



**Investigation into the death of a man  
at a hospice in October 2011,  
while a prisoner at HMP Liverpool**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**February 2014**

This is the report of an investigation into the circumstances of the death of a man in October 2011, at a hospice, while in the custody of HMP Liverpool. He was 49 years old and had been diagnosed with lung cancer shortly before his death. I offer my condolences to his family and friends.

The local Primary Care Trust (PCT) appointed a clinical reviewer to review the man's medical care in prison. HMP Liverpool cooperated fully with the investigation. I apologise for the delay in issuing this report.

The investigation has identified serious deficiencies in the man's treatment. Two years before he was remanded to prison in December 2009, he was treated for a cancer in his neck for which he continued to be monitored. It is unclear how much information was available to prison staff on his reception at HMP Forest Bank, as there are no medical records for the first two months of his period in custody. At Liverpool, he developed serious symptoms of illnesses that were not adequately followed up for treatment and, as his illness progressed, the management of his pain relief was unsatisfactory. Although he was a category D prisoner, awaiting transfer to an open prison, he was subject to restraints when he went to hospital, which was not justified by a properly considered risk assessment.

It appears that some of the clinical shortcomings in the man's case were as a result of poor record keeping or healthcare staff not fully taking into account or disregarding information about his previous medical history. The clinical reviewer considers, and I agree, that the standard of his care suggests the need for a detailed review of clinical care at Liverpool prison to ensure it is in line with good medical practice.

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.

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**Prisons and Probation Ombudsman**

**February 2014**

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## SUMMARY

1. The man, a 49 year old prisoner at HMP Liverpool, died of lung cancer in a hospice on 29 October 2011. In 2007, he received treatment in the community for cancer in his neck and was still being monitored for this at the time of his remand into custody on 2 December 2009.
2. During 2010 and 2011, the man reported feeling unwell and prison doctors referred him for various investigative medical procedures. However, owing to poor record keeping and clinical management at Liverpool prison, a succession of errors were made in managing referrals and following up tests. This meant there was no firm diagnosis of his condition. On 5 October 2011, he was taken to hospital with a suspected stroke. Scans taken during his admission showed that he had secondary brain tumours and cancer in his lungs. He did not return to the prison before his death.
3. A few weeks before his admission to hospital, the man had been re-categorised to D, the lowest security category, and was waiting for a transfer to an open prison. In seeming contradiction to this, when he went to hospital he was assessed as medium risk and was for some time subject to the highest level of security restraint - double handcuffing to an officer. This was eventually reduced to an escort chain. Despite his incapacity due to his illness, restraints were not removed completely until 18 October, when doctors informed him that he had only a few days to live. His family had complained that day to the National Offender Management Service (NOMS) about the use of restraints.
4. On 19 October, the prison began an application for early release on compassionate grounds but the man died days later before a decision was made. The prison only appointed a family liaison officer to liaise with his family after his death, rather than when he was diagnosed as terminally ill.
5. The medical care the man received in prison fell below the standard he could have expected in the community. Healthcare staff at Liverpool did not adequately investigate or manage his symptoms and the management of his pain relief was haphazard. Healthcare record keeping was poor and might have contributed towards the inadequate responses by doctors who did not take sufficient account of his previous medical history. We have made recommendations about these matters to help ensure that medical practice is consistent with General Medical Council (GMC) guidelines. Recommendations are also made about the use of restraints and family liaison.

## THE INVESTIGATION PROCESS

6. The investigator first visited HMP Liverpool on 11 November 2011. The Deputy Governor and the Head of Safer Custody gave him a full briefing about the circumstances surrounding the man's death. He viewed relevant parts of the prison, including the healthcare centre and the wing where he lived. He also met a representative of the Prison Officers' Association. Notices were issued to staff and prisoners, inviting anyone with relevant information to contact the investigator. One prisoner responded but he had left the prison when the investigator returned to conduct interviews. The prison provided copies of the man's prison and medical records.
7. The local Primary Care Trust (PCT) commissioned a clinical governance advisor to carry out a clinical review. He thoroughly examined the man's clinical care and reviewed his community medical records, his prison medical record and records provided by three hospitals. He also sought specialist advice about aspects of the man's treatment from a consultant ENT/Head & Neck Surgeon. After some initial difficulty requiring the PPO's intervention, the Wrightington, Wigan and Leigh NHS Trust released records to him on 20 April 2012.
8. One of the Ombudsman's family liaison team wrote to the man's family to tell them about the investigation and had a telephone conversation with them on 3 January 2012. His family had a number of issues which they wished us to consider in the investigation including the standard of his medical care in prison, particularly his pain relief given delays in being seen by medical staff, the inaccessibility of staff and the use of restraints in hospital.
9. The delay in issuing this report is regretted. This was partly due to the late receipt of the clinical review which was not received until 4 July 2012 and then further compounded by workload pressures in the office.
10. The man's next of kin were informed the draft report was available, but did not make any comment

## **HMP LIVERPOOL**

11. HMP Liverpool is a local prison serving the courts in the Merseyside catchment area and holds both convicted and unconvicted prisoners on remand. Liverpool holds up to 1184 men in eight accommodation wings. Healthcare is commissioned by Liverpool Primary Care Trust and is provided by Liverpool Community Health Care Trust.
12. The healthcare centre at the prison has a 28 bed in-patient facility. General practitioner and primary care clinics are held in the healthcare centre daily. Prisoners can also see nurses in the wing treatment rooms. A range of nurse-led and specialist clinics are run. An out-of-hours medical service is available from the local community provider. A registered nurse and healthcare worker are on duty in the in-patient unit during the night.
13. Clinical records are managed using the SystemOne computerised patient management system and external hospital appointments are managed by healthcare administrators. Pharmacy services are provided by a local supplier.

## **HM Inspectorate of Prisons**

14. The most recent inspection by HM Inspectorate of Prisons was a full, unannounced follow-up inspection, which took place in December 2011, six weeks after the man's death. The Inspectorate found that healthcare was well managed, with appropriately qualified staff. A wide range of clinics were provided, including a daily weekday general practitioner (GP) session, but there were some problems with prisoners getting to appointments. Pharmacy services were assessed as adequate but some issues of medicines management needed to be addressed.

## **Independent Monitoring Board (IMB)**

15. Each prison in England and Wales has an Independent Monitoring Board, made up of unpaid volunteers from the local community, who help to ensure that prisoners are treated fairly and humanely. In the most recent published IMB report for 2011 the IMB noted that work to implement a healthcare service reviews held in late 2009 and early 2010 was still ongoing. There was now a full time GP but recruitment was underway for two more posts. GP surgeries were now run on wings and prisoners had more access to nurse prescribers than previously.

## **Previous deaths at HMP Liverpool**

16. There were four other deaths at HMP Liverpool in 2011. Two were self-inflicted and the man's was one of two deaths from natural causes, both as a result of lung cancer. There were no recommendations comparable to those surrounding his death, but in one of the cases, the clinical reviewer identified the need for better record keeping. There were a further five deaths in 2012.

## KEY EVENTS

17. The man was born in March 1963. In 2007, he received treatment for cancer in his neck. He was initially remanded into custody on 4 December 2009, to HMP Forest Bank. At the time he was still under the care of his community doctor for the cancer. He was described as a moderate smoker. Prison healthcare staff wrote to his doctor in the community requesting the release of his medical records. (A response was not received until March 2010.) There is no record in either his paper-based or electronic medical notes that he underwent initial health screening on reception at Forest Bank, but he was seen frequently by healthcare staff at clinics for mental health, dental, blood testing and other doctors' appointments. He also attended external hospital appointments as part of his ongoing treatment for cancer.
18. On the morning of 8 February 2010, the man complained to nurses of pain in his throat and neck, for which he was already receiving tramadol (a painkiller). He was referred to the prison doctor. That afternoon he was found to have a large quantity of medication for pain relief and epilepsy. He explained that, contrary to the rules, he had bought the drugs in prison in case his pain worsened. A nurse explained the therapeutic dosage and warned him of the dangers of exceeding it. One of the prison doctors saw him the following day. They discussed switching to morphine-based pain relief, which he declined. It was planned to review the situation weekly.
19. Four days later, on 12 February, the man told a nurse that he had a strange feeling in his throat. She noted there was a definite change in the sound of his voice and that he was concerned. He saw a doctor for a medication review three days later and discussed his concerns. The doctor recorded that he would wait for the results of an appointment with a vascular surgeon and for a colonoscopy.
20. At the beginning of March, the man expressed a concern about a lump in his neck and questioned whether he would be able to get a follow up appointment at hospital. One of the healthcare administrators discovered that his care had been transferred to a consultant otolaryngologist (also known as ENT) at hospital and that he had to be re-referred as previous appointments arranged before his imprisonment had lapsed. The referral was made two weeks later.
21. In response to the request by reception staff the previous December, the man's community doctor wrote on 17 March, outlining his diagnosis and treatment of the metastatic cancer (a secondary cancer remote from the site of the primary cancer) on the left side of his neck. The site of the primary cancer was unknown and remained so. The letter said that he had been due for a follow up in June 2009, but there was no further correspondence from the ear nose and throat (ENT) clinic in his medical records.
22. In March 2010, a locum GP mistakenly recorded that the man had thyroid cancer and this error recurs throughout his records until his death. On 14 April, a letter from the consultant states "He still has no evidence of any primary on examination today and the lump that he was point out (sic) is a prominent

carotid artery. I have, therefore, simply reassured him and I will review him again in 12 months time”.

23. On 1 June 2010, the man transferred to HMP Liverpool for court appearances and had an initial health screening. A consultant vascular surgeon at hospital wrote on 16 June that a carotid artery scan showed no evidence of disease and concluded that he could be reassured by that outcome.
24. The man underwent a secondary health screen at Liverpool on 24 June, where he disclosed previous mental health and alcohol issues and said that he had outstanding hospital appointments. Healthcare administration staff checked this with the relevant hospitals, who said that there were no appointments pending. He was sentenced to five years imprisonment on 6 July 2010.
25. The man told a doctor on 26 August, that he had a headache, insomnia, pain around his ribs and other non-specific pains. He also said he had previously had cancer in his throat for which he had undergone radiotherapy but had had no follow up. The doctor prescribed Nytol to aid his sleep.
26. Following a request by a wing nurse on 13 September, a nurse manager examined a lump on the right side of the man’s neck as he was anxious because of his history of cancer. She diagnosed lymph node enlargement. (The lymphatic system is a network of vessels that transport tissue fluids to the bloodstream.) He also reported upper respiratory symptoms. She tried to reassure him but, because of his medical history, arranged for a full blood count test. Two days later, on 15 September, a prison doctor again examined him and diagnosed inflammation of the lymph nodes. On 6 October, the doctor noted that the outcome of a blood test requested on 22 September was abnormal, but this was attributed to an abscess under a tooth. He reported pain around his ribs, which was considered to be a soft tissue injury following a fight six months earlier.
27. On 13 October, a doctor wrote in the man’s medical record “Clinical Information – Haemoptysis” (coughing up blood) but the context of the note is unclear. The clinical reviewer wrote that ‘haemoptysis’ was on a laboratory report and concluded that the hospital laboratory had received a sputum sample from the prison, citing haemoptysis as the reason for analysis of the sample. His medical record does not provide any information as to who sent the sample or any clinical details relating to the haemoptysis. The laboratory report concluded there was no infection. The doctor recorded the report as normal with no further action required and informed him of the outcome.
28. On 19 October, the doctor told a nurse that he had been coughing up blood for two weeks and she referred him to a doctor for review. A doctor made an entry on his SystmOne file on 21 October “Mirtazapine 45mg Tablets – 28 tablets-PM 1.0 tablets”. Mirtazapine is an antidepressant. There is no evidence of a review of his symptoms of coughing up blood. Two weeks later, he reported a sore throat due to lack of saliva, for which he was prescribed artificial saliva. On 17 November, the doctor noted that although he was much better with the saliva replacement, he was still in pain. Her notes also indicate, “malignant

tumour of thyroid had surgery and radiotherapy”. Two unexplained entries follow, “Malignant tumour of oropharynx (Ongoing Episode)” and “Malignant tumour of thyroid gland”.

29. A letter received on 22 November, from a consultant of the Directorate of Oral Surgery, invited the man for a pre-operative assessment on 9 December, and an operation on 20 December. There is no indication in either the letter or notes as to the nature of the surgery although there are some references to dental procedures around that time.
30. On 7 December, a doctor re-referred the man to a consultant ear, nose and throat (ENT) surgeon for dysphagia (difficulty swallowing) and the hospital pain clinic. On 14 December, another doctor at Liverpool undertook a series of tests including renal, liver function and blood tests. The renal and liver function tests indicated that no further action was needed except to repeat the tests after a short period. The blood tests indicated the possibility of hyperthyroidism (an overactive thyroid) and anaemia.
31. A doctor noted on 11 January 2011, that the man was generally unwell. His voice sounded coarser and he complained of night sweats. As he was to be seen by an ENT consultant the following day at hospital, she planned to review him after that appointment. The day after the consultation, the consultant wrote that he had undergone radical surgery in 2007, on metastatic nodes (lymph nodes that have cancer originating elsewhere in the body) in his neck and that he still had no identifiable primary cancer and no sign of recurrence of his cancer.
32. On 18 January, a doctor faxed an urgent referral to a consultant oncologist at hospital for suspected head and neck cancer. The following day, the consultant responded indicating that the man had been discharged from his care and suggesting that if his pain persisted he should be assessed by an ENT surgeon. The consultant also pointed out that he did not accept referrals from primary care sources. It does not appear that a referral elsewhere was made.
33. At an appointment on 29 March, a doctor noted that the man wanted “adequate pain management for throat cancer post-radiotherapy” and was prescribed co-codamol three times daily. He also noted that he was suffering from dysphonia (impairment in the production of voice sounds). On 5 April, he complained of a cough and was noted to have a slight wheeze. This was diagnosed as a chest infection. On 3 June, he was again treated for a chest infection and a wheeze was noted. His cough was said to aggravate his other symptoms and he had breathing difficulties.
34. Just after midnight on the morning of 9 June, the man reported to a nurse that he had right sided abdominal pain under his ribs. The nurse advised him to take fluids in case he had a kidney infection and noted that he should be reviewed in the morning. A doctor examined him the next day and, although he could feel nothing amiss, made a tentative diagnosis of possible liver metastases (cancerous tumors that have spread to the liver from a cancer

somewhere else in the body). The doctor referred him for an urgent liver ultrasound scan and prescribed a 5ml dose of oramorph (liquid morphine) nightly for breakthrough pain. He was already taking co-codamol and tramadol regularly.

35. On 14 June, a doctor noted in the SystmOne record, in capital letters, that the man's oramorph prescription, specifically prescribed to be taken at night to ease breakthrough pain, had been altered to administration "PM". There were no notes to explain why and with whom that change had been discussed. He also recorded that he needed clarification about the gabapentin medication, which he was allowed to keep in his cell and he planned to discuss this with managers. There is no record of the outcome.
36. The man had a CT scan on 20 June. His discharge letter indicated that a follow-up appointment at the prison was necessary but there is no evidence that this took place.
37. Following his previous of 14 June, a doctor again noted on 21 July, that the man was still not getting an evening dose of oramorph. He instructed the nursing management team to liaise with night shift nurses about issuing the drug at the appropriate time. They then confirmed that they gave the medication at 10.00pm each night but there is no record of the issue of a controlled drug in his medical record. He also complained of increasing breathlessness. The clinical reviewer noted that the doctor had found an abnormality in his jugular venous pressure (JVP), which is at odds with the SystmOne note, "O/E - JVP Nil abnormal on examination". The doctor also found his air intake was reduced and that he was anaemic. He instructed that if there was any change in his breathing, an emergency ambulance should be called and requested a chest X-ray.
38. The man was re-categorised to category D (the lowest security category) on 28 July and he was recommended for transfer to HMP Kirkham, an open prison in Lancashire.
39. On 9 August, results from the man's CT scan and X-ray (taken six days earlier) were received. The CT scan of his abdomen was normal. It also showed part of his lower chest and, although inconclusive, indicated a possible recurrence of lung cancer. (There had been no previous reference to him having lung cancer so we assume this meant a recurrence of his cancer but this time in his lung.) The specialist's report recommended a full CT scan of his chest. The X-rays indicated the possibility of a lump in his chest and a follow-up X-ray was arranged for two weeks later, after the completion of his course of antibiotics. The doctor referred him to an oncologist at the hospital.
40. When advised of the scan results, the man became anxious as he felt that his symptoms were similar to those he had experienced during his previous cancer. To reduce his anxiety, propranolol was initially prescribed, but then stopped because of its side effects.

41. On 9 September, a doctor reviewed the man and found that his shortness of breath had not improved since taking the antibiotics. He was anxious to see an oncologist for a definitive diagnosis. On the same day, the consultant oncologist again rejected the referral to another hospital as inappropriate, and suggested referral to a local hospital.
42. When he saw a doctor on 13 September, the man declined referral to a Liverpool hospital. He asked to be referred to an ENT consultant at another hospital, despite advice from the doctor that this might delay treatment of a serious condition. The referral was made the following day. (A consultant ENT/Head and Neck surgeon replied a week later to say that the ENT Consultant no longer worked at the hospital and that the referral was inappropriate as it was a chest problem.) On 19 September, a healthcare administrator sent an ENT referral by post and fax to a hospital. The hospital advised that the referral should be re-directed to the Chest Department instead and this was done.
43. On 22 September, a doctor made a referral under the “two week rule” to the local chest clinic. (Under NHS guidelines, patients with suspected cancer have a right to be seen by a specialist within two weeks.) The appointment was subsequently made for 5 October. A Lead Clinician and Consultant ENT/Head and Neck Surgeon, consulted by the clinical reviewer, observed that “potential recurrent disease does not count under the Department of Health Guidelines for urgent referral and does not count as a two week rule referral”.
44. On 4 October, the prison completed an escort security risk assessment for the hospital appointment the following day. It was recorded on the risk assessment form that the man was an enhanced prisoner under the Incentives and Earned Privileges scheme which rewards good behaviour; that he had no negative entries in his case notes and had been subject to only one disciplinary matter. In addition, he had no history of hostage taking or gang connections. Security markers for violence, firearms and firearms were recorded, based on his original offences. He was assessed as a medium risk on all aspects of the form but no justification was given for the level of risk.
45. There was no input from healthcare about how his condition might affect his risk. Healthcare staff indicated that there were no medical objections to the use of restraints and that a single cuff or escort chain could be used during the appointment, but that they might have to be removed during treatment. The prison decided that he should be escorted by two officers and double handcuffed, with use of an escort chain during treatment.
46. The Head of Operations authorised the risk assessment and referred to the man as a category C prisoner. This appears to have been an error as the remainder of the document shows his status as category D. However, it is unclear whether the category C annotation had any bearing on the decision as to the level of security and it is not explained why a category D prisoner should have required such a high level of security.

47. On 5 October, the man was too unwell to attend his hospital appointment and his symptoms suggested a stroke. He was taken to hospital by emergency ambulance, where he was admitted for further tests. The risk assessment prepared the previous day for the hospital appointment was used for this unexpected journey but was reviewed to take into account the change in circumstances. It was recorded on the revised assessment that he was of a violent nature but there was no potential to escape. There was no indication as to what restraints were used during the journey to hospital but staff were instructed to apply handcuffs at the earliest opportunity (presumably after treatment).
48. At hospital, the man's condition deteriorated quickly. On 7 October, his consultant believed that he would die within one week, and asked for the restraints to be removed to allow him to do so with dignity. A prison manager visited the hospital that day and observed that he looked "old and frail", was coughing up blood and could "just about" get to the toilet. The prison's Head of Operations authorised the removal later that day. The consultant informed him of his condition and the escort officers observed that he was visibly upset.
49. Prison staff then started the process of release on temporary licence (RoTL) to hospital. The probation office responsible for the man approved the request the same day but no response appears to have been received from the police. This does not appear to have been followed up.
50. At 3.45pm on 8 October, the man's condition was re-assessed. Ward staff thought he would return to prison in the near future. He was more mobile and his capacity to escape was assessed as higher than previously thought. The duty governor authorised the re-application of an escort chain that day and the Head of Operations reviewed and endorsed the decision on Monday 10 October. On the same day, a CT scan showed that he had secondary brain tumours and a magnetic resonance imaging (MRI) scan showed that he probably had further cancer in his chest. A doctor discussed his prognosis with him the following day and the escort log described it as not very good.
51. On 17 October, a hospital palliative care nurse informed escort staff that the man's cancers were now developing quickly and he might die within the following few days. He had also developed pneumonia.
52. The following morning, a family member telephoned the Briefing and Casework Unit at the National Offender Management Service (NOMS) to express concern that the man was still handcuffed but he was not in any condition to escape and was also a category D prisoner. The complaint was referred immediately to Liverpool prison and the Head of Operations contacted the family to discuss it with them.
53. That day, (18 October), a doctor also told the man he probably only had a few days to live and, a short time later, his family were informed. Hospital staff placed him on the end of life care pathway. This aims to ensure that the end of a person's life is in line with their wishes and as comfortable and pain free as is possible. He was fitted with a syringe driver (an electronic device that delivers

a constant regulated supply of pain relief medication to the patient). At 4.30pm, the Head of Operations, visited with the prison nurse manager to reassess his condition. The nurse manager concluded that his condition considerably reduced his risk of escape. They agreed to the removal of the restraints and they were not used again.

54. The man remained in hospital until 20 October, when he transferred to a hospice, a specialist palliative care in-patient facility at the hospital. He saw his solicitor to put his affairs in order and his family visited daily. On 19 October, the day before his transfer, the prison began an application for release on compassionate grounds. They requested, by fax, a medical condition report from the consultant at the hospital in charge of him.
55. On 24 October, the consultant's secretary informed a prison healthcare administrator that the consultant was no longer the man's doctor. Further urgent requests for a report were sent to several doctors who were thought to be responsible for his care and on 26 October, a Clinical Lead Consultant in Palliative Medicine sent a report. On 27 October, a doctor completed the medical condition report and sent it for inclusion in the compassionate release application. When the man died the application had still not been submitted.
56. Prison staff told the investigator that for the last few days before the man died, escort staff wore normal clothing rather than prison uniform and remained outside his room.
57. A few days later the man was heavily sedated and close to death. Members of his family had been at his bedside since the early hours. He died at 9.33am and one of the escort officers informed the prison.
58. The duty governor, who was also acted as the family liaison officer, and a member of the Chaplaincy team, went to the hospice at about midday. The duty governor extended condolences to the man's family and explained his role. The family said they were concerned about the medical treatment he had received at Liverpool and that they would be seeking answers. The duty governor maintained contact with the family and subsequently arranged the return of his remaining property and money.
59. On his return to the prison, the duty governor informed the man's friends and fellow prisoners of his death. Notices to staff and prisoners were also published. He offered the escort officers the support of the prison care team (trained staff who support their colleagues through difficult events).
60. The Governor sent a letter of condolence to the man's family on 3 November. His funeral took place on 8 November. The duty governor attended on behalf of HMP Liverpool and the prison made a contribution towards the costs.

## ISSUES

### Clinical care

#### *Record keeping*

61. No medical records are available from the man's reception at Forest Bank on 4 December 2009, until SystmOne computerised recording begins on 2 February 2010. It is therefore unclear whether he received an initial health screen on reception or any early medical care. There is a very brief note with no detail, that he had cancer of the neck in 2008. The letter of 17 March 2010, from his community doctor outlining the diagnosis of cancer, the treatment given and the dates of his last appointment and prescription were not summarised on his clinical records. From March 2010 onwards until he transferred to HMP Liverpool on 1 June 2010, recording of his interactions with medical staff, treatments and outcomes were of an acceptable standard.
62. Throughout the man's time at Liverpool, the records kept by medical staff were inadequate. The clinical reviewer wrote "In my opinion the medical records kept by the staff at HMP Liverpool are insufficient and of poor quality". Important information was not recorded on his SystmOne patient record during his time in hospital and at the hospice. Although entries show that there were no changes to his condition and he remained comfortable, there is no record of his supervising doctor, important medical developments or significant events during that time. Examples are:
- His consultant told him about the seriousness of his condition and the likely outcome on 7 October.
  - On 10 October, he was informed that secondary cancers had been discovered in his brain.
  - He was placed on the end of life care pathway on 18 October.

The first two examples are recorded in escort logs and the third was recorded on a risk assessment. None were recorded in his medical record.

63. The clinical reviewer recommends that, in line with the General Medical Services (GMS) contract for general practices, there should be:

*"Development and Implementation of a Health records Summary Protocol.*

*The medical records of prisoners should follow the prisoner. The physical record ought to be kept at the institution and the content summarised into the prisoner's medical records at HMP. Medical records should be summarised and entered onto the Prison healthcare system within 8 weeks of receipt."*

64. The GMC Good Medical Practice standards on record keeping require that practitioners must:

- keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, the information given to patients, and any drugs prescribed or other investigation or treatment;
- make records at the same time as the events you are recording or as soon as possible afterwards.

We believe that the healthcare department should keep abreast of and record important developments in a prisoner's condition while they are in hospital. We support the view of the clinical reviewer that the records were insufficient and of poor quality and make the following recommendations:

**The Head of Healthcare should ensure that when prisoners are admitted to hospital, staff regularly obtain and record information about their condition and treatment.**

**The Head of Healthcare should ensure that healthcare staff comply with the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council.**

### ***Diagnosis of the man's condition***

65. The clinical reviewer's view of the medical treatment the man received at HMP Liverpool is unequivocal:

“In my opinion there has been repeated failure of medical staff working at HMP Liverpool to follow up serious symptoms and physical examination findings. This might partially be the result of doctors not taking previous medical record entries into account or ignoring them when they dealt with him. The lack of in-depth history taking and proper thorough physical examinations documented in the records could be either the result of poor medical management or poor record keeping.”

66. The clinical reviewer identified that medical staff did not follow up key events after the man's reception at Liverpool. In particular, he highlights that his haemoptysis (coughing up blood), which can be a symptom of lung cancer, was not referred under the “two week rule” for potential cancers which requires patients to be seen at that time; his wheezing (another condition associated with lung cancer) was not appropriately investigated; and his subsequent difficulties in breathing did not receive the appropriate medical management. Thus:

- He reported rib cage pain on 6 October 2010; on 13 October a sputum sample was returned indicating he had no infection; and, on 19 October, he reported coughing up blood for the previous two weeks and was referred to a doctor for review. An anti-depressant was prescribed but there is no evidence of a review of his coughing up blood. Yet these symptoms together suggested that he was suffering from a serious lung

disease which, according to Department of Health guidelines, should have been urgently referred for further tests.

- On 5 April 2011, he was found to have developed wheezing which can be associated with lung cancer yet this was not further investigated. Neither was a new onset of shortness of breath and reduced chest expansion on 10 May, which the clinical reviewer considers, in line with good medical practice should have been urgently investigated or referred to a lung physician. On 3 June 2011, he was diagnosed with a chest infection, yet there is no evidence from the record to support the diagnosis or that the doctor examined him. The clinical reviewer considers that it is more likely that he was displaying symptoms of lung cancer.
- On 9 June 2011, he suffered upper abdomen pain and the doctor considered this was the result of a possible spread of cancer cells to the liver. An urgent liver ultrasound scan was planned yet there is no indication this was done despite this serious diagnosis. On 21 July 2011, the doctor noted increasing breathlessness, reduced air entry and abnormal pressure in the veins leading to the heart, which can be caused by lung cancer. An X –ray should have been indicated for that day but one was not carried out until 3 August. Although the results were written up that day they were not scanned into his records until six days later. Despite the X-ray indicating a mass lesion, which the clinical reviewer states should have been viewed as cancer unless proven otherwise, it took until 13 September, for further action to be taken and there was still no urgent referral to a chest physician.

67. The clinical reviewer states:

“In my opinion there were a series of significant omission of the medical staff at HMP to not pursue the causes of those symptoms and therefore failed to provide good medical practice [GMC Good Medical Practice 2006, RCGP (2008) Good medical practice for general practitioners].”

“...From the medical records, I am not able to state with certainty when at the earliest time his lung cancer could have been diagnosed. However, in my opinion his poor medical management contributed to his early demise.”

68. The clinical reviewer concludes that the standard of medical care provided to the man at HMP Liverpool was below the standard expected for general practice as set in GMC good practice guidelines. He makes detailed recommendations which the prison and healthcare commissioner and provider will need to consider. We make the following recommendation based on the clinical reviewer and consultant’s conclusions.

**Liverpool PCT should commission a detailed review of clinical care at Liverpool prison, taking account of the clinical reviewer’s findings, and ensure that the provision of healthcare is in line with the GMC Good Medical Practice guidance.**

## ***Pain Management***

69. The clinical reviewer was also critical of the management of the man's pain. The medical records show that on numerous occasions, his pain management was insufficient. Among other deficiencies, he notes that on occasions such as 3 October when the man was suffering from neck pain there was no evidence of a detailed pain history, or of discussion of pain relief options or of recorded physical examination. He indicates that in February 2011, the records show that he ran out of painkillers and that a change of pain relief in April 2011 seemed to be of little benefit to him. The clinical reviewer states:

“In my opinion his pain relief showed little evidence of cohesive and sufficient management. This might have arisen as a result of poor record keeping but could also be the result of a careless attitude of the doctors involved.

“In summary the poor record keeping on behalf of the doctors does not allow any judgement on where the pain was when he complained about his pain, what type of pain he experienced, triggers and progression of the pain and the effect of pain killers. His medical record has no documentation of an assessment of his pain status nor any physical examination regarding his symptoms. Previous entries seemed not to have been taken into account when the patient was seen.”

We make the following recommendation:

**The Head of Healthcare should ensure that prisoners with advanced and progressive disease receive safe and effective pain relief in line with NICE guidelines.**

## ***Contact with health professionals***

70. In addition to concern about the man's treatment and pain relief, his family believed that he had cancer for two years and that for a long period he was not seen by medical staff in spite of repeated requests. Apart from the initial period when he first arrived at Forest Bank, which we cannot check because the records are missing, the subsequent medical records do not show a gap in the interactions between him and prison medical staff. His family also queried why prison officers, rather than medical staff, had found him unwell on 5 October. He lived on a normal residential wing staffed by prison officers. When staff found him, they immediately called for medical attention and a nurse examined him before he went to hospital.
71. The consultant, who provided a specialist report for the clinical reviewer, found significant gaps in the secondary care services follow up of the man's head and neck cancer. This issue is outside our remit but the health authorities will no doubt wish to consider.

## **Early release on compassionate grounds**

72. On 19 October, while the man was still in hospital, prison staff at Liverpool began the application process for early release on compassionate grounds. Reports were requested from various departments at the prison, including a medical condition report from the doctor in charge of his care. They wrote to several hospital doctors, without success, as they did not identify correctly the hospital doctor in charge of his care. Finally, on 26 October, a doctor at the hospice provided a report. Sadly, he died before the application was submitted for consideration.
73. The healthcare administrators at HMP Liverpool made appropriate efforts to secure a medical condition report from the doctor in charge of the man in his final days. Their efforts were frustrated by the failure to identify the correct doctor. He had moved from the main hospital to a hospice, and this might account for some of the delay. However, the hospice is on the same site as the hospital so there should have been minimal delay in identifying the correct doctor. Better record keeping and liaison by healthcare professionals would have assisted administrators to approach the right hospital doctor. A recommendation about record keeping has been made above.

## **Risk assessments and use of restraints**

74. 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 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.
75. The man was a category D prisoner who had been recommended for transfer to an open prison. He had enhanced status under the incentives scheme. However, on 5 October, when he was taken by emergency ambulance to hospital, the risk assessment concluded that he was medium risk and needed to be escorted by two officers and be subject to double cuffs. The risk assessment had been prepared for an appointment as an outpatient but it was reviewed once it became clear that he was to be admitted. Staff were instructed to apply double handcuffs as soon as possible.
76. The restraints were removed two days later, on 7 October, when it was thought that the man would die within a week and a prison manager observed that he

had poor mobility and looked old and frail. The following day, escort staff re-applied an escort chain as he could walk to the toilet unaided and information from the hospital nurses indicated that his condition was not as poor as previously thought. Staff noted on the review of hospital assessment form that he had “not attempted to escape but clearly capacity to escape is higher than previously written”. This seems at odds with the security information attached to the risk assessment on 5 October, which said there was no escape potential.

77. The man remained in restraints for a further ten days until 18 October, when he was told that his life expectancy was a just a few days. The prison agreed to remove the restraints and they were not used again. On the same day, his family made a complaint about the use of restraints.
78. It is hard to see how the risk assessment reached the conclusion that restraints were necessary for a man in the man’s state of health and who was a category D prisoner and thus judged to be low risk of escape and harm to the public. It is a particular concern that the assessment reached the conclusion that double cuffs were necessary. 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 the Prison Service requires that reasons should be recorded in writing. (The guidance does not envisage circumstances when double cuffs would be used for a category D prisoner.) There is no evidence to support the decision to use double cuffs and we can see no reason how it could be justified. In view of his security category, enhanced status and state of health, we consider there were no grounds to use restraints at any stage.

**The Governor should ensure that risk assessments are based on accurate information, consistent with the prisoner’s security category and medical condition and are fully documented.**

### **Family liaison**

79. The man’s family said that they had been unable to speak to a manager at the prison about his health and his treatment before he went into the hospice, but after he was told he was dying and moved to the hospice, prison staff became more accessible. Prison Service Instruction 64/2011 gives guidance on the support that should be offered to the families of terminally ill prisoners. The guidance states that “Prisons must ensure that arrangements are in place for an appropriate member of staff to engage with the next of kin or a nominated person of prisoners who are either terminally or seriously ill”.
80. A family liaison officer was not appointed until after the man’s death. Accordingly, we make the following recommendation:

**The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to act as a point of contact and support.**

## CONCLUSION

81. The man went into prison with a history of cancer, which had been treated and subsequently monitored before he went into prison. No medical records were available for the first two months of his stay at HMP Forest Bank so it is unclear whether any substantive medical care was given during that time.
82. The man transferred to HMP Liverpool and, soon after his reception, he began to experience serious symptoms. Clinicians repeatedly failed to follow up the causes of the symptoms adequately and did not seem to recognise them as potential indicators of lung cancer. In addition, his pain relief was not managed well. These deficiencies might have been a result of poor record keeping, which fell below that expected of medical professionals, or doctors not taking into account previous medical record entries when dealing with him.
83. We conclude that the medical care given to the man at HMP Liverpool was below the standard he could have expected in the community and recommend a review of clinical management at Liverpool. In addition, the risk assessment completed before he went into hospital was not fully evidenced. We consider that the level of restraint was excessive in view of his security category and prognosis.

## **RECOMMENDATIONS**

1. The Head of Healthcare should ensure that when prisoners are admitted to hospital, staff regularly obtain and record information about their condition and treatment.
2. The Head of Healthcare should ensure that healthcare staff comply with the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council.
3. The PCT should commission a detailed review of clinical care at Liverpool prison, taking account of the clinical reviewer's findings, and ensure that the provision of healthcare is in line with the GMC Good Medical Practice guidance.
4. The Head of Healthcare should ensure that prisoners with advanced and progressive disease receive safe and effective pain relief in line with NICE guidelines.
5. The Governor should ensure that risk assessments are based on accurate information, consistent with the prisoner's security category and medical condition and are fully documented.
6. The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to act as a point of contact and support.

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that when prisoners are admitted to hospital, staff regularly obtain and record information about their condition and treatment.	Accepted	On admission to healthcare all patients to have comprehensive clinical nursing care plan. Care plan will be updated on a daily basis and subject to quality checks by senior managers.	Immediate  Completed	
2	The Head of Healthcare should ensure that healthcare staff comply with the standards of record keeping specified by the General Medical Council and Nursing and Midwifery Council.	Accepted	All medical records are subjected to regular clinical audit and quality assurance processes. All nursing staff to be issued with a copy of nursing midwifery council guidance on record keeping.	March 2013	
3	Liverpool PCT should commission a detailed review of clinical care at Liverpool prison, taking account of the clinical reviewer's findings, and ensure that the provision of healthcare is in line with the GMC Good Medical Practice guidance.	Accepted	Offender health services lead to discuss with PCT commissioners as to the viability of a review.	March 2013	
4	The Head of Healthcare should ensure that prisoners with advanced and progressive disease receive safe and effective pain relief in line with NICE guidelines.	Accepted	Offender health leads GP to review current practices and liaise with Liverpool community health medicines management committee.	March 2013	
5	The Governor should	Accepted	All available information is taken into account	Immediate	

	ensure that risk assessments are based on accurate information, consistent with the prisoner's security category and medical condition and are fully documented.		and considered when making the appropriate decisions in relation to escorts and extended stays in outside hospital. Where cases become protracted or are of an end of life nature the enhanced case review meeting held weekly and chaired by the deputy governor will ensure assessments are informed and appropriate in respect of the prisoners medical needs and security.	Completed	
6	The Governor should ensure that when a prisoner is diagnosed with a terminal illness a family liaison officer is appointed to act as a point of contact and support.	Accepted	When a prisoner is diagnosed with a serious life threatening illness or is facing an end of life medical situation a family liaison officer will be deployed and make contact with the family at the very earliest time.	Immediate Complete	