A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in September 2013 while in the custody of 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 man, who died of liver cancer in September 2013 at hospital, while in the custody of HMP Liverpool. He was 50 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care the man received at HMP Liverpool. The prison cooperated fully with the investigation.

The man was originally sentenced to four years imprisonment in 2011for drugs offences. He had a long history of drug and alcohol misuse and a number of pre-existing health conditions including hepatitis C. He was released from prison on licence in January 2013, but was recalled to custody in July.

The clinical reviewer noted that the medical care and follow up treatment the man received when he returned to prison in January led to his eventual cancer diagnosis in September 2013. He was appropriately referred to hospital when necessary, but prison healthcare staff did not provide additional nutritional support sufficiently quickly in August when the hospital identified that he was malnourished.

Overall, I am satisfied that the standard of healthcare the man received was satisfactory. However, I do not consider that the use of restraints when he attended hospital was always justified by appropriate risk assessments which fully took into account his state of health. I am particularly concerned that a very ill man was double handcuffed on the journey to the hospital, although this would not usually be required for a fit man in his security category. This is an area of concern raised in previous investigations at the prison and I expect the governor to satisfy himself that lessons are being learned.

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 **April 2014**

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SUMMARY

1. On 24 January 2011 the man was sentenced to four years imprisonment and sent to HMP Liverpool. He transferred to HMP Kennet In March 2011.

2. The man had a history of mental illness and had a long history of drug and alcohol abuse. He had long standing hepatitis C (a virus infection of the liver).

3. While in prison, the man was found to have cirrhosis of the liver as a result of the hepatitis C (cirrhosis is a chronic liver disease). He suffered with continuing ill health throughout his time in prison, including oesophageal varices (a type of varicose vein in the lining of the oesophagus and upper stomach) and hepatic encephalopathy (declined brain function occurring when the liver is no long able to remove toxic substances from the blood). He was diagnosed with liver failure in August 2012. He was seen regularly at the liver clinic at hospital.

4. The man was released on licence in January 2013. On 20 July, because he continued to use drugs his licence was revoked and he was returned to HMP Liverpool. He was clearly unwell and, on 1 August, admitted to hospital as an emergency. He remained there until 14 August, when he returned to the inpatient unit at HMP Liverpool. The hospital had found him to be severely malnourished, but the prison did not fully act on this information until some weeks later.

5. On 5 September, a hospital consultant told the man than an MRI scan had identified a cancerous tumour on his liver, which could not be treated.

6. On 12 September, the man was admitted to hospital as an emergency and diagnosed with end stage liver failure. He was discharged the following day and returned to the inpatient unit at the prison. His condition deteriorated quickly and he was re-admitted to hospital the next day. He was referred to the hospital palliative care team three days later. He died with his family present.

7. We are satisfied that overall, the standard of healthcare the man received was satisfactory. However, there are some concerns that his nutritional needs were not met when he was recalled to prison in July 2013. We are also concerned that restraints were used for hospital visits without risk assessments which justified their use and that his family were not allowed to spend some private time with him before he died. We make three recommendations about these issues.

THE INVESTIGATION PROCESS

8. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and inviting anyone who had relevant information to contact her. No one responded.

9. The investigator obtained copies of the man's prison and prison medical records. She visited HMP Liverpool on 28 November and interviewed three members of staff and three prisoners. She gave feedback on the preliminary findings of the investigation and followed this up in writing.

10. NHS England commissioned a clinical reviewer to assess the man's clinical care at the prison.

11. The investigator informed HM Coroner for Liverpool City of the investigation, who provided the cause of death. We have sent the Coroner a copy of this investigation report.

12. One of the Ombudsman's family liaison officers and the investigator visited the man's family on 6 November to discuss issues they wished the investigation to consider. They were unhappy about the standard of healthcare he received in prison and were concerned about the use of restraints and the number of escorting officers while he was in hospital.

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

14. The family received a copy of the draft report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP LIVERPOOL

15. HMP Liverpool is a local prison which serves the courts in Merseyside. It holds up to 1,400 men. The prison has eight residential wings and a purpose built healthcare unit, which opened in 2007.

16. Liverpool Community Health Trust provides health services at the prison. The prison healthcare centre has 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 in-patient service.

HM Inspectorate of Prisons

17. 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.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its 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

19. The man’s death was one of five deaths from natural causes at Liverpool during 2012/13. 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

20. On 24 January 2011, the man was sentenced to four years imprisonment and sent to HMP Liverpool. He was moved to HMP Kennet in March 2011 and released on licence in January 2013. However, in July he was recalled to prison and sent to HMP Liverpool.

21. The man had a history of mental illness which was treated both in the community and during his time in prison. He also had a long history of drug and alcohol abuse for which he also received treatment. He had hepatitis C.

22. While in prison, the man was found to have cirrhosis of the liver as a result of his hepatitis C. He suffered with continuing ill health throughout his time in prison, including oesophageal varices and hepatic encephalopathy. He was diagnosed with liver failure in August 2012. He was seen regularly at the liver clinic at hospital.

23. When the man was released from prison in January 2013, he was no longer drug dependent and was advised that due to his liver condition he should abstain from all drugs and alcohol on release. However, after his release he failed three drug tests and his license was revoked.

24. The man returned to HMP Liverpool on 20 July 2013. At his reception health screen it was noted that he was unkempt and underweight. He tested positive for cocaine, heroin, and methadone and began a methadone reduction programme.

25. On 1 August, a doctor reviewed the man. He found him to be lethargic and confused, and suspected he had jaundice. He was admitted to the inpatient unit at the prison. He was reviewed again later that day and still displayed signs of drowsiness and an inability to mobilise. The doctor sent him to hospital as an emergency.

26. The man was found to be malnourished and suffering with hepatic encephalopathy. While in hospital, he had scans of his liver and abdomen. He remained in hospital for treatment and was discharged back to the inpatient unit at Liverpool prison on 14 August.

27. The discharge letter from the hospital recorded that the man was severely malnourished. It noted that he had been prescribed high calorie nutritional supplement drinks and appeared to eat regular meals while in hospital. Despite the information recorded on the discharge letter, there is no evidence that healthcare staff at the prison treated this adequately. A 'Malnutrition Universal Screening Tool' (MUST) assessment was not completed until 5 September, when he was diagnosed with liver cancer and the hospital consultant indicated that malnutrition was a greater risk to his health. The MUST assessment scores the risk of malnutrition and allows staff to plan and care for patients who need additional nutritional support. It is a mandatory

requirement of the NHS Standard for Nutritional Support. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware of the NHS Quality Standard for Nutritional Support and use the Malnutrition Universal Screening Tool to ensure prisoners who need it receive appropriate nutritional support.

28. On 19 August, a doctor noted that the man was alert, coherent with no evidence of confusion and was self caring. He was moved from the inpatient unit to H wing. At 7.00pm that evening, he was re-admitted to the inpatient unit as he appeared confused and was throwing things around his cell.

29. On 5 September, the man, accompanied by a nurse, attended the gastroenterology clinic at hospital. A consultant informed him that his scan results showed a cancerous tumour on his liver. His liver would not tolerate any treatment and a transplant was not an option. However, his condition was not considered palliative at that time.

30. On 12 September, healthcare staff contacted the medical team at hospital as the man had a swollen abdomen. The team advised that he should be admitted to hospital. He was diagnosed with end stage liver failure and discharged the next day. He returned to the inpatient unit at the prison.

31. At 10.00pm on 13 September, the man was re-admitted to hospital after he had vomited blood. His condition continued to deteriorate and he was referred to the hospital palliative care team on 16 September. His family were with him when he died.

32. The post-mortem examination indicated that the cause of death was hepatocellular carcinoma (liver cancer); cirrhosis of the liver; end stage alcoholic disease; and hepatitis C.

33. The man had a number of health conditions and had long term liver disease which was managed effectively during his time is prison, both by the specialist clinic at the hospital and healthcare staff at the prison, who sought specialist advice when required. He was kept informed of his treatment and condition by hospital and prison healthcare staff. The diagnosis of cancer was made just eleven days before he died. The clinical reviewer commented that, "despite advice from hospital specialists his lifestyle choice to use drugs had a catastrophic effect on his already failing liver".

The man's medical treatment

34. The man had been diagnosed with hepatitis C before he went to prison. The clinical reviewer found that there was appropriate follow up during his prison sentence. A specialist hepatitis C nurse visited him four times while he was at Kennet, and he was seen regularly at the liver clinic at hospital.

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35. Healthcare staff, at both Kennet and Liverpool, were aware of the man's conditions and he was treated appropriately. The clinical review noted that it was evident from the records that he had appropriate access to emergency care when necessary, and that healthcare staff were aware of the signs and symptoms of his liver and associated conditions and reacted appropriately. There were suitable care plans at both Liverpool and Kennet.

36. The consultant informed the man that he had a cancerous tumour on 5 September. The tumour was small and it was not considered that he needed palliative care at that time. This was to be reviewed a month later, but he died before then.

37. On 13 September, the man began to vomit blood and he was admitted to hospital. He was diagnosed with oesophageal varices but immediate surgery to rectify the problem was unsuccessful. The consultant in charge of his care decided that no further active treatment would be offered. The clinical reviewer commented that he was referred appropriately to the hospital palliative care team on 16 September. He died soon after.

38. The clinical reviewer commented that prison nurses often accompanied the man to appointments and had demonstrated a compassionate and caring approach, particularly when he was given bad news. We are satisfied that he received appropriate treatment for his health conditions.

The man's location

39. The man was recalled to prison on 20 July 2013. On 1 August, the man admitted him to the inpatient unit at Liverpool for observations as he was concerned about his health. His condition deteriorated further and he was admitted to hospital later that day. He was discharged on 14 August and returned to the inpatient healthcare unit where he remained until his final admission to hospital on 13 September.

40. We are satisfied that the man was appropriately located in the patient's inpatient unit when he was not in hospital.

Restraints, security and escorts

41. 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 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 also 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.

42. The man was admitted to hospital on 1 August 2013 as an unplanned emergency escort. A risk assessment was not completed for the escort however the Person Escort Record (PER) noted that at 4.10pm that day "D cuffs [single handcuff] and escort chain applied". (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.) At 6.15pm an operational manager gave permission for the use of an escort chain for medical treatment. He remained restrained by an escort chain until the early hours of 9 August when he was reported as trying to open one of the escorting officer's bags. As a result the level of restraint was increased and a single handcuff was used.

43. On 9 August at 3.35pm, the man's restraints were reviewed and the single handcuff replaced with an escort chain. He was discharged back to the prison on 14 August.

44. On 5 September, the man was escorted by two officers and a nurse to hospital for a gastroenterology appointment. Although the risk assessment noted he was low risk, double handcuffs were used. (Double cuffing is 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.) An escort chain was authorised when he arrived at hospital.

45. We are concerned that double handcuffs were used on a very sick prisoner, who was also assessed as low risk. The man was a category C prisoner. Double cuffing 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 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 unjustified 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) with little evidence that there was any consideration of how his health condition impacted on his risk of escape as the court judgement required.

46. The man was admitted to hospital by emergency ambulance at 10.00pm on 12 September. At this time he was very ill and vomiting blood. The risk assessment noted him as a low risk to the public, but medium risk of escape. It is not clear what level of restraint was used during the emergency escort as this section of the risk assessment was incomplete. However an entry at 9.00am on 14 September noted that an escort chain was in use.

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47. On 14 September the man was taken to theatre at 1.00pm for urgent exploratory surgery and restraints were removed. The risk assessment was reviewed at 5.35pm and it was agreed that he would remain unrestrained with an escort of three prison officers (the records note that he was restless and

had lashed out at one of the officers). The escort was reduced to two officers on 16 September.

48. We are concerned that despite his extremely poor health and impaired mobility, the man remained restrained until he was taken for surgery on 14 September. In a previous investigation of a death at Liverpool, we raised similar concerns and the prison told us that they had introduced an enhanced care review process for end of life cases to ensure assessments are informed and appropriate. We have seen the notes of three case reviews where he was discussed, but in each case there is nothing recorded about the level of restraints to be used and whether the arrangements were appropriate. We make the following recommendation:

The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.

Liaison with the man's family

49. The man's sister and brother were kept informed of his hospital admissions from 2011 and offered visits. When he received his diagnosis on 5 September, his brother (who was also at HMP Liverpool) was taken to the healthcare centre to help support him.

50. The prison family liaison officer met the man's family at the hospital on 16 September and visiting restrictions were lifted. His family were at his bedside when he died. The prison contributed towards the cost of the funeral in line with national guidance.

51. The man's family were concerned at the number of prison officers present in the room and that they were not allowed any privacy with him before his death. While there had been some concern about his conduct there is a need for escorting officers to be sensitive to the needs of the family when they are with a dying prisoner. We note the number of officers present was reduced to two on 16 September, but we believe that some consideration should have been given to posting them outside the room to allow his family some private time with him before he died. We make the following recommendation:

The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.

Compassionate release

52. Prisoners can be considered for release on compassionate grounds for medical reasons. In order to be released on these grounds, a prisoner must have been diagnosed with a terminal illness and there must be an indication that death is likely to occur soon (usually within three months).

53. The man was diagnosed with liver cancer on 5 September 2013. He was told by his hospital consultant the same day that active treatment would not be possible as his liver would not tolerate treatment. The consultant did not give a prognosis. His health deteriorated very quickly after that, but in the absence of a clear prognosis we accept that it would have been difficult for the prison to have pursued an application for early release on compassionate grounds.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff are aware of the NHS Quality Standard for Nutritional Support and use the Malnutrition Universal Screening Tool to ensure prisoners who need it receive appropriate nutritional support.

2. The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time

3. The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.

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 all healthcare staff are aware of the NHS Quality Standard for Nutritional Support and use the Malnutrition Universal Screening Tool to ensure prisoners who need it receive appropriate nutritional support.	Accepted	The Malnutrition Universal Screening Tool is in use, but will be reviewed. To ensure that staff are competent in its use, the screening tool now forms part of the training being delivered by a senior ward manager from the community. If the review finds that a new screening tool is necessary this will be added to the clinical system.	Healthcare 31 March 2014	
2.	The Governor and the Head of Healthcare should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position, and that assessments fully take into account the health of a prisoner 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	Safer Custody and Healthcare. 31 July 2014	

			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. 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.		
3.	The Governor should ensure that unless there are overriding security concerns, escorts should allow the family of dying prisoners some private time with them.	Accepted.	Training will be delivered to Governors via a briefing to give greater understanding of chronic diseases and terminal illnesses. This	Safer Custody and Healthcare 1 May 2014	

			will enable more informed decisions when making risk assessments to allow unsupervised access to family whilst ensuring security and duty of care to the prisoner is maintained.		