Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Coysh, a prisoner at HMP Wymott, on 26 April 2021

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

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.

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.

Mr Edward Coysh died on 26 April 2021 of cancer while a prisoner at HMP Wymott. He was 74 years old. I offer my condolences to Mr Coysh's family and friends.

The clinical reviewer concluded that the healthcare Mr Coysh received at HMP Wymott was not equivalent to that which he could have expected to receive in the community.

The clinical reviewer was concerned that healthcare staff failed to pick up Mr Coysh's ongoing liver function issues when he arrived at the prison and that he was not referred to the NHS specialist cancer pathway for investigation sooner. In addition, his pain management was poor and healthcare staff failed to seek specialist advice which could have significantly improved Mr Coysh's quality of life.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **April 2023**

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Summary

Events

1. On 25 May 2018, Mr Coysh was sentenced to 10 years in prison for sexual offences and was sent to HMP Liverpool.

2. Before entering prison, Mr Coysh had been diagnosed with non-alcoholic fatty liver disease, type 2 diabetes, and Barrett's oesophagus (a condition in which the oesophagus becomes damaged by acid reflux).

3. On 13 December 2018, Mr Coysh transferred to HMP Wymott. When he arrived, he told a nurse that he was under the care of a liver specialist at hospital in Liverpool and was awaiting the results of a liver scan taken the previous week. The nurse noted this but took no follow up action.

4. In May 2019, a prison GP saw Mr Coysh because he was complaining of ongoing back and abdominal pain. The GP prescribed pain killers and arranged a scan and blood tests. When the results were received in July, the GP referred Mr Coysh to hospital specialists. Mr Coysh did not receive an appointment and healthcare staff at Wymott did not chase this up.

5. In September 2020, the GP reviewed Mr Coysh again after blood tests showed abnormal liver function. He again referred Mr Coysh to hospital specialists. In November, Mr Coysh had a telephone consultation with a gastroenterology consultant who arranged a routine liver scan and said he would see Mr Coysh again in six months.

6. In February 2021, the GP saw Mr Coysh again as he was complaining of abdominal pain. The GP contacted the hospital who said that the liver scan had not yet taken place and that Mr Coysh was due to see the consultant again in May. The GP took no further action.

7. On 24 March, a prison paramedic saw Mr Coysh because he was complaining of ongoing back pain. Mr Coysh said that he also had pain in his abdomen, and his urine was dark orange and had a strong smell. The paramedic requested an appointment for Mr Coysh with a prison GP.

8. On 1 April, a prison GP saw Mr Coysh and ordered an urgent blood test and a repeat liver function test.

9. On 7 April, a GP saw Mr Coysh, reviewed his recent test results and made an urgent referral under the NHS pathway which requires prisoners with suspected cancer to be seen by a specialist within two weeks. He prescribed stronger pain relief as Mr Coysh said he was still in a lot of pain.

10. On 10 April, a nurse saw Mr Coysh in his cell at the request of prison staff. He said he was in a lot of pain. She noted he was due to see a GP in two days and advised him to tell prison staff if the pain got worse in the meantime.

11. On 12 April, a GP saw Mr Coysh and told him he may have pancreatic cancer. He prescribed stronger pain relief.

12. On 14 April, Mr Coysh was taken to hospital due to increased pain and vomiting over the previous two days. On 18 April, while in hospital, Mr Coysh was told that he had terminal cancer.

13. The prison began the process to apply for early release on compassionate grounds on Mr Coysh's behalf. However, on 26 April, Mr Coysh died in hospital before the application could be completed.

Findings

14. The clinical reviewer concluded that the clinical care Mr Coysh received at HMP Wymott was variable. There were some examples of good practice but also notable areas for improvement.

15. The clinical reviewer considered the prison's overall management of the threat of COVID-19, the management of Mr Coysh's risk of contracting COVID-19, and the management of his diabetes were all examples of good practice. She concluded that in these respects Mr Coysh's care was equivalent to that which he could have expected to receive in the community.

16. She did, however, raise a number of significant concerns. In particular she was concerned that:

    - no action was taken to monitor Mr Coysh's liver disease when he arrived at Wymott in December 2018 and that his liver disease was not identified until May 2019;
    - no action was taken to follow up a referral to hospital made in July 2019;
    - no further action was taken until September 2020 when Mr Coysh was again referred to hospital; and
    - Mr Coysh was not referred to hospital under the suspected cancer pathway on 1 April 2021 following abnormal blood tests.

    The clinical reviewer considered that these were all missed opportunities to have referred Mr Coysh to specialists earlier (although she was unable to say if this might have changed the outcome for him).

17. The clinical reviewer was also concerned that Mr Coysh's pain was not effectively managed.

18. She concluded that in these respects Mr Coysh's care was not equivalent to that which he could have expected to receive in the community.

19. We are also concerned that the prison's Family Liaison Officer (FLO) did not inform Mr Coysh's next of kin that he had been admitted to hospital on 14 June 2021, and that the FLO did not properly record all of their communications with Mr Coysh's next of kin.

Recommendations

- The Head of Healthcare at HMP Wymott should ensure that staff revisit the guidance outlined within NG 57 Physical Healthcare for Prisoners, and that those prisoners identified at reception with any ongoing treatment needs are referred to relevant services to ensure continuity of healthcare is maintained.

- The Head of Healthcare at HMP Wymott should put processes in place to ensure that prisoners with health concerns that require ongoing surveillance are referred to the local service provider.

- The Head of Healthcare at HMP Wymott should liaise with the Lead GP to ensure that healthcare staff:

    - revisit national guidance in relation to suspected cancer, jaundice and deranged liver function tests; and

    - refer prisoners with a concerning presentation to appropriate specialist services.

- The Head of Healthcare at HMP Wymott should ensure that:

    - there are systems in place for tracking the progress of routine referrals sent to specialist services; and

    - if a patient does not receive an appointment for specialist assessment in line with the timescales outlined in national guidance, this is followed up in a timely manner with the secondary care provider.

- The Head of Healthcare at HMP Wymott should ensure that staff are aware of the different processes in place for arranging appointments for those patients requiring a prompt GP assessment.

- The Head of Healthcare and Lead GP at HMP Wymott should ensure that:

    - there is comprehensive guidance in place so that healthcare professionals are better able to identify and manage those prisoners who are experiencing pain; and

    - there are agreed criteria for accessing specialist services to ensure that prisoners receive appropriate, effective pain relief.

- The Governor of HMP Wymott should ensure, in line with PSI 64/2011, that staff notify prisoners' next of kin immediately when a prisoner becomes seriously ill.

- The Head of Healthcare at HMP Wymott should share this report with all healthcare staff named in it, including GPs, so that they are aware of the Ombudsman's findings.

The Investigation Process

20. HMPPS notified us of Mr Coysh's death on 26 April 2021.

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

22. NHS England commissioned a clinical reviewer to review Mr Coysh's clinical care at the prison. The investigator and the clinical reviewer interviewed three members of staff on 26 April 2021 and the clinical reviewer interviewed one member of healthcare staff separately. The interviews were conducted by telephone because of the COVID-19 restrictions.

23. We informed HM Coroner for Lancashire of the investigation. The coroner provided us with the cause of death. We have sent the coroner a copy of this report.

24. One of the Ombudsman's family liaison officers contacted Mr Coysh's son to explain the investigation and to ask if he had any matters they wanted the investigation to consider. Mr Coysh's son raised concerns about his father's healthcare and pain management and the family's lack of contact with the prison's Family Liaison Officer. We have addressed his concerns in this report and the clinical review.

25. Mr Coysh's son received a copy of the initial report. He did not make any comments.

26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Wymott

27. HMP Wymott is a medium secure prison holding adult men. Greater Manchester Mental Health NHS Foundation Trust provides the majority of healthcare services at the prison. Indigo Primary Care Services provides GP services and GTD Healthcare provides out of hours GP services.

HM Inspectorate of Prisons

28. The most recent full inspection of HMP Wymott was in 2016. Inspectors reported health care provision was weak and, in some areas, potentially unsafe. Clinical governance and cleanliness were insufficient, and despite there being some committed staff, the care of men with chronic health problems was not good enough. There were a number of serious shortcomings in medicine management. Although those with acute or urgent problems received good care, overall they considered the service had some substantial failings.

29. HMIP also conducted a Scrutiny Visit (a shortened inspection during the COVID-19 pandemic) at Wymott in August 2020. Inspectors reported that Public Health England had commended healthcare staff and the prison for their management of the early stages of the pandemic. However, they found that delays in prisoners receiving their medication and poor governance in the prison pharmacy had created unnecessary risks and caused severe distress for many prisoners. They said that this required immediate attention.

Independent Monitoring Board

30. 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 ending May 2021, the IMB acknowledged that the COVID-19 pandemic had had a significant impact on the provision of primary healthcare services but said “the longstanding problems raised in previous reports still persist”. The Board reported that there was still too great a reliance on agency staff, especially pharmacy staff, leading to cancellations and problems with the distribution of medication, and that the healthcare centre remained too small, with insufficient treatment rooms.

Previous deaths at HMP Wymott

31. Mr Coysh was the 13th prisoner to die at Wymott since April 2019. Of the previous deaths 11 were from natural causes and one was drug related.

32. In our previous investigations into deaths at Wymott in 2019 and 2020, we were concerned about the management of long-term conditions. We recommended that the Head of Healthcare should ensure that clinical staff assess and manage prisoners effectively to enable good standards of care, including that all treatment and care is fully documented in prisoners’ medical records to enable effective

continuity of care; and that clinical staff are aware of the triggers for escalation and when to organise further investigations. The Head of Healthcare accepted our recommendations and said that all healthcare staff follow templates that are embedded into SystmOne (the electronic medical records system) so that documentation is consistent and ensures continuity of care, and that a comprehensive individual care plan is completed for specific needs. We were also told that all healthcare staff were reminded verbally about documentation at every monthly staff meeting, and that all staff were aware of escalating a concern to the shift lead, management, the onsite doctor or calling for an ambulance, in line with policy.

33. In another investigation in 2020, we recommended that the Head of Healthcare should ensure that care plans are initiated and developed in a timely manner. The Head of Healthcare accepted our recommendation and said that healthcare staff had been reminded that care plans should be implemented at the first initial consultation when seeing the healthcare professional and should ensure that the prisoner is in agreement with the plan and level of care that they need. We were also told that healthcare staff had been reminded where the care plans were kept and how to input them onto the system and how to personalise them to each prisoner, and that the community matron would complete an audit to ensure that all prisoner with a long-term condition have a care plan in place.

Key Events

34. On 25 May 2018, Mr Coysh was sentenced to 10 years imprisonment for sexual offences and was sent to HMP Liverpool.

35. Before entering prison, Mr Coysh had been diagnosed with non-alcoholic fatty liver disease, type 2 diabetes, and Barrett's oesophagus (a condition in which the lining of the swallowing tube [oesophagus] that connects the mouth to the stomach becomes damaged by acid reflux). He had also had bilateral knee replacements.

36. He was seen by a hepatology (liver) specialist at Aintree Hospital in Liverpool. It was decided that he should have six-monthly scans of his liver to monitor for the development of any abnormalities and he had two scans while he was at HMP Liverpool (in May and early December 2018). He was also due to have a fibro scan (a specialist scan of the liver), although no date had been fixed for this appointment.

37. In addition, Mr Coysh was due to have routine surveillance of his Barrett's oesophagus (since this condition can develop into cancer) and was on the waiting list for an endoscopy (when a camera on a tube is inserted into the oesophagus).

38. On 13 December 2018, Mr Coysh transferred to HMP Wymott. When he arrived at Wymott, a nurse completed his reception health screen. He told her that he was under the care of a consultant hepatologist at Aintree Hospital and had attended the hospital for a liver scan the week before and was awaiting the results. The nurse noted "possible cirrhosis of the liver". There is no evidence that she took any action in response to Mr Coysh's disclosure, either by checking his prison medical records – SystmOne - or by contacting HMP Liverpool.

39. Later that month, a nurse carried out Mr Coysh's secondary health screen. Nothing is recorded in the medical records to indicate that Mr Coysh's liver disease and treatment at Aintree Hospital was discussed or that any action was taken in response.

2019

40. In May 2019, a prison GP, saw Mr Coysh after he reported that he had had back pain and pain in his upper abdomen for about a month. The GP prescribed pain killers and arranged for blood tests and an ultrasound.

41. In July, a prison GP reviewed the results of the blood tests and ultrasound. The blood tests were abnormal and there was a suspected noncancerous mass on Mr Coysh's liver. The prison GP reviewed Mr Coysh's medical records and found that he was under the care of the Hepatology Department at Aintree Hospital. He also noted that Mr Coysh was should have had a fibro scan of his liver in late 2018 but that this had not been completed as it had been missed when he transferred from Liverpool to Wymott. He referred Mr Coysh to the local gastroenterology team at Royal Preston Hospital. There is no information in the

medical records to suggest that Mr Coysh was offered an appointment or that healthcare staff ever chased this up.

2020

42. On 7 September 2020, Mr Coysh was reviewed by the prison GP after recent blood tests results had identified abnormal liver function. Given Mr Coysh's history, the prison GP refer him to the Gastroenterology Department at Royal Preston Hospital. (The prison GP told the investigator that during this consultation, he had not identified that a previous referral had been sent in July 2019 and he was unable to explain why the previous referral had not been followed up.)

43. In November, Mr Coysh had a telephone consultation with a consultant gastroenterologist at Royal Preston Hospital. Mr Coysh reported that he was generally well in himself but had been experiencing some mild central/lower abdominal pain for around 18 months which was not worsening. The consultant arranged a liver screen and a routine ultrasound scan of the liver and told Mr Coysh that he would review him again by telephone in six months' time.

2021

44. On 24 February 2021, the prison GP saw Mr Coysh after he complained of intermittent left sided abdominal pain. He asked the healthcare administration team to confirm when the liver ultrasound planned in November 2020 was due to take place. He advised Mr Coysh to seek further medical advice if the abdominal pain increased in severity or became constant in nature.

45. Prison healthcare staff liaised with the gastroenterology team at the hospital and were told that Mr Coysh was not due for a follow up appointment with the consultant until May 2021. The hospital said that Mr Coysh was on the routine list for a liver ultrasound scan and would be scheduled for an appointment as soon as possible. Given the disruption caused by the COVID-19 pandemic, the hospital said that as this appointment was routine, it could not be expedited. At interview a prison GP said he was satisfied with this response.

46. On 24 March, Mr Coysh was examined by a prison paramedic, because he was complaining of ongoing back pain. Mr Coysh told the prison paramedic that he also had pain in his abdomen and that his urine was dark orange and had a strong smell. He was reluctant to prescribe medication to address the pain because of Mr Coysh's liver disease, so he sent an electronic message to the GP task group asking for GP appointment for Mr Coysh for a general assessment and review of his pain relief as he was experiencing ongoing back and abdominal pain.

47. On 1 April, Mr Coysh saw a prison GP. The prison GP had some concerns about Mr Coysh's recent liver function tests which indicated that his bilirubin level was high. (This can be a sign of jaundice, which can in turn indicate liver problems). The prison GP was not available for interview but he provided a statement in which he said that he was not convinced that Mr Coysh was jaundiced. He ordered an urgent blood test and repeat liver function test, and prescribed paracetamol and a topical non-steroidal inflammatory gel for Mr Coysh's back

pain. He told Mr Coysh he would be reviewed as soon as the blood test results were available.

48. On 7 April, a prison GP saw Mr Coysh. Mr Coysh's liver test results were abnormal, and he noted he was jaundiced. He made an urgent referral to the gastroenterology department under the NHS pathway which requires prisoners with suspected cancer to be seen by a specialist within two weeks. He prescribed codeine (an opiate drug for mild to moderate pain) for Mr Coysh's ongoing pain.

49. On 10 April, an officer was asked to check on Mr Coysh after a family member left a message on the safer custody hotline expressing concerns about his health.

50. On the same day, a nurse saw Mr Coysh in his cell because prison staff asked healthcare staff to check on him. Mr Coysh reported increased pain, despite taking codeine. The nurse noted that Mr Coysh "appeared in pain." She recorded that he had a GP appointment booked for 12 April and that she had advised him to let the officers know if the pain got worse and ask them to contact healthcare again.

51. On 12 April, a prison GP saw Mr Coysh as the codeine had not had any impact on the pain he was experiencing. He prescribed dihydrocodeine (an opioid pain reliever drug used to treat moderate to severe pain) as an alternative. He told Mr Coysh that the latest blood tests indicated that he could have pancreatic cancer.

52. On 14 April, Mr Coysh had a telephone consultation with a hospital specialist in response to the suspected cancer pathway referral. A prison nurse accompanied Mr Coysh during this consultation. Mr Coysh said he had vomited dark fluid the previous night and was experiencing abdominal pain which was spreading into his back. This had got worse in the previous 10 days and was now so bad that he could not climb stairs. The specialist said she would arrange tests and it was agreed that a nurse would speak with the GP to discuss whether Mr Coysh should be admitted to hospital as an emergency.

53. The nurse noted that Mr Coysh looked pale and jaundiced and that he struggled to sit or get up from the chair due to the degree of pain that he was experiencing. He rated his pain as "10" on a scale of 0 to 10 and said the change to dihydrocodeine had had no effect on his pain. She took his clinical observations, and, despite a low NEWS2 score, it was decided to send him to Royal Preston Hospital, because he was experiencing increased pain and vomiting.

54. On 18 April, while in hospital, Mr Coysh was told that he had terminal cancer which had mainly affected his liver and lungs. Although Mr Coysh's prognosis was not yet clear and his life expectancy unknown, the prison began the process of applying for early release on compassionate grounds on Mr Coysh's behalf.

55. On 26 April, Mr Coysh died in hospital, before the compassionate release application had been completed.

Contact with Mr Coysh's family

56. The prison appointed the Chaplain as the Family Liaison Officer (FLO) and he made contact with My Coysh's daughter by phone. When Mr Coysh died, his family were with him. The FLO contacted his daughter by phone shortly after Mr Coysh's death. He offered his condolences, explained the processes with the Coroner and PPO, and outlined the prison's contribution to funeral costs.

57. Mr Coysh's funeral was held on 14 May. In line with Prison Service instructions, the prison contributed towards the costs of the funeral.

Cause of death

58. The Coroner accepted the cause of death provided by a hospital doctor and no post-mortem examination was carried out. The doctor gave Mr Coysh's cause of death as carcinomatosis (extensive spread of cancer to multiple locations in the body) which was secondary to metastatic cancer (when cancer spreads to a different body part from where it started) of unknown origin. He also had non-alcoholic fatty liver disease which did not cause but contributed to his death.

Findings

Clinical care

59. The clinical reviewer concluded that the clinical care Mr Coysh received at Wymott was variable. She found some examples of good practice and some areas that required improvement.

60. The clinical reviewer considered that proactive monitoring, management and mitigation of the threat of COVID-19 spreading through the prison and reducing Mr Coysh's risk of contracting COVID-19, were examples of good practice. She also considered that healthcare staff managed his type 2 diabetes well. He also had access to services relevant to his age, which met his individual health needs. The clinical reviewer concluded that these aspects of Mr Coysh's care were equivalent to those which he could have expected to receive in the community.

61. She did, however, identify a number of areas of significant concern.

Continuity of care and first and secondary health screens

62. The clinical reviewer was concerned that staff at HMP Wymott did not identify Mr Coysh's ongoing medical needs and appointments during the first and second stage health screenings. HMP Liverpool had uploaded information relating to ongoing issues to the SystmOne records, a shared record visible to both prisons.

63. A nurse, who saw Mr Coysh when he arrived at Wymott, took no action when he told her that he had recently been to hospital for a scan of his liver and was awaiting the results, and that there is no evidence that the nurse explored this with Mr Coysh when she conducted his secondary health screen later that month.

64. As a result, healthcare staff at Wymott were not aware of the results of Mr Coysh's December 2018 liver scan and did not identify his history of liver disease until July 2019, and Mr Coysh did not have the six-monthly scans of his liver that had been planned.

65. The clinical reviewer could not say whether this had an impact on the outcome for Mr Coysh, but she said that if healthcare staff at Wymott had been aware of the results of the December 2018 liver scan result, this might have prompted an earlier referral to a local specialist team. She said that the management of Mr Coysh's liver disease was not of the expected standard.

66. In addition to the failure to identify Mr Coysh's needs in respect of his liver disease, there was also a failure to ensure continuity of care for Mr Coysh's Barrett's oesophagus. He was awaiting an endoscopy to monitor this condition, but when prison healthcare were told in June 2019 that an appointment had been made for him in August, an unknown person said he would not be able to attend as it was too far away. There is no evidence that the individual who said this highlighted that Mr Coysh would require a local referral to ensure that the routine surveillance of his Barrett's oesophagus continued at a local hospital. As a result,

Mr Coysh did not have access to routine surveillance of his Barrett's oesophagus during his time at Wymott. We recommend:

The Head of Healthcare at HMP Wymott should ensure that staff revisit the guidance outlined within NG 57 Physical Healthcare for Prisoners, and that those prisoners identified at reception with any ongoing treatment needs are referred to relevant services to ensure continuity of healthcare is maintained.

The Head of Healthcare at HMP Wymott should put processes in place to ensure that prisoners with health concerns that require ongoing surveillance, are referred to the local service provider.

Referral to specialist services

67. The clinical reviewer was concerned that although a prison GP referred Mr Coysh to the gastroenterology team at Royal Preston Hospital in July 2019, he was never offered an appointment, and this was never identified or followed up by healthcare staff at Wymott. As a result, Mr Coysh was not reviewed again in relation to his liver disease by the healthcare team at Wymott until September 2020 (more than a year later). This was another missed opportunity for Mr Coysh to receive specialist care and assessment at an earlier stage.

68. The clinical reviewer also noted that on 1 April 2021, a prison GP made the decision not to refer Mr Coysh for a specialist opinion as he was not convinced at the time of the consultation that Mr Coysh was jaundiced. The clinical reviewer said that jaundice is not a common presentation in primary care but is usually indicative of serious illness that requires urgent investigation and treatment. National guidance suggests that anyone with unexplained jaundice should be referred to specialist services. Given the uncertainty over whether Mr Coysh was jaundiced, together with his abnormal liver function tests, the clinical reviewer considered that a referral for a specialist opinion would have been the most prudent approach.

69. She could not say if the decision not to refer Mr Coysh to the gastroenterology team either urgently or using a cancer referral pathway would have impacted on the eventual outcome. However, she said that a referral for a specialist opinion at this point would have ensured that an earlier diagnosis and prognosis was received. We recommend:

The Head of Healthcare at HMP Wymott should liaise with the Lead GP to ensure that healthcare staff:

- **revisit national guidance in relation to suspected cancer, jaundice and deranged liver function tests; and**
- **refer prisoners with a concerning presentation to specialist services.**

The Head of Healthcare at HMP Wymott should ensure that:

- **there are systems in place for tracking the progress of routine referrals sent to specialist services; and**
- **if a patient does not receive an appointment for specialist assessment in line with the timescales outlined in national guidance, this is followed up in a timely manner with the secondary care provider.**

Referral to prison GPs

70. The clinical reviewer was also concerned that, although the prison paramedic referred Mr Coysh to prison GPs for assessment and review of his pain relief on 24 March 2021, he was not seen by a GP until 1 April. The clinical reviewer said that, given Mr Coysh's presentation, his appointment should have been prioritised and that the delay before he was reviewed by a GP was a concern.

71. At interview, the prison paramedic said he was surprised that Mr Coysh had not been seen sooner. However, the Head of Healthcare, told us that if a task requires a speedy response, it should be marked as urgent. As the prison paramedic's task was not marked as urgent, it was not actioned until 31 March. the Head of Healthcare also said that, if a GP review was required urgently, the prison paramedic should have arranged an emergency GP appointment, rather than sending a task. We recommend:

The Head of Healthcare at HMP Wymott should ensure that staff are aware of the different processes in place for arranging appointments for those patients requiring a prompt GP assessment.

Pain management

72. The clinical reviewer also considered that Mr Coysh's pain management was inadequate. She acknowledged that pain management in patients with liver disease can be challenging, but she was concerned that the significance of the pain Mr Coysh was experiencing was not always recognised. As a result, it was not acted upon, and Mr Coysh continued to experience pain. The clinical reviewer was also concerned that when a nurse saw Mr Coysh is significant pain on 10 April 2021, she did not consider bringing his GP appointment forward.

73. The clinical reviewer considered that more could have been done to provide Mr Coysh with effective, safe pain relief. In particular, she considered that the support of specialist services should have been sought sooner. We recommend:

The Head of Healthcare and Lead GP at HMP Wymott should ensure that:

- **there is comprehensive guidance in place so that healthcare professionals are better able to identify and manage those prisoners who are experiencing pain; and**

- **there are agreed criteria for accessing specialist services to ensure that prisoners receive appropriate, effective pain relief.**

Liaison with Mr Coysh's family

74. When Mr Coysh was taken to hospital on 14 April, it was not yet known that he had widespread cancer and was terminally ill. However, given his age, and the fact that he had suspected cancer and that his health had deteriorated over the last few days, we consider that the prison should have informed Mr Coysh's next of kin that he had been admitted to hospital. We recommend:

    The Governor of HMP Wymott should ensure, in line with PSI 64/2011, that staff notify prisoners' next of kin immediately when a prisoner becomes seriously ill.

75. The prison appointed a chaplain as the FLO. It is not clear when he was appointed as the first contact, he had with Mr Coysh's family is not recorded on the FLO log. There is also a gap in FLO log between 27 April and 10 May.

76. In interview, the FLO said that he thought there would have been contact during this two-week period given the way he would usually work with a family. He said that he recalled typing up his handwritten notes of his contact with the family but had mislaid them. He also said that there had been an issue with his IT. He said that once he types up the notes, he discards them, so he could not be certain of exactly what he did in that two-week period.

77. It is important that the FLO keeps contemporaneous notes of every contact with the next of kin. We appreciate that FLOs have other jobs to do which may keep them very busy and that they are entitled to have rest days and take holidays. For this reason, it is good practice to appoint a deputy FLO to ensure that there is always someone available to answer questions from the bereaved family at what is likely to be a very difficult time for them.

78. Following the issuing of the initial report, the prison informed the investigator that at the time of Mr Coysh's death it was indeed undergoing the implementation of a new IT system which caused a number of issues with the prison's computer systems.

79. While we do not deem it necessary to make a recommendation of this issue, we have raised it with the prison. The prison accepts that the Family Liaison Log could have been completed to a better standard and they have taken steps to ensure that in the future that will be the case.

Learning lessons

80. It is important that staff learn from the Ombudsman's reports. We therefore recommend:

    The Head of Healthcare at HMP Wymott should share this report with all healthcare staff named in it, including GPs, so that they are aware of the Ombudsman's findings.

Inquest

81. The inquest, heard on 27 February 2023, concluded that Mr Coysh died from natural causes.

Prisons & Probation Ombudsman
Independent Investigations

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