Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Wilkinson, a prisoner at HMP Liverpool, on 5 April 2023

A report by the Prisons and Probation Ombudsman

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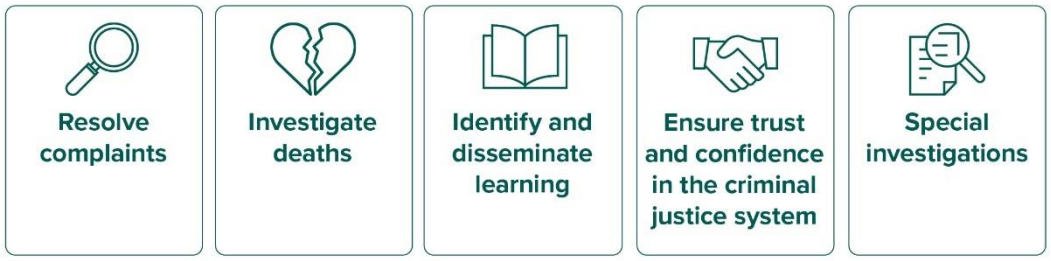
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

Summary

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Ian Wilkinson died from lung cancer at St Joseph's Hospice, Liverpool, on 5 April 2023, while a prisoner at HMP Liverpool. He was 64 years old. We offer our condolences to Mr Wilkinson's family and friends.

4. The clinical reviewer concluded that the clinical care Mr Wilkinson received at Liverpool was equivalent to that which he could have expected to receive in the community. The clinical reviewer made no recommendations.

5. We found that the non-clinical care provided to Mr Wilkinson was of a good standard, so we have not made any recommendations.

The Investigation Process

6. We were notified of Mr Wilkinson's death on 5 April 2023.

7. NHS England commissioned an independent clinical reviewer to review Mr Wilkinson's clinical care at HMP Liverpool.

8. The PPO investigator investigated the non-clinical issues relating to Mr Wilkinson's care at Liverpool.

9. The PPO family liaison officer wrote to Mr Wilkinson's next of kin, his brother, to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond to our letter.

10. We shared the initial report with HM Prison and Probation Service. They identified no factual inaccuracies.

Previous deaths at HMP Liverpool

11. Mr Wilkinson was the 17th prisoner to die at Liverpool since April 2020. Twelve of the previous deaths were due to natural causes.

Key Events

12. Mr Ian Wilkinson was diagnosed with bilateral lung cancer in the community in July 2021. He started chemotherapy in October 2021. In June 2022, the chemotherapy was found to have been unsuccessful, so was stopped. Mr Wilkinson was not a suitable candidate for radiotherapy because of his lung disease, so he was transferred into palliative care.

13. On 12 January 2023, Mr Wilkinson was found guilty of sex offences and remanded to HMP Liverpool. This was his first time in prison.

14. During the reception process, healthcare staff recorded Mr Wilkinson's terminal lung cancer diagnosis. They recorded several other long-term medical conditions including type 2 diabetes, hypertension (high blood pressure), chronic obstructive pulmonary disease (COPD – a group of lung conditions affecting the breathing), pulmonary fibrosis (a group of serious lung diseases that affect the respiratory system) and depression.

15. A GP at Liverpool reviewed Mr Wilkinson shortly after his arrival. She clarified that he had stopped treatment for lung cancer on 24 June 2022 and had been given 12 months' life expectancy.

16. On 13 January, the mental health team reviewed Mr Wilkinson due to his prognosis and history of depression. No concerns were raised and he was informed how to access help if needed. Later the same day, healthcare staff created care plans for Mr Wilkinson's end of life/palliative care, hypertension, COPD, type 2 diabetes, acute and chronic pain.

17. On 17 January, the prison appointed a family liaison officer (FLO) for Mr Wilkinson.

18. On 18 January, Mr Wilkinson was referred for palliative care with the Integrated Mersey Palliative Care Team.

19. On 24 January, following a conversation with Mr Wilkinson about his final wishes, a GP completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order.

20. On 25 January, Mr Wilkinson's legal team submitted an application for early release on compassionate grounds to the Governor. The Governor rejected the application because Mr Wilkinson was on remand and therefore, in accordance with national Prison Service policy, he was not eligible for early release.

21. On 31 January, Mr Wilkinson was sentenced to nine years imprisonment. (Mr Wilkinson and his legal team did not reapply for early release following his sentencing. Prison Service policy states that applications should consider the knowledge the court had of the circumstances (of the diagnosis) at the point of sentencing, and that applications would only be considered if the situation had changed significantly since that point.)

22. On 5 February Mr Wilkinson moved to the prison healthcare unit where he could be monitored by clinical staff.

23. On 23 March, a nurse noted that Mr Wilkinson's condition had deteriorated over the previous week. His breathing was more laboured and he experienced pain in his lungs. Mr Wilkinson now used a nebuliser three times a day to help him breathe and his pain relief medication was adjusted accordingly.

24. On 24 March, healthcare staff assessed Mr Wilkinson using the Fast Track Tool for NHS Continuing Healthcare. The assessment showed rapid deterioration in his condition and that he was now in the terminal phase. His symptoms included uncontrolled and increased chest secretions, dysphasia and increased anxiety.

25. On 27 March, Mr Wilkinson was transferred to St Joseph's Hospice for end of life care. He was not restrained on route or at any point during his time there. The FLO informed Mr Wilkinson's family of his move to the hospice. They visited Mr Wilkinson and remained in contact on the telephone throughout his stay in the hospice.

26. During the morning of 5 April, hospice staff informed Mr Wilkinson's next of kin that end-of-life care had started. Mr Wilkinson died at 10.35am. His wife and son arrived soon after.

Cause of death

27. The coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Wilkinson's cause of death as advanced lung cancer and pulmonary fibrosis.

28. The inquest, held on 19 April 2023, concluded that Mr Wilkinson died from natural causes.

Findings

29. Mr Wilkinson's condition was monitored closely by healthcare staff throughout his time in prison, and his medication was adjusted accordingly. Prison staff ensured that Mr Wilkinson's needs were appropriately accommodated and that he was treated with compassion throughout his imprisonment. The clinical reviewer found that Mr Wilkinson received care of a good standard and equivalent to that which he could expect to receive in the community.

Good Practice

30. Mr Wilkinson was not restrained on route to the hospice or at any point during his time there. This good practice has been noted.

Adrian Usher
Prisons and Probation Ombudsman **November 2023**

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