



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at hospital in April
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, a prisoner at HMP Liverpool, in April 2013. The cause of his death was bilateral chronic subdural haematoma (bleeding in the brain) with underlying metastatic lung cancer. He was 82 years old. I offer my condolences to his family and friends.

A clinical reviewer assessed the man's clinical care in prison. HMP Liverpool cooperated fully with the investigation.

The man had been in prison for ten months. He had been diagnosed with a number of chronic ailments and had been in remission from lung cancer since 1995. Soon after his arrival at Liverpool, he began to suffer from bouts of confusion, chest pains and had a number of falls in his cell. The healthcare team made prompt and appropriate referrals to specialists and during his last inpatient admission at hospital in March 2013 he was diagnosed with vascular dementia. He died a month later.

The recurrence of the man's cancer had not been detected in tests conducted before his death. I am satisfied that staff at Liverpool responded appropriately to his reported symptoms and ailments and that there were no missed opportunities at the prison to diagnose the conditions that caused his death. However, as in previous investigations at Liverpool, I consider that there is a need for improvement in the standard of record keeping by healthcare staff. I am also concerned that restraints were used for hospital visits without proper justification, another matter I have raised with the prison before.

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

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SUMMARY

1. The man was sentenced to 3 years imprisonment on 8 June 2012, at Crown Court and was sent to HMP Liverpool the same day. He was 81 years old.
2. The man had been diagnosed with a number of chronic health conditions before his imprisonment, including heart disease and chronic obstructive pulmonary disease (COPD). He was in remission from lung cancer which was first diagnosed in 1963 and had returned in 1995 when the affected part of his right lung had been removed. Healthcare staff recorded his medical history, put in place appropriate care management plans and continued his treatments and medication.
3. Within a few weeks of arriving at Liverpool, the man showed symptoms of confusion and, over time, had a number of falls in his cell. He also reported chest pains on several occasions. Healthcare staff moved him into a disability suite in the healthcare centre, referred him for tests and sought advice from specialist secondary care providers. They also attempted, without success, to arrange a transfer to a prison better placed to provide for his care needs. On 8 March 2013, after another fall in his cell in which he sustained a fractured hip, he was taken to hospital where he remained until he died in April.
4. The post-mortem initially indicated that the cause of the man's death was meningitis and metastatic lung cancer. However, further analysis and a subsequent post-mortem report, clarified that the primary cause of death was bilateral chronic subdural haematoma. Neither of these illnesses had been diagnosed in the months leading to his death and chest X-rays taken between July and November 2012, had showed nothing abnormal.
5. The clinical reviewer found a number of omissions in general medical provision at Liverpool, but concluded that none of these had impacted adversely on the cause of the man's death. She has made a number of clinical recommendations.
6. We agree with the clinical reviewer that the entries in the man's medical records did not fully reflect his care and the outcome of medical investigations. We therefore repeat a recommendation we have made to Liverpool before about the need to improve the quality of the record keeping.
7. Apart from his last hospital admission, risk assessments determined that restraints should be used when the man attended hospital, in spite of him being an elderly wheelchair user judged to be a low risk of escape and low risk to the public. We do not believe that the level of restraint was justified by fully considered risk assessments and make a recommendation about this, a matter we have previously raised with Liverpool.

THE INVESTIGATION PROCESS

8. Notices were issued announcing the investigation to staff and prisoners at HMP Liverpool, asking anyone with relevant information to contact the investigator. No one came forward.
9. The investigator visited Liverpool on 29 April 2013. He met healthcare staff who worked with the man and obtained copies of his prison records, including his medical record. NHS England asked a clinical reviewer to assess his clinical care. On 25 July, the investigator returned to the prison with the clinical reviewer and interviewed four members of staff. He gave preliminary feedback on the investigation to the Governor.
10. The investigation report has been sent to the Coroner to assist his enquiries into the man's death.
11. One of the Ombudsman's family liaison officers wrote to the man's family to explain the investigation process and ask if there was anything that they wished to be considered. The family raised a number of issues about his care, including:
 - The management of his dementia.
 - Whether opportunities were missed to diagnose his lung cancer?
 - The number of falls he sustained.
 - His location.
 - The use of restraints for hospital appointments.
12. After our draft report was issued in September 2013, a further post-mortem revised the cause of death and the final report has therefore been amended to reflect this. The investigator consulted the clinical reviewer about the new findings.
13. The man's family and legal representatives received copies of the draft report in September 2013. Following the revised cause of death, they asked for the investigation to be re-opened and the draft report re-written. While the final report has been amended to reflect those findings, the amendment of the cause of death did not impact on the factual accuracy of the report. The opportunities for diagnosis of his condition and his falls were fully explored during the investigation. The solicitors concerns have been addressed in correspondence.

HMP LIVERPOOL

14. 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.
15. At the time of the man's death, the local Primary Care Trust (PCT) commissioned healthcare services at the prison, which were provided by the Community Health Trust. 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 in-patient service.

HM Inspectorate of Prisons

16. Her Majesty's Inspectorate of Prisons (HMIP) carried out a full unannounced inspection in December 2011. The inspection 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 and a good range of nurse-led and specialist clinics were provided and patients could see staff trained in the care of older prisoners and those with life-long conditions. HMIP found that cells had not been adapted for use by prisoners with limited mobility as previously recommended and that anyone with acute physical disability was located in the healthcare centre.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and humanely. In its most recent report, the Board at Liverpool reported favourably on the healthcare provided. They also noted that plans to reduce the services in the inpatient unit would result in more serious health conditions being treated in hospital.

Previous deaths at HMP Liverpool

18. We have investigated a number of natural cause deaths at Liverpool. Three investigations since 2011, found shortcomings in record keeping and there are similar concerns in this investigation. We also repeat a recommendation made in several previous investigations about risk assessments and the use of restraints.

KEY EVENTS

19. The man was sentenced to three years imprisonment at a Magistrates' Court on 8 June 2012. He received a custodial sentence as a result of his failure to comply with a previous court order relating to forfeiture proceedings under the Proceeds of Crime Act 2002. He was taken to HMP Liverpool. He was 81 years old. He had previously served a short prison sentence relating to this offence.
20. At an initial reception health screen, a nurse noted that the man had been diagnosed with ischaemic heart disease and diabetes. He had also had lung cancer in 1963, which had reoccurred in 1995, resulting in surgery to remove one of the lobes in his right lung. One of Liverpool's GPs reviewed him the same day. The GP noted that he had also been diagnosed with chronic obstructive pulmonary disease (COPD) and reviewed his medication. As a result of his poor health, he was given a cell in the inpatient unit of the prison healthcare centre.
21. The man settled well. It was recorded that he mixed with other prisoners and staff and was fully compliant with his medication, requiring only minimal assistance with daily tasks.
22. On 22 June, the man reported to a nurse that he had a mild headache and difficulty speaking. Although he displayed no outward signs of memory loss and was aware of people around him, she suspected that he might have had a mild stroke. He was therefore taken to the accident and emergency department at hospital for a second opinion. After examination by a doctor, he was discharged and there is no record that any treatment was required.
23. On 23 June, a mental health nurse reviewed the man. She concluded that he should have a mini mental state examination (MMSE) and the results would be discussed at a multidisciplinary team meeting the following week. Later that day, before the MMSE could be carried out, he fell in his cell and sustained a small cut to his head. He was sent to hospital, where doctors concluded that his medication might have been a contributing factor to the fall.
24. In line with the discharge advice from the hospital, prison healthcare staff reviewed his medication and completed a falls risk assessment. (The purpose of the falls risk assessment is to consider a person's environment kept and minimise the risk of further injury. The assessment is updated regularly to reflect any changes.) The man was judged to be low risk. Despite the perceived low level of risk, staff put in place a careplan to ensure that his cell remained free from clutter, that he understood he could request help with moving around and that he was monitored regularly by nurses.
25. A GP reviewed the man on 29 June, as nurses had noted that he had become increasingly confused since his fall on 23 June. He then contacted a medical registrar at the hospital, who advised him to send the man to the accident and emergency department for examination. There is no record of the outcome.

26. On 3 July, a prison GP examined the man after he had complained of chest pain. She noted that he had not used his glycerol trinitrate (GTN spray - used to treat angina and heart pain) as prescribed, she reminded him of the importance of the spray and when to use it. Later that day, she carried out an ECG (electrocardiogram to measure the electrical activity of the heart) and referred him for a chest X-ray. The results of both tests were normal.
27. The GP reviewed the man on 5 July, after another fall. Although the results of the chest X-ray and ECG had revealed nothing abnormal, she felt a further review was necessary. After discussion with the medical registrar at the hospital, she arranged for him to be taken to hospital, where he remained as an inpatient until 7 July. When he returned to the prison, he remained in the healthcare unit, where he was regularly monitored by both nurses and GPs in accordance with his careplan.
28. On 6 August, the GP examined the man after he again reported mild chest pain. He told the doctor that he was still not using his GTN spray. She advised that if he had any further occurrences of chest pain, he should inform a nurse, who would administer the GTN spray for him. She noted that he had a reduced chest expansion when breathing and "dullness" in the base of his right lung. She therefore referred him for a second chest X-ray which showed nothing of concern.
29. On 8 August, during a multidisciplinary team meeting to review the man's care, the GP noted that he had been prone to bouts of forgetfulness and had shown signs of depression. A referral was made to the prison's mental health in-reach team (MHIRT) to assess his emotional state. The in-reach team later referred him to primary care psychological services who examined him but did not consider they would be of any benefit.
30. The same day the lead nurse for the care of older prisoners, carried out a dementia screen, the results of which were normal. Staff discussed whether Liverpool was an appropriate prison for the man given his state of health and frailty. They decided that a transfer to HMP Wymott, which has an older prisoners unit, would be beneficial to him. The healthcare service manager contacted Wymott to explore the possibility of a transfer.
31. On 28 August, the man reported severe stomach pain and feelings of nausea. A GP examined him and suspected that he might have a gastric bleed (internal bleeding from the area of the upper intestine). She requested an emergency ambulance, which took him to hospital. He returned later that day, with a diagnosis of gastro-oesophageal reflux disease (caused by stomach acid leaking into the oesophagus).
32. Healthcare staff moved the man to the disability suite near to the nurses' desk in the healthcare centre on 13 September. This was to give him more room to move around in as well as access to his own shower and specialist equipment such as a hospital bed. The disability suite also offered some companionship

and security for him, as it was a shared. His falls risk assessment and careplan continued to be updated regularly.

33. On 19 September, the lead nurse carried out the mini mental state examination. The man's score was 18 out of 30 (the Alzheimer Society advises that scores above 27 are considered normal. A score of below 27 could indicate early onset, or a mild case, of dementia). As a result of the test, the GP made a referral to psychogeriatric services to get advice and assistance in caring for him. There is no evidence of a response to the referral in his medical records.
34. At a review on 8 October, a GP noted that the man appeared frail and displayed signs of dementia. She recorded that she was awaiting a response to her referral to secondary care providers for elderly patients. A month later, on 8 November, she noted that the request for a transfer to Wymott had been refused. As a category D prisoner, he did not meet the criteria for acceptance by Wymott, a category C prison. She asked for the decision to be reviewed at an enhanced care meeting. She also noted that he had developed a chronic cough and that the results of a further chest X-ray were again normal.
35. On 21 December, a nurse recorded that the man had become increasingly confused and agitated. She suspected that he might have contracted a urinary infection and ordered a mid-stream urine test for the next day. However, he refused to provide a sample. On 24 December, the nurse noted that he was much improved, so the urine sample was not pursued.
36. Another doctor at Liverpool examined the man on 14 January 2013, as he had had a cough for a week. The doctor recorded that he had previously had lung cancer and that after a reoccurrence in 1995, he had had surgery on his right lung. The doctor noted that he had not suffered any haemoptysis (coughing up blood) and that his previous chest X-rays were clear. He prescribed a course of antibiotics and planned a review a week later. At that review, held on 21 January, he noted that his cough was much improved.
37. A nurse examined the man on 1 February and sent a urine sample for analysis after she noticed he had become very confused in the preceding days. There is no evidence of the results in his medical records.
38. On the evening of 2 February, the man's cellmate called for assistance from healthcare staff. He had fallen in his cell striking his head, hip and injuring his wrist. Healthcare staff applied Tubigrip to his wrist and gave him painkillers to help him sleep. They intended to monitor his wrist in case he had a fracture. The next day, a nurse noted some swelling and bruising and that he could not make a fist. He was referred to a GP, who saw him the next day, but no details of the examination are in his medical records.
39. A prison GP sent the man to hospital on 6 February, after he had appeared extremely confused and disorientated. Hospital staff diagnosed a chest infection

- and discovered that he had sustained a fractured wrist in the fall four days earlier. He received treatment and returned to Liverpool the next day.
40. As the man's episodes of confusion became more frequent, on 15 February, the lead nurse asked an assessor at Liverpool NHS Older Person and Unplanned Care Unit to assess his care needs. The assessor did not respond to either the initial request or a second email sent on 26 February. The nurse finally contacted him on 6 March. He told her that he could not attend the prison due to other commitments and advised her to contact a geriatric specialist. A referral was made to the specialist the same day.
 41. In the evening of 8 March, healthcare staff went to see the man after he had fallen in his cell. He had slipped while walking around in his socks, which staff had advised him not to do. He complained of pain in his left hip. Staff gave him painkillers and noted he should be reviewed the following day. A nurse examined him the next morning and he was then taken to hospital. He had fractured his hip and required surgery.
 42. Healthcare staff from the prison frequently contacted nurses at hospital for updates on the man's condition. The lead nurse liaised with occupational health staff to ensure that the prison had any necessary equipment for his return.
 43. On 22 March, a psychiatrist at hospital telephoned the prison and told a nurse that in his opinion the man had vascular dementia (a condition caused by restrictions to the flow of blood to the brain) and that "prison was not the best place for him". The nurse referred the psychiatrist to her line manager and contacted the man's family to ensure that the hospital doctors had relevant information about the extent of his dementia before he went into prison. At interview the primary care manager said that the psychiatrist had written to confirm his view but there are no details of any correspondence between him and the prison in his medical record.
 44. Healthcare staff continued to liaise with staff at the hospital to discuss plans for the man's discharge as he was in the hospital's intermediate care centre and there was a shortage of beds. They considered several options, including placing him in a nursing home but those approached said he did not meet their criteria. (The primary care manager speculated that they might have been concerned about him being an escorted prisoner.) Unfortunately, on 17 April, before further arrangements could be explored, he fell in hospital, again resulting in a fractured hip. He had surgery to repair the fracture the next day.
 45. After the operation the man's condition deteriorated. On 18 April, nurses told the escort officers that his family should be contacted and advised of his worsening condition. His family visited him in hospital later that day.
 46. On the morning of 19 April, the Head of Offender Management began an application for early release on compassionate grounds. He contacted the relevant agencies that are required to have input into the application but the

man died before their responses could be collated and a decision taken. The same day an operational manager at the prison visited the hospital to introduce himself as family liaison officer to the man's family.

47. The man's condition continued to deteriorate and hospital staff informed his family that they did not expect him to survive. A few days later, with his family at his bedside, he died.
48. The operational manager arranged for the man's daughter to visit the prison's healthcare centre on 29 April, where she met staff who had worked with her father and a prisoner who knew him. The funeral was held on 2 May and representatives from the prison attended. In line with national guidance, the prison contributed towards the cost of the funeral.
49. A post-mortem initially stated the cause of the man's death as meningitis and metastatic lung cancer. However, a later post-mortem report established that the cause of death was due to bilateral subdural haematoma. The pathologist considered that this was consistent with the history of repeated falls and other symptoms such as confusion, imbalance and unsteadiness but it was not possible to determine what had caused the subdural haematoma.

ISSUES

Clinical care

50. The man was an elderly man who arrived at Liverpool with a number of pre-existing chronic medical conditions for which he was receiving treatment. His medical history was well documented and healthcare staff were aware of his existing and previous health issues. He was thought to have died from meningitis, discovered post-mortem and this was the cause of death indicated in our draft report. It subsequently transpired that he died from bilateral subdural haematoma.
51. The clinical reviewer concluded there were some gaps and omissions in the man's care, such as lack of consistent care planning and assessments, and insufficient engagement with the specialist elderly care team. Nevertheless, she does not consider that any of these issues had a bearing on his death. She also considered the revised post-mortem findings which were circulated after the draft report. She commented that his observations had been performed after his falls had been documented and there was no indication he had deteriorated as a result.
52. The clinical reviewer makes a number of recommendations in relation to the management of chronic diseases at HMP Liverpool, which the Head of Healthcare will need to consider. This report focuses on the principal issues identified by the investigation.

The man's mental health

51. Concerns about the man's mental health were first recorded on 22 June 2012, when a nurse examined him after he complained of a mild headache and difficulty speaking. Staff recorded episodes of short term memory loss, forgetfulness and confusion. As his mental state deteriorated, healthcare staff correctly referred him to both primary and secondary mental health services. Entries in his medical records indicate that advice was sought from specialist care providers at the appropriate time. On one occasion, planned interventions were not completed due to him injuring himself in his cell. However, we are satisfied these were followed up within a reasonable timeframe.
52. In March 2013, while the man was an inpatient in hospital, he was diagnosed with vascular dementia. Healthcare staff at Liverpool explored various care options for his expected discharge from hospital but due to his deteriorating condition, he remained under the care of the hospital until his death.
53. We are satisfied that the man's treatment and the handling of his mental health at Liverpool were both prompt and appropriate.

Lung cancer

54. The man was first diagnosed with lung cancer in 1963. He had a reoccurrence in 1995, for which he had surgery and he was subsequently considered to be in remission from cancer. Before his imprisonment he had also been diagnosed with COPD and used inhalers.
55. After reporting chest pain and, latterly, developing a cough, the man had chest X-rays in July, August and November 2012. Each time, the results showed nothing abnormal.
56. The post-mortem examination showed that the man had lung cancer which had spread to other areas of his body. There is no evidence in his medical records, or correspondence from secondary care providers, to indicate that his lung cancer had returned. We are satisfied that in response to his reported symptoms, healthcare staff referred him to secondary care for further specialist investigation both promptly, and appropriately.

Record keeping

57. The clinical reviewer points out that entries in the man's medical records lacked detail and follow-up information. She added that without a comprehensive record of a patient's examinations and consultations, medical professionals cannot fully assess and review a prisoner's condition. We also found instances of incomplete medical records and a lack of discharge information. We therefore make the following recommendation:

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

Location

58. In view of the man's pre-existing chronic medical conditions, when he arrived at Liverpool, staff rightly decided to allocate him to a cell in the inpatient unit of the healthcare centre, and he remained in the healthcare centre throughout his time at the prison. He suffered a number of falls in his cell and staff completed a falls risk assessment, which was frequently updated and the suitability of his location reviewed.
59. In August 2012, prison staff applied for the man to transfer to HMP Wymott, a prison with an older persons' unit which Liverpool they considered more suited to his needs. Wymott refused to accept him on the grounds that it is a category C prison and he was category D, a lower security. We are surprised that his lower security category should preclude such a move, particularly as it is unlikely that

any open prison to which category D prisoners would usually be allocated would have been suitable and he was in a category B prison at the time.

60. The man moved into a disability suite in the healthcare centre in September. This was a more appropriate setting with relevant facilities and help close at hand if he needed it. When he went into hospital, prison staff tried to secure alternative accommodation, without success.
61. We are satisfied that, given the constraints of the prison environment, the man's location was appropriate for his needs. Reasonable attempts were made to find a place in another prison when his health began to fail and healthcare staff also tried to find suitable accommodation when he was due to be discharged from hospital.

Compassionate release

62. Early 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) of the National Offender Management Service (NOMS).
63. An application for compassionate release on medical grounds was made for the man on 19 April, when it became clear that he was not going to recover from his illness. Unfortunately, he died before the compassionate release application could be finalised and submitted to the National Offender Management Service for consideration. We are satisfied that the initiation of the application was timely and it is unfortunate that it could not be completed before his death.

The use of restraints

64. 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. 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 a 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 to be regarded as inhumane unless justified by other relevant considerations.

65. The investigator examined the risk assessments and escort logs for several of the man's hospital visits. On 2 January 2013, staff completed a risk assessment for a cardiology assessment at hospital. He was assessed as a low risk of escape and to escort staff as well as low risk to the public and hospital staff in the event of an escape. In the healthcare section of the form, staff recorded no objections to the use of restraints despite his age and physical condition. He was accompanied by two prison staff, who were instructed to use double handcuffs (two pairs - one to cuff the prisoner's wrists together and the other to cuff one of his wrists to that of an officer) if necessary. However, as he used a wheelchair to move around, an escort chain (a long chain with a handcuff at each end, one attached to the prisoner and the other to an officer) was authorised instead.
66. On 13 February, the man was admitted to hospital after an injury to his wrist sustained in a fall in his cell. By then, he had been recategorised as a category D prisoner (the lowest security category, which indicates that a prisoner is suitable for open conditions). His risk was assessed at the same levels as those described previously, authorising double cuffing if necessary, but instructed the use of an escort chain because of his wrist injury. The risk assessment concluded that he should be restrained at all times.
67. The man's risk was assessed at the same level as his previous escorts for his final admission to hospital on 9 March. However, restraints were not used.
68. Prison Service guidance is that restraints are not normally necessary for an escort when the prisoner's mobility is severely limited. The man was 81 years old with several chronic physical and mental health conditions who required the use of a wheelchair to travel any significant distance. By the time of at least one of his hospital escorts when restraints were used was in the lowest security category. We have previously made a recommendation to Liverpool about the use of restraints in hospital for a category D prisoner and although the recommendation was accepted it does not appear to have been implemented. Security measures must be proportionate to a prisoner's individual circumstances. The man had been assessed as a low risk of escape and a low risk to others should he do so. In the light of the severity of his condition and lack of mobility, we do not consider the risk he presented warranted the use of an escort chain. We therefore make the following recommendation:

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

RECOMMENDATIONS

1. The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.
2. The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.

ACTION PLAN: The Man – HMP Liverpool

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1.	The Governor should ensure that risk assessments for prisoners taken to hospital are completed fully, take into account individual circumstances, are updated regularly and are based on the actual risk the prisoner presents at that time.	Accepted	<p>A review of the risk assessment process for prisoners taken to hospital will be undertaken in order to ensure that risk assessments are based on a consideration of the individual's circumstances and the actual risk the prisoner presents at the time. Account will be taken of the prisoner's security category, their risk of escape and also their risk to the public. The new risk assessment processes will include a management checklist to ensure compliance. Staff will be briefed on the new risk assessment process.</p> <p>All 'end of life' cases are monitored at the weekly enhanced case review meeting, which is chaired by the Deputy Governor. In those 'end of life' cases where escorts are not considered routine, cuffing arrangements are discussed and monitored at this meeting.</p>	1 December 2013	
2.	The Head of Healthcare should ensure that all healthcare staff fully adhere to the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and Nursing and Midwifery Council.	Accepted	<p>All Liverpool Community Health staff are subject to mandatory clinical record keeping training every three years.</p> <p>A weekly audit of care plans and records has recently been implemented. This is carried out by a Band 7 senior nurse. For those staff whose record keeping falls below the required standard, individual supervision via the staff appraisal system will be implemented.</p>	Completed and ongoing	

			<p>Record keeping will be added to the monthly staff meeting agenda for discussion on required standards and best practice.</p> <p>Record keeping is also subject to external audit from NHS (Prison Health Performance and Quality Indicators), HM Chief Inspector of Prison and the Care Quality Commission.</p>		
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