastroscopy on 21 December, the IBD clinic referred him for another and made referrals for a barium swallow (an examination of the oesophagus and the stomach) and biopsies. These referrals were marked as routine. A follow up appointment for the IBD clinic was arranged for 8 April.
24. The man did not attend the gastroscopy appointment on 4 March as he went to court that day and another gastroscopy appointment was made for 18 March. The prison cancelled this appointment and the IBD appointment for 8 April because of insufficient escort staff. The gastroscopy was rebooked for 30 April and the IBD clinic for 13 May. The prison said that they have staff for up to four hospital escorts a day and priority was given to the most urgent. The man's appointment was not prioritised as the security department were unaware of the urgency.
25. The man had a barium swallow examination on 7 March, the results of which showed no significant problem. The rescheduled gastroscopy was eventually performed on 30 April. Biopsies were taken and cancer was suspected. On 7 May, a hospital consultant told the man that it was likely that he had cancer of the oesophagus but further diagnostic tests were needed. There is no record of what support the man was offered at that stage. A PET scan to provide more detailed images was carried out on 13 June (it had been delayed as the man had developed diabetes which needed to be treated first.)
26. Dr Iftikar Khan a consultant surgeon at the hospital wrote to the prison on 18 June as The man had not attended an appointment for the results of his scan that day. The surgeon had been told that the appointment was cancelled for security reasons, because The man had been aware of the appointment. The surgeon emphasised that the appointment had been to discuss the diagnosis and treatment options of a major cancer diagnosis and requested that future appointments were not cancelled. He asked that the man's family should be informed, so that they could attend the clinic for these discussions.
27. The Prison Service's National Security Framework, does not require hospital appointments to be cancelled automatically when prisoners become aware of the time and date, although our experience is that this is often the case. The security guidance expects that the prisoner's condition and the urgency of the treatment required should be taken into account when taking a decision. There is no evidence that this happened.

28. It is evident that there were a number of failures which led to an unacceptable delay in the man's diagnosis. The actions of the hospital are outside our remit so we do not comment on those, which have been the subject of a serious incident review. However, there were also deficiencies in prison processes. The prison did not request the man's community GP records so his full medical history was not considered when the doctor first made a referral to hospital. Had this been done it might have emphasised the need for an urgent two week referral. The prison healthcare department failed to note that the repeat gastrology appointment was urgent and we are very concerned that the prison cancelled a number of further appointments which led to additional delay. We make the following recommendations:

The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health problems.

The Head of Healthcare should ensure that prisoners in high risk groups for cancer have an urgent referral under the NHS two week pathway and that referrals are followed up.

The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.

The man's medical treatment

29. On 30 April the hospital told the man that he required a PET scan to determine the best course of treatment, but this could not take place until his blood sugars were controlled. He was told that, dependent on the extent of his disease, he would receive chemotherapy. On 25 June, a doctor saw the man at the Clatterbridge Cancer Centre, Liverpool, after scan results showed that the cancer had spread and was inoperable. He was offered palliative radiotherapy to control progression of the disease and to help manage his symptoms. The man was admitted to Aintree hospital on 1 July and the following day he had an oesophageal stent fitted (a flexible tube to help with swallowing). The man remained in hospital until 22 July. He started radiotherapy treatment at the Clatterbridge Clinic on 12 August, which he attended daily for five days.
30. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put in place. The NHS document 'The route to success in end of life care – 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 plan when and how care will be delivered, and helps patients make choices about how they are cared for towards the end of their lives. There are various examples of end of life pathways.
31. The clinical records show that the hospital palliative care team were involved in the man's care, and that arrangements were made for a MacMillan nurse to visit him. The records also state that the Gold Standards Framework (a

palliative care plan) was in place for the man and his care was discussed with him, especially relating to his preferred place of care, although the records do not show whether he wanted resuscitation to be attempted in the event of a cardiac or respiratory arrest. The man was referred to the mental health team for counselling on 22 May, and had a full assessment on 31 May, and again on 1 July after he was told that his condition was incurable.

32. The man's care continued to be delivered at the prison until he developed a bleed in his stomach and was admitted to Aintree Hospital on 15 September. He moved to Woodlands Hospice on 20 September, where he died on 24 September. The cause of death was given as metastatic cancer of the oesophagus.
33. There was clear evidence of discussions with the man about his psychosocial and spiritual needs. A patient centred approach was provided and the staff delivered care that met the man's preferred care approach so far as possible. However, the clinical reviewer notes that there was no comprehensive formal assessment of pain documented, either before or after his diagnosis of cancer, until 14 August 2013. Towards the end of his life, the clinical reviewer is satisfied that his pain relief and symptoms were monitored more closely. We are satisfied that the man received a generally good standard of care after his diagnosis but it is important that there is a comprehensive, documented assessment of pain for patients with chronic, long-term or terminal conditions. We make the following recommendation:

The Head of Healthcare should ensure that a comprehensive assessment of pain is carried out for all prisoners with chronic, long term or terminal conditions, and that this is fully documented.

The man's location

34. The man lived on the second floor landing (all facilities are on this level) of G wing at Liverpool. He told staff and his friends that he wanted to remain living on the wing, rather than be admitted to the prison's inpatient unit, where he was not allowed to smoke. Healthcare staff facilitated this decision, and changed his pain relief medication from a syringe driver to oral medication to allow him to return. The man was frequently offered the opportunity to return to the inpatient unit but chose to remain on G wing.
35. On 20 September, the man moved to a hospice, his preferred place of death if he was not able to be released. The clinical reviewer noted that respecting the man's wish to remain on his wing as long as possible, was in line with the approach taken in the community and we are satisfied he was appropriately accommodated during his illness.

Restraints, security and escorts

36. 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 and which also takes into account factors such as the prisoner's health and mobility. A judgement in the High Court in 2007 (the Graham judgement) 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 handcuffing 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.
37. The escort risk assessments for the man were inconsistent, often incomplete and assessments of risk changed with no recorded justification. The risk assessment for 13 May noted that the man was a low risk of escape, but gave no indication of the level of restraints that were authorised. The risk of escape was raised to medium on 20 May, with no recorded justification for the increase in risk, and double handcuffs (when the prisoner's hands are cuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs) were authorised. The assessments dated 18 and 20 June were incomplete.
38. When the man was admitted to hospital on 1 July, double cuffs were initially authorised but they were removed later the same day. The escort risk assessment was reviewed on 5 July, but there was no medical input. On 17 July, an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) was applied due to concerns about the man's behaviour. The risk assessments for 22 and 26 July were not made available to the investigator.
39. On 31 July, the man was taken to Aintree Hospital and an old risk assessment was re-used by the security manager and the date over-written. The assessment dated 12 August did not include the level of restraints used and the assessment for the next day is missing the security risk assessment. On 4 September, the risk assessment was changed and the man was noted to be low risk of escape and risk to staff, although double cuffs were still authorised.
40. The final risk assessment on 15 September was incomplete, and contained some incorrect information about the man's regime status, although restraints were not applied. The man was unrestrained and accompanied by two escorting officers during his final days in hospital and at the hospice.
41. We are concerned that on at least two occasions double cuffs were authorised for the man. 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. This is usually required for moving category A or category B

prisoners in good health. When, exceptionally, double cuffs are used for a category C prisoner like the man the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified. The unnecessary use of double cuffing is a matter we have raised with the prison before. The risk assessment used was based entirely on a security risk assessment (although this identified him as low risk most of the time) with little evidence that there was any consideration of how his health condition impacted on his risk of escape as the court judgement required.

42. The investigator discussed the escort risk assessments with the new security manager at the prison. The security manager accepted that the risk assessments were not adequate, and told the investigator that a review of the assessment process was planned.
43. Public protection is important, but security measures must be proportionate to a prisoner's individual circumstances which must be fully considered, taken into account and balanced against the security risks. We are not satisfied that the man's physical health was sufficiently taken into account in assessing his risk and that use of double cuffs in particular was not justified.

The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

44. The prison appointed the security manager as their family liaison officer at the end of May 2013 (although both the security manager and the man's family thought contact had been made earlier), after the man's was told his probable diagnosis. The man agreed that his family should be informed about his medical condition. The security manager subsequently arranged for the man's family to attend hospital appointments with him, and to have private visits in the prison chapel.
45. While general communication with the man's family appeared to be good and he had regular family visits, we were concerned to note that the escort risk assessment form, completed when the man was taken to hospital on 15 September, indicates that his family were not to be notified of his admittance to hospital. No one has been able to explain the reason for this. The family liaison officer noted in his log that the man was admitted to hospital that day, but there is no record when his family were informed. After the man died the prison made a contribution to funeral expenses in line with national guidance. The man's family wrote to the prison thanking them for their support.
46. Despite, generally good communication with the man's family, we are concerned that it appears that they were not informed promptly of his last admission to hospital when he was clearly very seriously ill. This is a requirement of Prison Rule 22. We make the following recommendation:

The Governor should ensure that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill.

Compassionate release

47. Release on compassionate grounds is a means by which prisoners who are seriously ill can be permanently released from custody before their sentence has expired. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000 and prisoners are usually expected to have less than three months to live. The criteria include 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) within the National Offender Management Service (NOMS). The decision over whether to release a prisoner on compassionate grounds is made by the Secretary of State for Justice taking into account medical opinions on the prisoner's condition and information provided by NOMS staff. A clear medical opinion on life expectancy is required.
48. An application for compassionate release was instigated by the prison and submitted to PPCS on 24 July. On 7 August, the Secretary of State refused to grant early release as the man did not meet the criteria, and that his life expectancy at that time was not less than three months. On 8 August, updated medical reports were requested as the man's condition had deteriorated. The prison's primary care manager, said the man had responded to medication and in her opinion he could survive for a few more months. She said that given his presentation at the time there was no case for resubmission of the application.
49. After this, the man's case was discussed at weekly Enhanced Care Review Meetings. Although there is no evidence that the application was re-considered as the man's condition worsened, without a clear prognosis it is unlikely that any further application would have been successful.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health problems.
2. The Head of Healthcare should ensure that prisoners in high risk groups for cancer have an urgent referral under the NHS two week pathway and that referrals are followed up.
3. The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.
4. The Head of Healthcare should ensure that a comprehensive assessment of pain is carried out for all prisoners with chronic, long term or terminal conditions, and that this is fully documented.
5. The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.
6. The Governor should ensure that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill.

ACTION PLAN:

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that GP records are requested for newly arrived prisoners, particularly those with ongoing health problems.	Accepted	The Head of Healthcare has reviewed the procedure for requesting medical records and is satisfied that a robust procedure is now in place. On arrival at HMP Liverpool all prisoners are interviewed by a registered nurse and a fully comprehensive medical screening takes place. This is then followed up by the administrative team who are responsible for obtaining records.	Completed and ongoing Head of Healthcare	
2.	The Head of Healthcare should ensure that prisoners in high risk groups for cancer have an urgent referral under the NHS two week pathway and that referrals are followed up.	Accepted	The Head of Healthcare has reviewed procedures and a robust system has now been established for the management of referrals for patients who present as high risk for cancer. Patients deemed as potentially having an undiagnosed cancer are given a generic " <i>fast track cancer referral</i> " code on SystemOne. The administration team retrieve a report from the SystemOne on a weekly basis and check that appointments have been confirmed for the listed patients. If no appointment has been booked the administration team will contact the relevant department at the hospital and arrange an appointment. GPs will review all results and take appropriate action.	Completed and ongoing Head of Healthcare	
3.	The Governor and Head of Healthcare should ensure that hospital appointments are not cancelled unless	Accepted	In the event that any hospital appointment needs to be cancelled/rescheduled, the Duty Governor will liaise with the senior member of the healthcare team on duty. The clinical	31 March 2014 Governor / Head of Healthcare	

	there are overriding, fully justified and documented security reasons and there is no detriment to the prisoner's health.		system will then be endorsed by the healthcare registry, clearly identifying the reason for cancellation and documenting dialogue with the hospital to arrange a further appointment. An auditable record of cancelled appointments is kept to ensure the same person does not have multiple cancellations.		
4	The Head of Healthcare should ensure that a comprehensive assessment of pain is carried out for all prisoners with chronic, long term or terminal conditions, and that this is fully documented.	Accepted	All patients with long term or chronic conditions will have a care plan. The care plan, in accordance with NICE guidance, will include an assessment to monitor and manage pain. This assessment is scored and pain relief can be prescribed accordingly. The care plan will be kept electronically within the SystmOne.	31 March 2014	Head of Healthcare
5	The Governor should ensure that risk assessments for prisoners taken to hospital fully take into account individual circumstances and are based on the actual risk the prisoner presents at the time.	Accepted	Duty governors are now required to visit all prisoners on bed watch the day following confirmation of their admission to hospital. This will ensure that risk assessments and cuffing arrangements are appropriate. Training will be delivered to Governors via a briefing to give a greater understanding of chronic diseases and terminal illnesses. This will enable more informed decisions to be made. The risk assessment process and information sharing between healthcare and security will be reviewed to ensure that risk assessments are better informed. The enhanced case review meeting will continue to monitor prisoners with chronic illness. Discussions relating to cuffing arrangements will be documented.	31 July 2014	Governor / Head of Healthcare / Head of Safer Custody

			<p>A designated Band 6 palliative care nurse will co-ordinate hospital appointments and treatments for those prisoners who fall into this category and those who have the potential to have a life threatening condition</p> <p>HMP Liverpool's death in custody action plan is monitored monthly via the senior management team's meeting. The issue of risk assessments and cuffing arrangements will be discussed via this forum to serve as a reminder to Duty Governors.</p>		
6	The Governor should ensure that a prisoner's family is notified as soon as possible when a prisoner becomes seriously ill.	Accepted	<p>A designated Band 6 palliative care nurse will co-ordinate hospital appointments and treatments for those prisoners who fall into this category and those who have the potential to have a life threatening condition. This will allow improved communication between Healthcare and Duty Governors to enable family liaison deployment at the earliest opportunity</p> <p>All cases where a potential for life threatening illness exist will be referred to and monitored via the enhanced case review meeting. A family liaison officer (FLO) will be appointed where an identified risk to life exists.</p> <p>Duty governors are now required to visit all prisoners on hospital escort the day following confirmation of their admission. This provides an early opportunity to assess the need for FLO deployment.</p>	30 April 2014	Head of Healthcare / Head of Safer Custody