Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Eric Eastman a prisoner at HMP Liverpool on 16 March 2019

A report by the Prisons and Probation Ombudsman

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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*

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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 Eric Eastman died of cardiorespiratory (heart and lung) failure caused by cancer of the larynx and chronic obstructive pulmonary disease (COPD) on 16 March 2019 while a prisoner at HMP Liverpool. He was 72 years old. I offer my condolences to his family and friends.

I am satisfied that the care that Mr Eastman received at Liverpool was equivalent to that which he could have expected to receive in the community.

Mr Eastman was an elderly man, with terminal cancer and limited mobility. In these circumstances, I am concerned that Mr Eastman was inappropriately restrained when he was escorted to hospital five days before he died.

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

Sue McAllister CB
Prisons and Probation Ombudsman **October 2019**

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Summary

1. In 2016, while living in the community, Mr Eric Eastman was treated for throat cancer for which he continued to have hospital reviews. He also had chronic obstructive pulmonary disease (COPD - a group of lung conditions which cause breathing difficulties).

2. On 8 May 2018, Mr Eastman was remanded to HMP Liverpool and had a first night reception screen. The next day, he was sentenced to 16 years in prison for sexual offences. He had a secondary health screen on 22 May.

3. In October and November 2018, Mr Eastman attended outpatient appointments and had tests in hospital. At an appointment on 5 November, he was told that he had cancer of the larynx (voice box).

4. In January 2019, Mr Eastman was offered the choice between an operation to remove his larynx or palliative treatment. He chose to have palliative treatment. Mr Eastman was moved to the prison's healthcare unit, where his symptoms were managed. On 25 January, he was told that he had approximately three months to live.

5. On 11 March, Mr Eastman attended hospital for the last time and was restrained.

6. At 8.20am on 16 March, Mr Eastman was found unresponsive in his cell. In line with his wishes, healthcare staff did not try to resuscitate him. He was confirmed dead at 9.25am.

Findings

7. The clinical reviewer found that the care that Mr Eastman received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community.

8. Although it did not contribute to his death, we are concerned that Mr Eastman did not have had a secondary health screen within seven days of his initial health screen, as he should have done. This did not happen until 14 days after his initial health screen.

9. We consider that Mr Eastman was inappropriately restrained when he was taken to hospital for an x-ray, five days before he died.

Recommendations

- The Head of Healthcare should ensure that healthcare staff complete secondary health screens within seven days of a prisoner's initial health screen to ensure that prisoners receive appropriate treatment and support, in line with National Institute for Clinical Excellence (NICE) guidance.

- The Governor and Head of Healthcare should continue to ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

- The Prison Group Director for Greater Manchester, Merseyside and Cheshire should write personally to the Ombudsman after the Group Safety Team's next quarterly report in September 2019, to set out what progress has been made since Mr Eastman's death and what further action is being taken to ensure that restraints are not used inappropriately.

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 Eastman's prison and medical records.

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

13. We informed HM Coroner for Merseyside Liverpool District of the investigation. He confirmed that a post-mortem examination was not completed. We have sent the Coroner a copy of this report.

14. One of the PPO's family liaison officers, contacted Mr Eastman's wife, to explain the investigation and to ask if she had any matters she wanted us to consider. She did not respond.

15. We have assessed the main issues involved in Mr Eastman's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his next of kin, and whether compassionate release was considered.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HM Prison Liverpool

17. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1,400 adult men. Spectrum provides healthcare services at the prison. There is a 24-hour inpatient unit.

18. On 1 June 2018, Liverpool was placed in special measures by HM Prison and Probation Service (HMPPS), which means that HMPPS considered that it needs additional, specialist support to improve performance.

HM Inspectorate of Prisons (HMIP)

19. The most recent inspection of HMP Liverpool was in September 2017. Inspectors reported an abject failure of the prison to offer a safe, decent and purposeful environment. The inspection team could not recall having seen worse living conditions, which they described as squalid.

20. While inspectors concluded that primary health care had improved, they found that staff shortages had had a negative impact on all aspects of health services, especially mental healthcare. They found that inpatients had a very poor regime and were offered little therapeutic activity. Inspectors noted that the integrated mental health and substance misuse team did not have capacity to meet the needs of a complex population.

21. In their annual report for the year 2017-18, HMIP noted that they had found some of the worst conditions they had ever seen at Liverpool, and that, if the urgent notification protocol (which came into force in November 2017) had been in place at the time of their inspection, they would most likely have invoked it.

Independent Monitoring Board

22. 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 2017, the IMB reported that many cells were in poor condition, with no electrics, running water and blocked toilets. They noted that Liverpool struggled to cope with older prisoners with significant healthcare needs and staff were not trained in social care. They noted that the Victorian design of the prison did not lend itself to those with mobility issues.

Previous deaths at HMP Liverpool

23. Mr Eastman was the fourteenth prisoner to die at Liverpool since January 2017, and the fifth to die from natural causes. Since Mr Eastman's death, two more prisoners have died at Liverpool from natural causes and one death is yet to be classified.

24. In a previous investigation into the death of a prisoner in January 2019, we recommended that Liverpool should ensure that healthcare staff complete secondary health screens within seven days of a prisoner's initial health screen

to ensure that prisoners receive appropriate treatment and support. The Head of Healthcare has accepted our recommendation.

25. In our investigations into the deaths of prisoners in November 2017, September 2018 and January 2019, we made recommendations to address the inappropriate use of restraints. The prison agreed to implement our recommendations on each occasion. On the last occasion we also escalated the issue to the Prison Group Director. It is therefore disappointing that we have again identified the inappropriate use of restraints in this investigation.

Findings

The diagnosis of Mr Eastman’s terminal illness and informing him of his condition

26. On 8 May 2018, Mr Eric Eastman was remanded to HMP Liverpool, charged with sexual offences. A nurse completed Mr Eastman’s first night reception screen. He noted Mr Eastman’s diagnosis of throat cancer and treatment in 2016, for which he had ongoing hospital reviews. The nurse noted that Mr Eastman also had COPD and referred him to the COPD community team. The nurse assessed Mr Eastman as suitable to live in a standard double cell.

27. On 9 May, Mr Eastman was sentenced to 16 years in prison, and returned to Liverpool.

28. On 10 May, Mr Eastman did not attend an appointment with a prison GP and it was re-booked for 15 May 2018. At the appointment, a prison GP noted that Mr Eastman had had radiotherapy in March 2016 for cancer of his right vocal cord, and that the cancer had not returned.

29. On 22 May, a nurse completed a secondary health screen. He noted a family history of cancer and that Mr Eastman was taking various medications.

30. On 23 May, a prison GP reviewed Mr Eastman and explained what symptoms he should report.

31. On 26 June, a prison GP reviewed Mr Eastman’s COPD and found that Mr Eastman had an infection in his lower respiratory tract, for which he prescribed medication.

32. On 2 July, Mr Eastman attended a routine follow up appointment at the Ear, Nose and Throat (ENT) department at the hospital.

33. On 21 September 2018, a prison GP reviewed Mr Eastman. He noted that he had had a sore throat and hoarseness for the past two weeks and had lost approximately 2kg since May 2018, which Mr Eastman put down to a poor appetite. The prison GP diagnosed Mr Eastman with a throat infection, prescribed antibiotics and noted that he had a hospital outpatient appointment on 15 October 2018.

34. Mr Eastman had several follow-up appointments with healthcare staff and on 8 October, a nurse noted that he had completed his course of antibiotics and was feeling much better.

35. On 15 October, Mr Eastman attended a hospital outpatient appointment, as planned, and he had an urgent magnetic resonance imaging (MRI) scan.

36. On 5 November, Mr Eastman attended a follow-up hospital outpatient appointment, where, after tests, he was diagnosed with cancer of the larynx (voice box).

37. On 2 January 2019, Mr Eastman attended a hospital appointment and was offered the choice between surgical removal of the larynx or palliative treatment.

He decided to think about his options for a few days and a nurse supported him by breaking the news of his diagnosis to his wife.

38. On 9 January, a nurse assessed Mr Eastman as fit to make decisions about his treatment.

39. Also on 9 January, Mr Eastman attended a hospital outpatient appointment. He told the consultant that he had decided not to have surgery and gave permission for prison healthcare staff to speak to his wife about his consultations, diagnosis and symptom control.

40. A palliative care plan was created for Mr Eastman and he was added to the palliative care register.

41. On 15 January, Mr Eastman was admitted to the healthcare department and had a full assessment of his needs, including skin integrity and a malnutrition risk assessment and an assessment using the National Early Warning Scores system. He was given nutritional supplement drinks and a soft diet as he found it difficult to swallow food.

42. On 17 January 2019, Mr Eastman said that he did not want to be resuscitated if his heart or breathing stopped and signed an order to that effect. Three days later, healthcare staff created an advanced care plan with Mr Eastman to assess his needs and wants.

43. On 25 January, a palliative care consultant reviewed Mr Eastman in the inpatient unit as he did not feel well enough to attend his hospital appointment. The consultant told Mr Eastman that he had approximately three months to live.

44. On 28 January 2019, Mr Eastman was admitted to hospital. Tests showed that the potassium levels in his blood were high and an electrocardiogram (ECG) showed that his heart rate was abnormal. A chest x-ray also showed that he had an infection and he was prescribed antibiotics and steroids. Mr Eastman's potassium levels returned to normal after taking medication.

45. From 13 March, Mr Eastman was given medication for pain and agitation and his symptoms were managed. He was given his medication by injection at first but it was changed to oral medication at his request.

46. On 11 March, Mr Eastman attended hospital for a chest x-ray as an outpatient. He was restrained with a single cuff on the authority of the Head of Security and Intelligence, who said that the restraints should only be removed for medical treatment with prior approval.

47. At 8.20am on 16 March, two nurses went to Mr Eastman's room to give him medication and found him unresponsive and not breathing. They did not try to resuscitate him.

48. At 9.25am a prison GP confirmed that Mr Eastman had died.

49. There was no post-mortem examination. The Coroner confirmed that Mr Eastman died of cardiorespiratory (heart and lung) failure caused by cancer of the larynx and COPD.

Mr Eastman's clinical care

50. The clinical reviewer concluded that the care Mr Eastman received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community. She found that that the healthcare team had effective systems in place to manage his COPD, and that evidence-based care plans were in place.

51. She was satisfied that the continuity of care that Mr Eastman received was good and that prison GPs saw him for planned and unplanned reviews. She found that he had emotional and practical support and that his capacity to consent was appropriately assessed in line with good practice.

52. The clinical reviewer found that Mr Eastman received responsive, supportive and personalised care at the end of his life, in line with NHS England's Dying Well in Custody Charter. She said that Mr Eastman was involved in the planning of his care which was monitored through multi-disciplinary team meetings, and that conversations about his condition were timely. She was satisfied that he received support from specialist palliative care services.

Secondary health screen

53. A secondary health screen enables a prisoner's health issues to be explored in more detail than during the initial health screen and ensures that prisoners receive the necessary treatment and support. Guidance from the National Institute for Health and Care Excellence (NICE) on the physical care of prisoners recommends that secondary health screens are carried out within seven days of a prisoner's initial health screen. This did not happen for Mr Eastman.

54. Mr Eastman's initial health screen took place on 8 May 2018 and his secondary reception screen was completed fourteen days later. While the clinical reviewer found that this did not affect the care that Mr Eastman received, such a delay could have serious consequences in other circumstances. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff complete secondary health screens within seven days of a prisoner's initial health screen to ensure that prisoners receive appropriate treatment and support in line with NICE guidance.

Mr Eastman's location

55. Mr Eastman lived in a standard double cell when he arrived at Liverpool. On 4 January 2019, he was moved to a single cell and on 15 January, he was appropriately admitted to the healthcare department.

Restraints, security and escorts

56. 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.

57. 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 he has 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.

58. Mr Eastman was restrained with a single cuff when he attended his hospital appointments, including his last hospital appointment on 11 March 2019, five days before he died.

59. In the Escort Risk Assessment on 11 March, Mr Eastman was assessed as a medium risk of harm to children and a low risk to the public, hospital staff, of hostage taking, potential escape and of external assistance. Healthcare staff noted that he was receiving palliative care, could not walk long distances and required a wheelchair. However, they ticked the box to say that they had no medical objections to the use of restraints.

60. The Head of Security and Intelligence, concluded that two officers should escort Mr Eastman using a single cuff, and that the restraints should only be removed for medical treatment with prior approval.

61. We are concerned that the approach that the Head of Security and Intelligence applied to using restraints was inconsistent with the provisions of the High Court judgement. Mr Eastman was 72 years old, terminally ill and with poor mobility. None of his risks were assessed as high and many of them as low. We do not consider in these circumstances that restraining Mr Eastman was proportionate to the risk he posed, especially as he was escorted by two officers. Staff appear to have been influenced by Mr Eastman's offences, rather than considering his risk at the time and the impact of his very poor health on his risk.

62. In November 2017, September 2018 and May 2019, we made recommendations to address the inappropriate use of restraints at Liverpool. The prison agreed to implement our recommendation in all three cases. The prison told us that an email had been sent to all appropriate staff by the Head of Safer Living in January 2019, to remind them of their responsibilities in relation to restraints. It is, therefore, very disappointing to find a further inappropriate use of restraints in Mr Eastman's case in March 2019.

63. This suggests that the measures taken so far to remind staff have not been effective. We note that the Safer Custody Manager reminded governor grades, healthcare managers and custodial managers again at a meeting on 19 July 2019 and we hope that this will have an effect.

64. In May 2019, we also escalated the issue to the Prison Group Director for Greater Manchester, Merseyside and Cheshire. He told us in response that his Group Safety Team is responsible for "providing assurance that progress is being

made against the PPO's recommendations" and that progress is reported to him quarterly, most recently in June 2019 and next in September 2019. He also said that PPO recommendations are discussed at his bilaterals with prison Governors.

65. We make the following recommendations:

The Governor and Head of Healthcare should continue to take steps to ensure that all staff undertaking and reviewing risk assessments for prisoners taken to and admitted to hospital understand the legal position, that assessments fully take in to account a prisoner's health and are based on the actual risk he presents at the time.

The Prison Group Director for Greater Manchester, Merseyside and Cheshire should write personally to the Ombudsman after the Group Safety Team's next quarterly report in September 2019, to set out what progress has been made since Mr Eastman's death and what further action is being taken to ensure that restraints are not used inappropriately.

Liaison with Mr Eastman's family

66. Mr Eastman's next of kin was his wife. He had regular contact with her and she visited him frequently.

67. On 30 January 2019, a prison manager was appointed the family liaison officer (FLO) and supported Mr Eastman's wife during his palliative care. Healthcare staff appropriately kept Mr Eastman's wife informed about his consultations, diagnosis and symptom control, in line with his wishes.

68. On 16 March 2019, prison staff were arranging to inform Mr Eastman's wife that he had died when she called the healthcare unit to check his condition. In the circumstances, we are satisfied that it was reasonable and appropriate that a nurse told her over the phone that Mr Eastman had died.

69. A Custodial Manager (CM) acted as the family liaison officer (FLO) as the prison manager was unavailable. She offered her condolences to Mr Eastman's wife and explained that the prison manager would contact her

70. Two days later, the prison manager and an operational support grade visited Mr Eastman's wife at home and offered their condolences and support.

71. Mr Eastman's funeral took place on 10 April 2019. Liverpool contributed to its cost, in line with national instructions.

Compassionate release

72. 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. 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.

73. Mr Eastman submitted an application for compassionate release in February 2019. Mr Eastman's probation officer and the Governor did not support Mr Eastman's application on the grounds that he was in the very early stages of a sentence for serious offences and had not completed any programmes to address his offending behaviour and reduce his risk. In addition, as Mr Eastman and his wife had not told family and friends that he was in prison and did not want his victim told if he was granted early release, it would not be possible to put effective safeguarding measures in place.

74. In these circumstances, we consider that it was reasonable that the prison did not submit an application for Mr Eastman's early release on compassionate grounds.

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