Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Stephen Woods a prisoner at HMP Liverpool on 29 April 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Stephen Woods died on 29 April 2016 of cancer of the oesophagus while a prisoner at HMP Liverpool. He was 51 years old. I offer my condolences to Mr Woods' family and friends.

Overall, I am not satisfied that Mr Woods received a standard of care in prison that was equivalent to that he could have expected to receive in the community. In particular, following Mr Woods' cancer diagnosis, healthcare staff did not implement a palliative care plan for several weeks and only after his condition had already deteriorated. I am also concerned that is clear that his pain was not effectively managed.

I am also concerned that the use of restraints when Mr Woods was taken to hospital was not always justified by fully considered risk assessments, which took into account his poor health. Furthermore, family liaison was deficient and Liverpool did not properly consider Mr Woods' application for compassionate release.

It is very disappointing that I have previously had to raise concerns over Liverpool's inappropriate use of restraints and failure to appoint a family liaison officer promptly. The governor needs to address these matters as a priority.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2016**

Contents

Summary

Events

1. Mr Stephen Woods had been at HMP Liverpool since December 2014. He was a cigarette smoker and had declined help to stop. Mr Woods took medication to help lower his cholesterol.

2. On 16 January 2016, Mr Woods complained to a prison GP of difficulty in swallowing, weight loss and a dull pain in the right side of his chest. The prison GP made an urgent referral to a gastroenterologist.

3. On 1 February, investigations revealed Mr Woods was suffering from a cancerous tumour on his oesophagus and the hospital arranged an urgent CT scan to see if it had spread further. The prison cancelled the CT appointment because no escort staff were available. A CT scan on 19 February revealed the cancer had spread to Mr Woods' liver.

4. On 25 February, hospital doctors concluded that Mr Woods' condition was not curable and he should be treated palliatively. Healthcare staff created a care plan to manage his pain relief but Mr Woods, who wanted to remain on the wing rather than be admitted to healthcare, did not always receive his medication on time.

5. On 19 April, nurses implemented a palliative care plan. However, this was several weeks after his diagnosis and Mr Woods' condition had already deteriorated.

6. On 21 April, a prison GP sent Mr Woods to hospital because he was dehydrated. Two officers escorted him and used double handcuffs to restrain him for the journey and an escort chain after he was admitted. Mr Woods' condition continued to deteriorate and officers removed the restraints on 28 April. Mr Woods died in hospital on 29 April. His family were with him.

Findings

7. The investigation found that Mr Woods did not receive a standard of care equivalent to what he would have expected to receive in the community. Following his cancer diagnosis, healthcare staff did not implement a palliative care plan for several weeks, after his condition had already deteriorated. We are also concerned that Mr Woods did not always receive his pain relief medication on time which meant he was often in pain. It is not acceptable that the prison cancelled an appointment for an urgent CT scan because there were no staff available to escort Mr Woods.

8. We are concerned that prison managers decided to restrain Mr Woods when he went to hospital on 21 April, despite him being very unwell. He continued to be restrained even as he was receiving intravenous treatment. Prison managers did not review the use of restraints and only authorised their removal the day before he died. We do not consider that the decisions to restrain Mr Woods was based on fully considered risk assessments, which took full account of Mr Woods' poor health and how it affected his risk of escape.

9. We are also concerned that the prison did not consider Mr Woods' application for early release on compassionate grounds despite several letters from his family and his solicitor. We consider that the earlier appointment of a family liaison officer or other suitable member of staff would have provided Mr Woods and his family with a single point of contact and additional support.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners do not miss important hospital appointments unless there are properly justified, exceptional and fully recorded reasons.
- The Head of Healthcare should ensure that an effective palliative care plan is implemented in a timely way for all prisoners who are terminally ill which ensures access to appropriate levels of pain relief at all times.
- The Governor and Head of Healthcare should ensure that 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.
- The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support the families of seriously ill prisoners.
- The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Woods' prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Woods' clinical care at the prison.

13. We informed HM Coroner for Merseyside-Liverpool District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Woods' sister to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Woods' sister asked why the prison did not consider Mr Woods' application for early release on compassionate grounds. She was also concerned about the lack of communication between the family and the prison. Mr Woods' sister also asked why he was restrained in hospital and they were only removed the day before he died.

15. The investigation has assessed the main issues involved in Mr Woods' care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

16. Mr Woods' sister received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

17. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Liverpool

18. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. Lancashire Care NHS Foundation Trust provides all healthcare services. There is 24-hour inpatient care.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Liverpool was in May 2015. Inspectors reported that the new healthcare provider had inherited a failing service. They found the prison and the healthcare provider were working effectively to address the deficiencies. Waiting times for most primary care services, including the GP, were too long and the management of lifelong conditions needed to improve. Inspectors found that prisoners with palliative care needs were identified and discussed at a weekly enhanced care review meeting, but this was not reflected in clinical records or effective care planning.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2015, the IMB reported that Lancashire Care had been successful in securing the prison healthcare contract after Liverpool Community Health NHS Trust had been served notice on its contract. Lancashire Care had implemented many changes and redesigned the service to meet the needs of the health needs assessment and the service specification commissioned by NHS England.

Previous deaths at HMP Liverpool

21. Mr Woods was the seventh person to die from natural causes at Liverpool since January 2014. Two people have died since. We have raised the issue of earlier appointment of a family liaison officer before. We have also raised the issue of inadequately justified use of restraints on two occasions before.

Findings

The diagnosis of Mr Woods' terminal illness and informing him of his condition

22. On 12 December 2014, Mr Stephen Woods was remanded to HMP Liverpool charged with sexual offences. On 23 January 2015, he received a thirteen year prison sentence and returned to Liverpool.

23. Mr Woods was a cigarette smoker and declined help to stop. On 17 December, Mr Woods refused a detailed assessment of his physical and mental health by a prison GP. Healthcare staff requested his medical history from his community GP which showed he suffered with high cholesterol for which he took medication. Prison GPs re-prescribed his medication. Over the next year, Mr Woods received his medication as prescribed, saw the dentist on several occasions and underwent mental health screening. There is nothing else of significance in the records.

24. On 16 January 2016, a prison GP saw Mr Woods, who complained of pain and discomfort when eating, difficulty swallowing and a dull pain on the right side of his chest. Mr Woods told him he had lost weight over the past month, which was not intentional. The GP made an urgent referral to a gastroenterologist under the NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks.

25. On 1 February, Mr Woods went to hospital for a gastroscopy (a thin tube is used to look inside the oesophagus, stomach and small intestine). The results revealed a cancerous tumour on Mr Woods' oesophagus. Hospital doctors explained Mr Woods' condition to him and said they would arrange an urgent CT scan to establish the size of the tumour and to see if it had spread to other parts of Mr Woods' body.

26. The hospital arranged the CT scan for 7 February. However, because it was a Sunday the prison did not have any officers available to escort him so cancelled the appointment. The hospital rescheduled the appointment for 19 February.

27. On 19 February, Mr Woods had a CT scan of his thorax and abdomen. The results revealed that the cancer had spread to his liver. Hospital doctors discussed the results with Mr Woods the same day.

28. We are satisfied that prison GPs appropriately referred Mr Woods to investigate his symptoms. However, we are concerned that Mr Woods missed the urgent CT scan on 7 February, due to a lack of staff availability.

29. Prison Service Order 3050, Continuity of Healthcare for Prisoners, states that prisons must ensure that local systems are in place to give appropriate priority to urgent cancer referrals and other clinically urgent appointments. A prison manager told us that limited staff were on duty during the weekend, which meant non-emergency hospital escorts could not always take place. We are concerned that it was not recognised that the CT scan was urgent and it was twelve days later before the appointment took place. The clinical reviewer commented that, while this did not affect the outcome for Mr Woods, it was highly likely that the

delay caused him additional anxiety and worry. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners do not miss important hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

Mr Woods' clinical care

30. On 25 February, a consultant gastroenterologist told Mr Woods his condition was not suitable for active treatment and he would be treated palliatively, which could include chemotherapy treatment to manage his symptoms. The consultant referred him to a consultant oncologist and noted that Mr Woods was concerned he was not receiving regular pain relief at Liverpool.

31. On 28 February, nurses created a care plan to manage Mr Woods' medication. The care plan said nurses should take Mr Woods' medication to his cell if he was unable to collect it and monitor his pain score. Records show that although he usually received his pain medication it was often late and his pain was not well controlled.

32. On 29 February, a hospital palliative care nurse contacted a prison practice manager to discuss Mr Woods' concerns that he had not received his pain relief. The practice manager said nurses would closely monitor Mr Woods' pain relief.

33. On 1 March, a prison nurse saw Mr Woods in his cell to discuss his pain relief medication. Mr Woods said his pain was not controlled and the nurse referred him to a prison GP. The GP reviewed and increased Mr Woods' dose of oromorph (liquid morphine).

34. Prison GPs regularly reviewed Mr Woods' pain relief medication and a prison dietician prescribed him nutritional drinks.

35. On 22 March, Mr Woods refused to attend an appointment with a consultant oncologist because he felt unwell. The same day, he told a prison GP he was unsure if he wanted to receive chemotherapy treatment. She noted that Mr Woods' condition had deteriorated and nurses had created but not implemented a draft palliative care plan to plan the practical aspects of his care.

36. On 31 March, a hospital palliative care nurse contacted healthcare and said she was unable to visit Mr Woods in prison to provide assistance with the palliative care plan but that someone from a hospice would visit him.

37. On 6 April, Mr Woods told a prison GP he did not want to have chemotherapy treatment. Mr Woods said he had discussed his decision with his family and was clear that this was his wish. She was satisfied that he had the mental capacity to make this decision.

38. On 11 April, a prison nurse told a prison GP that Mr Woods' still did not have an active palliative care plan. She assessed Mr Woods who told her he did not always receive his pain relief medication on time. She increased Mr Woods' dose of oromorph and noted in the healthcare daily duties record that Mr Woods must receive his medication as prescribed and on time.

39. On 15 April, a palliative care consultant from a hospice reviewed Mr Woods and advised nurses how to manage his symptoms as his condition deteriorated. The consultant discussed with Mr Woods the benefits of a short stay in the hospice. Mr Woods agreed to go to the hospice for assessment, but a bed was unavailable at the time.

40. On 19 April, nurses implemented a palliative care plan to support Mr Woods in achieving a quality of life and to maintain his dignity. The next day, a nurse noted that Mr Woods did not receive his pain relief medication on time but did not take any action.

41. On 21 April, Mr Woods vomited and a prison GP diagnosed dehydration. She arranged for an emergency ambulance to take Mr Woods to hospital.

42. The hospital admitted Mr Woods and commenced intravenous fluids and treatment. Nurses maintained daily contact with hospital staff and received regular updates about his condition. Mr Woods' condition continued to deteriorate and he died at 6.50am on 29 April.

43. The clinical reviewer commented that there were often delays in giving Mr Woods' his pain relief medication. Mr Woods' palliative care was at times inconsistent because nurses were unsure whom they could contact for specialist palliative care advice and support.

44. Once it becomes evident that a serious medical condition will not be responsive to active treatment, it is appropriate that a palliative care plan is put into place to help nurses plan a patient's care and help them make choices about how they are cared for towards the ends of their lives. Healthcare staff did not implement a palliative care plan for several weeks following Mr Woods' diagnosis and only after his condition had already deteriorated. We make the following recommendation:

    The Head of Healthcare should ensure that an effective palliative care plan is implemented in a timely way for all prisoners who are terminally ill and that this ensures access to appropriate levels of pain relief at all times.

Mr Woods' location

45. Mr Woods lived in a double cell on the vulnerable prisoners' wing. On 1 March, he told a prison GP that he did not want to move to the inpatient unit and wanted to remain on the wing for as long as possible.

46. On 30 March, a prison GP assessed Mr Woods and asked if he would consider moving to the inpatients' unit. Mr Woods declined and said he wanted to remain on the wing where he felt supported by his friends.

47. While we are satisfied that staff considered Mr Woods' wishes to remain on the wing, we note that Mr Woods' decision made the management of his condition more difficult. We consider that the early implementation of a palliative care plan could have addressed some of these difficulties, including how timely pain relief could be achieved.

Restraints, security and escorts

48. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. 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 takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

49. Mr Woods went to hospital several times for investigations and treatment. On each occasion the security risk assessments completed indicated that he was a low risk to hospital staff and hostage taking. Security staff assessed Mr Woods as a medium risk to the public and of escape. The medical section of the form did not record any objection to the use of restraints or comment on how his condition affected his risk of escape. Mr Woods' health was poor and he was unable to walk long distances. Each time, a prison manager authorised officers to restrain Mr Woods with double handcuffs for the journey to the hospital and an escort chain when in hospital. Double cuffing is when the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs. 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.

50. On 21 April, Mr Woods was admitted to hospital with dehydration, by this time he was very ill. The risk assessment was the same as before with little healthcare input. The prison manager authorised officers to restrain Mr Woods with an escort chain. No one reviewed the restraints risk assessment while Mr Woods was in hospital and he remained on an escort chain until 28 April, the day before he died.

51. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances. Double handcuffs are only usually used for category A and B prisoners in good health. Mr Woods was a category B prisoner, but he was very poorly. The records suggest that prison managers based their decisions on the nature of his offences rather on his actual risk at the time. No one reviewed the use of restraints while Mr Woods was in hospital, so he remained restrained until the day before he died, despite being extremely unwell. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that 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 Mr Woods' family

52. After Mr Woods was admitted to hospital on 21 April, the prison informed his family. Mr Woods' mother visited him the next afternoon and his family continued to visit him frequently until he died. His mother and sisters were with him when he died.

53. On 29 April, the prison appointed a prison manager as the family liaison officer. She contacted Mr Woods' family and offered condolences and support.

54. Mr Woods' funeral was on 20 May. The prison contributed to the funeral costs in line with national instructions.

55. Prison Service Instruction (PSI) 64/2011 states that prisons must have arrangements for an appropriate member of staff to engage with families of prisoners who are either terminally or seriously ill. On 1 February, Mr Woods was diagnosed with a cancerous tumour on his oesophagus. We consider that from this point, the prison should have appointed a member of staff to liaise with Mr Woods' family.

56. We note that after Mr Woods' diagnosis, his sister wrote to the prison to ask if she could accompany Mr Woods to future hospital appointments. When she did not receive a response, Mr Woods' sister emailed the prison to raise concerns about his wellbeing. Approximately six weeks later, the prison responded to the email, saying that a member of staff would discuss with Mr Woods. Mr Woods' sister did not receive any further update.

57. Mr Woods' sister told us when his condition deteriorated he was unable to walk to the wing's telephone to contact his family and he could not walk to the visits area, which meant that visits could not take place. We have been unable to find any evidence that the prison offered Mr Woods additional support, such as the use of a wheelchair, to enable him to reach the visits area.

58. We consider that the earlier appointment of a family liaison officer or appropriate member of staff would have provided a single point of contact to address the family's concerns about communication and visits and to provide support to Mr Woods. We make the following recommendation:

    The Governor should ensure that an appropriate member of staff is appointed promptly to engage with and support the families of seriously ill prisoners.

Compassionate release

59. Release on compassionate grounds is a means by which prisoners who are seriously ill, usually with a life expectancy of less than three months can be permanently released from custody before their sentence has expired. A clear medical opinion of life expectancy is required. The criteria for early release for determinate sentenced prisoners are set out in Prison Service Order (PSO) 6000. Among the criteria is that the risk of re-offending is expected to be minimal, further imprisonment would reduce life expectancy, there are adequate arrangements for the prisoner's care and treatment outside prison, and release would benefit the prisoner and his family. An application for early release on

compassionate grounds must be submitted to the Public Protection Casework Section (PPCS) of the National Offender Management Service (NOMS).

60. On 26 February, Mr Woods' sister wrote to the Governor to ask if Mr Woods was eligible for early release on compassionate grounds. On 5 April, an administration officer from the prison replied and said she had passed the letter to the relevant department but did not provide any further information.

61. On 22 April, Mr Woods' solicitor wrote to the prison to ask them to consider Mr Woods' application for early release on compassionate grounds.

62. The PPCS told us they did not receive an application for compassionate release for Mr Woods and we have been unable to find any evidence that the prison considered Mr Woods' application. The prison was not able to give us any information on what happened to Mr Woods' application. It is important that applications for compassionate grounds are considered quickly and any action taken is clearly documented. We make the following recommendation:

The Governor should ensure that when a prisoner is diagnosed with a terminal illness with a short time left to live, the possibility of compassionate release is fully considered and documented.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141