Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Hamilton a prisoner at HMP Liverpool on 10 January 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*

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 Paul Hamilton died of gallbladder cancer in hospital on 10 January 2019 while a prisoner at HMP Liverpool. He was 65 years old. I offer my condolences to his family and friends.

The physical healthcare that Mr Hamilton received at Liverpool was equivalent to that which he could have expected to receive in the community. Mr Hamilton also had mental health issues, for which he was appropriately treated and supported.

However, I am concerned that Mr Hamilton did not have a secondary health screen for 17 days after he arrived at Liverpool. I am also concerned that healthcare staff failed to refer Mr Hamilton for tests for suspected cancer after he presented with a number of non-specific symptoms that justified a referral from October 2018 onwards. It is not possible to say if this affected the outcome for Mr Hamilton.

The decision to restrain Mr Hamilton when he was taken to hospital in November 2018 was unjustified, and did not take account of his age, mobility and serious ill-health. I am disappointed that I must raise this matter with the prison again.

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 **January 2020**

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Summary

Events

1. On 22 August 2017, Mr Paul Hamilton was remanded and sent to HMP Liverpool, where he had an initial health screen. Mr Hamilton had a significant medical history, including cancer of the mouth, which had been successfully treated five years earlier.

2. On 29 August, Mr Hamilton was sentenced to nine years and six months in prison for sexual offences and returned to Liverpool.

3. Mr Hamilton did not have a secondary health screen until 8 September.

4. While in prison, Mr Hamilton received treatment for serious mental health issues. Between October 2017 and April 2018, he lived in the Vulnerable Prisoners' Unit, where he was monitored and supported.

5. In April 2018, Mr Hamilton's physical health declined and he was moved to the prison's inpatient unit, where he had tests but no issues were found. In May, Mr Hamilton was admitted to hospital and had investigations which concluded that he did not have a malignant disease.

6. From October, Mr Hamilton's health deteriorated significantly and he had a number of non-specific symptoms. Healthcare staff treated him for a possible infection but his health did not improve. In November, Mr Hamilton went to hospital, restrained. He had further tests, which again found no issues.

7. On 27 December, Mr Hamilton had a fall and was urgently transferred to hospital, where he was diagnosed with abdominal cancer on 4 January 2019.

8. Mr Hamilton died on 10 January 2019. The inquest concluded that he died of gallbladder cancer which had spread.

Findings

9. Mr Hamilton should have had a secondary health screen within seven days of his initial health screen. This did not happen. Although Mr Hamilton had an initial health screen when he arrived at Liverpool, he did not have a secondary one until 8 September, 17 days later.

10. Between October and December 2018, Mr Hamilton had a number of non-specific symptoms and should have been referred for assessment under the suspected cancer pathway.

11. We are concerned that the risk assessment which the prison undertook when Mr Hamilton went to hospital on 9 November 2018 was not informed by medical information. Mr Hamilton was a 65-year old man in poor health and with poor mobility, and there is no evidence that it was appropriate or proportionate to restrain him.

12. We are concerned that this is the third investigation into a death at Liverpool since November 2017 in which we have concluded that a prisoner was

inappropriately restrained and that the assessment did not fully take into account the health of a prisoner.

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 NICE guidance.
- The Head of Healthcare should ensure that clinical staff appropriately refer prisoners with possible cancer for specialist assessment, using the suspected cancer pathway in line with NICE guidelines.
- The Governor and Head of Healthcare should 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 assure himself that meaningful action is taken to ensure that this happens.

The Investigation Process

13. 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.

14. The investigator obtained copies of relevant extracts from Mr Hamilton's prison and medical records.

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

16. We informed HM Coroner for Merseyside Liverpool District of the investigation. An inquest took place on 1 February 2019 which concluded that Mr Hamilton died of metastatic carcinoma of the gallbladder. We have sent the Coroner a copy of this report.

17. One of the Ombudsman's family liaison officers contacted Mr Hamilton's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

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

Background Information

HMP Liverpool

19. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1,400 adult men. Lancashire Care NHS Foundation Trust provides healthcare services at the prison. There is a 24-hour inpatient unit.

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

HM Inspectorate of Prisons (HMIP)

21. 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. They noted that many cells were not fit for use and some posed a danger to prisoners, with occupied cells with emergency cell bells that were not working. They found that there were hundreds of unrepaired broken windows, with jagged glass left in the frames and that many toilets were filthy, blocked or leaking. They noted that there were infestations of cockroaches in some areas, broken furniture, graffiti, damp and dirt.

22. 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.

23. They found that leadership was not effective or sufficiently rigorous to drive the prison forward in a meaningful way.

24. 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 had the urgent notification protocol (which came into force in November 2017) been in place at the time of their inspection, they would most likely have invoked it.

Independent Monitoring Board

25. 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 the number of elderly and frail prisoners was increasing across the whole estate, 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

26. Mr Hamilton was the thirteenth prisoner to die at Liverpool since January 2017, and the fourth to die from natural causes. Since Mr Hamilton's death, three more prisoners have died at Liverpool from natural causes.

27. In our investigation into the deaths of a prisoner in November 2017, we recommended that Liverpool should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 prison accepted our recommendation. We repeated this recommendation in our report into the death of a man in September 2018, which Liverpool again accepted. It is, therefore, disappointing that we have again identified the inappropriate use of restraints in this investigation.

Key Events

28. On 22 August 2017, Mr Paul Hamilton was remanded to HMP Liverpool for sexual offences, and a nurse completed an initial health screen with Mr Hamilton. She noted his significant medical history, including epilepsy, rheumatoid arthritis, partial removal of the stomach due to an ulceration, and cancer of the mouth which had been successfully treated with radiotherapy in 2012. A prison GP prescribed medication to manage Mr Hamilton's conditions.

29. The nurse noted that Mr Hamilton used a walking stick but assessed that he was suitable to live on a standard wing as he was able to care for himself. Mr Hamilton was significantly underweight. She recorded his weight as 39kg (6st 2lbs) and calculated his body mass index as 14.33. (The ideal body mass index for most adults is between 18.5 to 24.9.) She noted that Mr Hamilton had a history of depression and had taken an overdose in January 2017. She referred him to the prison's mental health team for an assessment.

30. On 29 August, Mr Hamilton was sentenced to nine years and six months in prison and returned to Liverpool.

31. From 29 August, Mr Hamilton was managed under suicide and self-harm prevention measures (known as ACCT), as he struggled to adapt to prison life and sometimes had thoughts about self-harm.

32. On 8 September, a psychotherapist completed a secondary health screen with Mr Hamilton. He noted that Mr Hamilton was receiving all of his medication and had no thoughts about suicide or self-harm.

33. On 20 October, Mr Hamilton was transferred to the Vulnerable Prisoners' Unit due to his mental health issues, and ACCT monitoring was stopped. His mental health was stable until March 2018.

34. On 13 November 2017, a dental officer reviewed Mr Hamilton and found that he had some exposed bone in the lower right area of his jaw. As he had previously had mouth cancer, she referred Mr Hamilton to the Oral and Maxillofacial Surgery Team (specialists in treating diseases, injuries and defects of the head, neck, face and jaw) at the hospital under the urgent two-week referral for suspected cancer pathway.

35. On 29 November, Mr Hamilton was reviewed at hospital and diagnosed with osteoradionecrosis (bone death due to radiation) of the right jaw and an extra-oral draining sinus in the area of his right jaw (an abnormal channel that drains from a longstanding dental abscess). Assessments were arranged and Mr Hamilton was prescribed medication.

36. On 24 January 2018, hospital staff discussed test results and treatment options with Mr Hamilton, and created a care plan for him. Mr Hamilton agreed to have his right jaw reconstructed, and was told that the wait for surgery would be at least six months.

37. From March, Mr Hamilton's mental health deteriorated and on 16 April, a prison psychiatrist diagnosed him with possible psychotic phenomena (altered experiences of reality). He changed Mr Hamilton's medication and he received ongoing support from the mental health team. Despite this, his mental health got worse, and he was managed under ACCT procedures on two further occasions.

38. Mr Hamilton's physical health was relatively stable until April 2018. He became frail, was sometimes confused and needed help with his basic self-care needs. It was unclear to healthcare staff what impact the deterioration of his mental health had on his physical health. From April, Mr Hamilton's weight was recorded frequently and ranged between 46kg (7st 2lbs) and 60.1kg (9st 8lbs).

39. On 20 April, Mr Hamilton was transferred to the prison's inpatient unit for monitoring. A healthcare assistant noted his weight as 52kg (8st 3lbs). He had had blood tests and an electrocardiogram (ECG, a test to check the heart's rhythm and electrical activity) to find a physical reason for his deterioration, but no issues were found.

40. On 25 April, Mr Hamilton had an appointment with a prison GP, but did not attend. There is no evidence to explain the purpose of this appointment or why he did not attend.

41. Healthcare staff continued to monitor Mr Hamilton's health and on 1 May, an administrator noted that his general health had deteriorated.

42. On 1 May, a nurse assessed Mr Hamilton. He completed observations, which were stable, but identified that Mr Hamilton had a low National Early Warning (NEW) score (used by medical services to identify and respond to clinical deterioration in patients). This indicated that Mr Hamilton's observations should be reviewed. He also found that Mr Hamilton's arms were trembling and he looked pale. The nurse noted that Mr Hamilton told him that he had been feeling sick and vomiting and could only manage small amounts of food and liquid. He recorded his weight as 43.6kg (6st 12lbs). He was concerned about the deterioration of Mr Hamilton's health and referred him to a prison GP.

43. Later that day, a prison GP reviewed Mr Hamilton and noted his deterioration over the previous few weeks and, more particularly, in the previous four days. He arranged for Mr Hamilton to be transferred urgently to hospital for assessment as he appeared confused and there was no obvious reason for his deterioration.

44. At the hospital, the Urology Team (which focuses on the urinary-tract system and reproductive organs), the Gastroenterology Team (which focuses on the digestive system) and a dietician reviewed Mr Hamilton. He had a computerised tomography (CT) scan and an ultrasound scan, which did not find a malignant disease.

45. On 24 May, Mr Hamilton returned to Liverpool. The discharge letter said that he had lost weight, tests were inconclusive but that he had been diagnosed with benign prostatic hyperplasia (an enlarged prostate) and treated for a urinary tract infection and constipation. It also said that he should see the mental health team at Liverpool.

46. On 15 June, a consultant forensic psychiatrist reviewed Mr Hamilton. He concluded that Mr Hamilton should be transferred urgently to a medium secure psychiatric unit and detained under the Mental Health Act. However, commissioners (responsible for planning and purchasing healthcare services for the local population) told the psychiatrist that there were no beds available at the Scott Clinic (a medium-security psychiatric unit in Liverpool).

47. On 12 July, a consultant psychiatrist reviewed Mr Hamilton and concluded that he did not have the mental capacity to make decisions about his care and treatment.

48. On 17 August, two psychiatrists from the Scott Clinic assessed Mr Hamilton and concluded that he no longer needed to be admitted to a medium secure unit, and that if his mental health deteriorated he could be managed at a low secure service. That day, Mr Hamilton was referred to Rathbone Low Secure Unit in Liverpool, but he did not meet the criteria for admission.

49. On 2 September, a healthcare assistant noted Mr Hamilton's weight as 60.1kg (9st 8lbs).

50. On 19 September, the hospital reviewed Mr Hamilton and found that his osteoradionecrosis was stable. They concluded that Mr Hamilton should not have reconstructive surgery as his health had got worse but instead, the damaged tissue should be removed under anaesthetic. (Mr Hamilton died before this was done.)

51. Mr Hamilton's health remained relatively stable until October.

52. On 11 October, a nurse reviewed Mr Hamilton. He recorded his weight as 54.8kg (8st 9lbs) and noted that Mr Hamilton said that he was eating and drinking "ok" but continued to lose weight. The nurse arranged for him to have snacks between his meals and for his weight to be monitored weekly. Later that day, a prison GP contacted the hospital as he was concerned about Mr Hamilton's ongoing confusion and his depressive and psychotic symptoms. He was concerned that Mr Hamilton's cancer had spread to his brain.

53. On 20 October, the hospital advised that it was very unlikely that Mr Hamilton's symptoms were caused by a brain lesion as his cancer had been treated five years earlier, and the CT scan that he had had in May was clear.

54. On 25 October, a prison GP reviewed Mr Hamilton as he had a mouth ulcer and was tired. He noted that Mr Hamilton was awaiting surgery and that his blood tests showed a raised erythrocyte sedimentation rate (ESR) and C-reactive protein (CRP), both of which can indicate inflammation in the body and increase in response to certain inflammatory diseases such as rheumatoid arthritis, infections, abscesses, tissue injury and some cancers. The GP concluded that Mr Hamilton had an infection and prescribed antibiotics.

55. Mr Hamilton's mental health became worse. On 8 November, he was referred for a second time to Rathbone Low Secure Unit, and met the criteria for admission.

56. On 9 November, Mr Hamilton fell over in his cell. He banged his head and had bleeding from his scalp. A nurse noted that he was drowsy and had a high NEW score. A prison GP reviewed Mr Hamilton after his fall. He noted that he was difficult to rouse and did not seem to know where he was. He arranged for Mr Hamilton to be transferred to hospital for assessment. He was restrained by an escort chain and escorted by two officers.

57. Mr Hamilton had a CT scan, chest x-ray, an ECG and blood tests at hospital, but no issues were identified. He returned to Liverpool that day.

58. Between 10 and 12 November, Mr Hamilton fell over on two occasions.

59. On 12 November, it was agreed that Mr Hamilton's door could remain open to increase the support he could receive from healthcare staff. He also received one-to-one nursing support to reduce his risk of falls.

60. On 14 November, Mr Hamilton had a blood test and a nurse recorded his weight as 53.7kg (8st 6lbs).

61. On 15 November, a prison GP reviewed Mr Hamilton and noted that over the past few months, his weight varied between 50kg (7st 13lbs) to 58kg (9st 2lbs). He noted that Mr Hamilton had recently been treated for an infection but that the blood test from the day before indicated that his ESR and CRP levels were still raised although there was no obvious source. He noted that Mr Hamilton's CT scan and ECG results were normal. He referred Mr Hamilton to a doctor who specialised in care for older adults and a General Physician at hospital to review his frequent falls.

62. On 20 November, a nurse reviewed Mr Hamilton as he had pain in the right side of his back. He found no bruising or swelling and noted that he did not have trouble breathing. He gave Mr Hamilton paracetamol.

63. On 22 November, a prison GP reviewed Mr Hamilton as his back pain continued, even with regular pain relief. He noted that Mr Hamilton had tenderness on the left side of his chest but he did not find any symptoms that indicated Mr Hamilton had a chest infection. He concluded that Mr Hamilton had musculoskeletal pain (which affects the muscles, ligaments and tendons, and bones). He prescribed pain relief and asked for blood test results taken in the last six weeks to be sent to the hospital's General Physician.

64. On 29 November, commissioners agreed that Mr Hamilton should be admitted to Rathbone Low Secure Unit but there was a long waiting list. (Mr Hamilton did not secure a bed there before he died.)

65. On 29 November, a prison GP reviewed Mr Hamilton as he had constant pain in the right side of his abdomen. He noted that Mr Hamilton's abdomen was soft and he did not find a mass. He examined Mr Hamilton's lungs as he had had a cough for three days. He noted that he could hear a sound that indicated a lung infection, and that recent blood tests showed that his CRP was raised. Mr Hamilton's right-side ribs were tender. He concluded that Mr Hamilton had a chest infection and prescribed antibiotics and a laxative, as Mr Hamilton had not opened his bowels for four days.

66. On 6 December, a prison GP examined Mr Hamilton's chest and found that it was clear, but noted that a recent blood test showed that Mr Hamilton had a raised ESR level. He concluded that this was consistent with a recent chest infection and arranged for Mr Hamilton to have another blood test in two weeks.

67. On 8 December, a prison GP examined Mr Hamilton's chest. He found that Mr Hamilton had an abnormal lung sound which potentially indicated a lung infection. He prescribed antibiotics.

68. On 12 December, a prison GP reviewed Mr Hamilton as he had symptoms of a chest infection and his bowel movements had been looser over the past month. He noted that recent blood test results showed that Mr Hamilton's CRP had increased, and concluded that the antibiotics had not worked. He prescribed a different antibiotic, and arranged for a stool and urine sample to be taken. The results showed that Mr Hamilton did not have an infection.

69. On 13 December, a prison GP chased the referral made on 15 November to a General Physician for a specialist assessment. He noted that the hospital had received the referral, and the waiting list for an appointment was up to ten weeks. Mr Hamilton continued to complain of generalised pain and between 4 and 16 December his weight decreased from 56.9kg (8st 13lbs) to 51.2kg (8st 1lb).

70. On 20 December, a prison GP wrote to the General Physician to ask him to prioritise the referral as Mr Hamilton's CRP had increased further, despite being treated for a chest infection. He noted that he did not think that it was caused by an infection. He advised the General Physician that Mr Hamilton did not have any other symptoms, but was unsteady on his feet and frequently fell over. (The General Physician did not respond before Mr Hamilton was transferred to hospital for the last time on 27 December.)

71. On 25 December, a nurse noted that at approximately 4.00pm, the agreement to leave Mr Hamilton's cell door open was temporarily withdrawn due to staffing issues. She arranged for a healthcare support worker to sit outside Mr Hamilton's cell to monitor him constantly, and for prison staff to be contacted immediately if healthcare staff needed access to him. She completed an incident form, including details of the plan, and informed the healthcare on-call manager, who approved the arrangement.

72. Between 4.20pm and 6.30pm, Mr Hamilton fell over on two occasions but was not seriously injured. Healthcare staff contacted an officer on both occasions. He told us that he attended within five minutes to open Mr Hamilton's cell. The agreement to leave Mr Hamilton's door open was reinstated the next day.

73. At 8.30am on 27 December, a mental health nurse reviewed Mr Hamilton and noted that he was drowsy and confused. He completed Mr Hamilton's observations and found that his oxygen saturation level (a measure of oxygen in the blood) and respiratory rate (the number of breaths taken every minute) were low and his blood pressure, pulse and temperature were within the acceptable range. He also calculated Mr Hamilton's NEW score which indicated that he needed an urgent assessment. He arranged for a GP to review Mr Hamilton urgently.

74. At 9.44am, a prison GP noted in Mr Hamilton's medical record that he had reviewed him, and concluded that he should be transferred to hospital and that staff should monitor Mr Hamilton until an ambulance arrived. The control room log shows that healthcare staff requested an ambulance at 9.36am. Nursing staff stayed with Mr Hamilton until the ambulance arrived. Mr Hamilton was transferred to hospital at 10.39am, unrestrained, and escorted by two officers.

75. Mr Hamilton's condition deteriorated and, on 4 January 2019, hospital staff told healthcare staff at Liverpool that Mr Hamilton had abdominal cancer.

76. At 7.30am on 10 January, prison staff were informed that Mr Hamilton had died but that hospital staff were waiting for a doctor to attend to pronounce the time of death. At 10.30am on 10 January 2019, a doctor confirmed that Mr Hamilton had died.

Contact with Mr Hamilton's family

77. On 31 December 2018, a Custodial Manager (CM) was appointed as the family liaison officer, after hospital staff asked Liverpool to contact Mr Hamilton's next of kin. Mr Hamilton's next of kin was his daughter, who lived approximately 30 miles from HMP Liverpool.

78. At 2.20pm on 31 December, the CM telephoned Mr Hamilton's daughter and told her that Mr Hamilton had been taken to hospital on 27 December and that he was seriously unwell. The CM regularly updated Mr Hamilton's daughter about his health. She arranged for Mr Hamilton's daughter and other family members to visit him in hospital, where she met them and offered her support.

79. At 9.00am on 10 January, the CM telephoned Mr Hamilton's daughter to break the news that Mr Hamilton had died. Hospital staff had already told his daughter.

80. Mr Hamilton's funeral took place on 26 February. Prison staff did not attend in line with his daughter's wishes. Liverpool contributed to the costs of Mr Hamilton's funeral, in line with national instructions.

Support for prisoners and staff

81. The prison posted notices informing other prisoners of Mr Hamilton's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Hamilton's death.

Inquest's findings

82. The inquest concluded that Mr Hamilton died of cancer of the gallbladder which had spread.

Findings

Clinical care

83. The clinical reviewer concluded that although Mr Hamilton's non-specific symptoms warranted investigation and a referral for suspected cancer, the overall care that he received was of a reasonable standard, and equivalent to that which he could have expected to receive in the community.

84. The clinical reviewer considered that appropriate assessment and monitoring and assessment processes were in place to monitor and manage Mr Hamilton's pre-existing conditions and as a result, he had access to services that met his individual health needs.

85. The clinical reviewer found that by transferring Mr Hamilton to the inpatient unit on 20 April, nursing staff delivered responsive care. She considered that the inpatient unit ensured that healthcare staff could offer Mr Hamilton the emotional, physical and psychological support he needed. She found that healthcare staff responded appropriately with an interim care plan when the agreement to leave his door open was temporarily suspended on 25 December 2018.

86. The clinical reviewer found that when Mr Hamilton's health deteriorated, it affected his wellbeing and independence. She identified that his social care plan ensured that he was supported and that basic self-care tasks were maintained. She found that healthcare staff responded appropriately when Mr Hamilton's health deteriorated on 27 December 2018 by transferring him to hospital. She identified that healthcare staff liaised regularly with hospital staff.

87. The clinical reviewer identified that the healthcare team at Liverpool appropriately assessed and monitored Mr Hamilton's mental health, and appropriately supported him under ACCT procedures.

88. However, the clinical reviewer identified that Mr Hamilton was significantly underweight when he was weighed at his reception screen on 22 August 2017, and she would have expected this to be further investigated at the time.

Secondary health screen

89. 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.

90. Although Mr Hamilton had an initial health screen when he arrived at Liverpool on 22 August 2017, he did not have a secondary health screen until 8 September, 17 days later. While the clinical reviewer concluded that this did not impact on the eventual outcome for Mr Hamilton, it 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 the necessary treatment and support, in line with NICE guidance.

Referral for suspected cancer

99. NICE guidance on suspected cancer states that patients who present with non-specific complaints should be assessed for additional symptoms, signs or findings of cancer and that patients should be referred for urgent investigation under the two-week suspected cancer pathway.

100. The clinical reviewer acknowledged that hospital investigations in May 2018 concluded that Mr Hamilton did not have cancer and that a head CT scan, chest x-ray and ECG in November 2018 did not identify any issues. However, she concluded that between October and December 2018, Mr Hamilton had a number of symptoms that justified a referral for suspected cancer. Although she could not say whether a referral would have affected the outcome for Mr Hamilton, she found that he might have been diagnosed with cancer earlier. We make the following recommendation:

The Head of Healthcare should ensure that clinical staff appropriately refer prisoners with possible cancer for a specialist assessment, using the suspected cancer pathway, in line with NICE guidelines.

Restraints, security and escorts

101. 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 a prisoner's health and mobility.

102. 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.

103. We recognise that Mr Hamilton was not restrained when he was transferred to hospital on 27 December 2018. However, Mr Hamilton was restrained when he was transferred to hospital as an emergency on 9 November 2018.

104. A prison manager concluded at the time that two officers should escort Mr Hamilton, using an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) and that restraints should only be removed for medical treatment with prior approval. He noted in the escort risk assessment that he based his decision on the length of Mr Hamilton's sentence, his Personal Emergency Evacuation Plan, his age and limited mobility. There is no evidence that healthcare staff contributed to the escort risk assessment.

105. We are concerned that the approach that the prison manager applied to using restraints was inconsistent with the provisions of the High Court judgement. Mr Hamilton was 65 years old, in poor health and had poor mobility. We do not consider in these circumstances that restraining Mr Hamilton was proportionate to the risk he posed, especially as he was escorted by two officers. Staff appear to have been influenced by Mr Hamilton's offences, rather than considering his risk at the time and the impact of his poor health on his risk.

106. In our report into the death of a prisoner at Liverpool in November 2017, we recommended that the Governor should ensure all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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 prison accepted our recommendation and in May 2018, the Head of Safer Custody emailed all appropriate operational staff to remind them of the legal position on the use of restraints.

107. Despite this, we again identified the inappropriate use of restraints in a report into the death of another prisoner at Liverpool in September 2018, and repeated our recommendation, which Liverpool again accepted. They told us that they had emailed all appropriate staff in January 2019 to remind them of their responsibilities and to ensure that they maintain prisoners' dignity and balance the need to use restraints for security purposes with the decency and the health of the individual.

108. We are disappointed that an appropriate decision-making process was again not followed before restraining Mr Hamilton, and that he was inappropriately restrained. We repeat our recommendation and now also escalate our concerns to the Prison Group Director for Greater Manchester, Merseyside and Cheshire:

The Governor and Head of Healthcare should 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 assure himself that meaningful action is taken to ensure that this happens.

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