

**Investigation into the circumstances surrounding
the death of a man in May 2011, in hospital
while in the custody of at HMP Liverpool**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

November 2011

This is the report into the circumstances surrounding the death of a man who died in hospital in May 2011. The man had been admitted to hospital on 6 May, following deterioration in his physical health. He had recently been diagnosed with lung cancer as well as having a history of heart disease. The man died on 9 May, with his family at his bedside. I extend my sincere condolences to his family and friends.

Her Majesty's Coroner for Merseyside Liverpool District, commissioned a post mortem examination into the man's death. The pathologist concluded that the cause of death was congestive cardiac failure with severe lower respiratory tract infection, ischaemic heart disease and emphysema.

A review of the man's clinical care was commissioned with Liverpool Primary Care Trust (PCT). I am grateful to a doctor for that review.

I would like to thank the Governor of Liverpool and his staff for their assistance with this investigation. I am especially grateful to the liaison officer.

I make one recommendation and one housekeeping point in this report. The recommendation is for the attention of the Governor, to ensure that security checks for prisoners attending out patient appointments are made in advance of their departure from the prison. The housekeeping point is for the head of healthcare and concerns regular and concise entries made in patient medical records. Lastly, I note the professional manner in which two officers carried out their duties while on bed watch duty in the hours before the man's death.

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SUMMARY

1. The man was remanded to HMP Liverpool in March 2011, following his arrest in Staffordshire for failing to appear in court. On his arrival at Liverpool, he was seen by a nurse and noted to have several chronic diseases including diabetes, a serious heart condition and mild depression. The man had undergone a heart bypass operation in 2009. He was admitted to the healthcare unit for observation.
2. The following day, the man was assessed by a doctor who prescribed medication for his conditions. He was also referred for a hospital for tests on his kidneys. The man was transferred to K wing on 14 March and prescribed antibiotic medication to help with a cough.
3. On 5 April, the man was admitted to a hospital as his medical condition concerned staff. Two weeks later, he was discharged back to Liverpool's healthcare unit. It was later noted by staff that the hospital suspected he had lung cancer with secondary cancer in his bones. A doctor arranged for palliative care nurses and a care plan to be arranged for the man. (Palliative nursing is the specialist care given to patients with a terminal illness.)
4. An outpatient appointment for further tests was arranged for 3 May. However, due to a late security check before the man left the prison and a lack of a wheelchair at the hospital, the man was unable to have his medical tests and returned to Liverpool. Healthcare staff contacted the hospital and another appointment was made.
5. The man became unwell on 6 May and was re-admitted to hospital for further medical care and investigations. However, his condition deteriorated and he died on 9 May with his family at his bedside.
6. In this report, I make one recommendation for the attention of the Governor and one housekeeping point for the head of healthcare. I am pleased to note the professional manner in which officers carried out their duties on the day the man died.

THE INVESTIGATION PROCESS

7. The Ombudsman's terms of reference and notices to staff were sent to Liverpool, upon notice of the man's death. The Independent Monitoring Board (IMB) and the Prison Officers Association (POA) were notified of the investigation. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners. The POA is the trade union for prison officers.) Up to the circulation of this report there have not been any responses to those notices.
8. A colleague was appointed as the investigator and visited Liverpool on 12 May 2011. She met the prison's liaison officer and reviewed the man's prison file. Copies of those documents were made available for the investigator to take away. She met the Governor, and visited K wing. My investigator also spoke to an officer who had known the man.
9. A clinical review was commissioned by Liverpool Primary Care Trust (PCT). A doctor undertook the review on their behalf.
10. The investigator contacted Her Majesty's Coroner for Merseyside Liverpool District to inform him of the investigation. A copy of the report will be sent to him.
11. One of the office's family liaison officers, contacted the man's sister who was his nominated next of kin. The family liaison officer outlined the purpose of the investigation to the man's sister and invited her to raise any issues she would like the report to consider. The family raised no issues of concern at this stage, they will however have an opportunity to receive and comment on the draft report if they should chose to do.
12. The investigator wrote to the Governor on 29 June to give feedback on the preliminary findings of the investigation. There were no serious concerns brought to the Governor's attention, although the investigator was unable to comment on any clinical issues as she had not received the clinical review at that point.
13. My investigation assesses the following aspects of the man's care and treatment:
 - Whether his diagnosis was made in a timely fashion?
 - Whether the man was told about his condition and the treatment which followed?
 - Whether he was treated properly and attended hospital appointments as necessary?
 - Whether the liaison with the man's family was appropriate?
 - Whether the man was accommodated in the most appropriate part of the prison?

- Whether consideration was given to compassionate release from prison?
 - Whether appropriate palliative care was provided?
14. In response to the draft report, the NOMS feels that the comments relating to the removal of restraints are unfair and, considering the issues, the decisions made were appropriate. The reasons are:
- Removal of restraints was authorised at the earliest opportunity once the duty governor was made aware of the night time events, not just at 5am.
 - The man had, on a number of previous occasions, been very poorly in hospital and made a sudden recovery before being returned to the prison.
 - He had been convicted of some very serious public protection offences and had prior to his conviction, absconded from police.

I note their comments

15. In this final report, the recommendation has been accepted. The man's family have read the draft report and have no comment to make.

HMP LIVERPOOL

16. Liverpool is one of the country's largest prisons, with a maximum operational capacity of 1,439. It serves courts from the Merseyside area and holds remanded, unsentenced and convicted adult male prisoners. There are seven residential wings, including the vulnerable prisoner unit. (This holds prisoners who, due to their offences or other reason of vulnerability, are separated from the rest of the prison population.) One of the wings holds people who are unsentenced or on remand, and it is here that prisoners spend their first night and complete an induction process to help familiarise them with the prison regime.
17. Healthcare services at Liverpool are provided by North Liverpool Primary Care Trust (PCT). A purpose -built hospital unit, which opened in 2007, allows healthcare staff to provide outpatient and inpatient facilities. A doctor is on duty every day during normal working hours, and nursing staff remain on duty throughout the night. The night nursing cover consists of two nurses and one healthcare assistant.
18. The former Her Majesty's Chief Inspector of Prisons, carried out an inspection of Liverpool in September 2009. She noted that relationships between prisoners and staff were generally good.
19. The inspection report said of healthcare:

"The prison had good relationships with the primary care trust (PCT), with the governor and head of healthcare as members of the partnership board. The head of healthcare was a member of the prison senior management team, which provided support for the development of healthcare provision.

"There was a comprehensive range of primary care services equivalent to that provided in the community. Prisoners received care in good conditions that maintained their privacy and dignity. They were escorted to their healthcare appointments by discipline staff, who continued to supervise those in the holding rooms. The environment was clean, with measures to manage the control of infection. The head of healthcare managed a large team of nursing and support staff in addition to three full-time GPs."
20. In their recent report the Independent Monitoring Board (IMB) specifically commented on the healthcare unit as follows:

"The opening of the purpose built facility in 2007 has proved to be a considerable asset to HMP Liverpool. The Board considers the general care to be a high standard in excellent facilities."
21. The man's death was the first natural cause death to occur at Liverpool for nearly two years. There are no similarities between his death and that of the last natural cause death in June 2009.

ISSUES

The diagnosis of the man's terminal illness

22. The man was born in 1940 in Liverpool. In March, the man was arrested by police in Staffordshire for failing to attend a court hearing. The following day, he appeared in court and was remanded into custody to await sentencing. The man was seen in the reception area by a nurse. The nurse noted that the man had insulin dependent diabetes, congestive heart failure (the heart loses the ability to pump blood efficiently) and had recently been treated for mild depression. It was also recorded that he underwent a triple heart bypass in 2009.
23. Later, he saw another nurse who wrote in the man's medical record : " ... attended hospital last night, ? renal stones for further review by GP today". The nurse took the man's observations. His blood pressure was 150/80 (an average reading is 130/80) and a pulse rate of 104 beats per minute (bpm) (an average reading is between 60-100 bpm)
24. A doctor examined the man in March and noted his medical history. A diabetic care plan was opened and the doctor ordered a referral to hospital for a renal (kidney) computerised tomography scan (CT). (A CT scan takes internal pictures of the body tissue.) This was in response to the man's visit to hospital the day before his court appearance. The doctor ordered blood tests to be taken for a full blood count.
25. The clinical reviewer noted that when the man arrived at Liverpool the assessment of his health care needs was "comprehensive". The man's medical history was noted including his mental health. Furthermore, there was also a good record of his social history.
26. The man remained in the healthcare unit while he waited for a place on K wing, the vulnerable prisoner unit. A doctor reviewed the man's medication. It was noted that he had a cough, so the doctor ordered a sputum sample to be taken for analysis. The man was prescribed a laxative for constipation. However, he was coping well and it was agreed that he could be transferred to K wing on 14 March.
27. The following day his sputum sample indicated an abnormality. The man's medical record shows that it was decided that if his cough did not improve the doctor would consider prescribing a course of anti biotics. On 20 March, the man was prescribed an anti biotic. Nine days later, it was recorded that he had not taken prescribed medication for fluid retention and constipation. The man was advised about the importance of taking his medication.
28. The man was admitted to a hospital on 5 April, as his health had not improved and was a cause for concern. He was admitted to ward nine and escorted by two officers. The man was restrained by an escort

chain (a 1.8 metre length of chain with one cuff attached to the prisoner and other to an officer). He remained an inpatient until he was discharged back to Liverpool's healthcare unit on 22 April.

29. The man's medical record notes that when he returned to Liverpool's healthcare unit on 22 April, it was planned that he would be attend hospital as an out patient for a bronchoscopy. (A bronchoscopy is a procedure where a camera is inserted into the chest area via the mouth to examine the lungs.) An x-ray had shown a shadow on his lung indicating a suspected diagnosis of lung cancer.
30. In the hospital discharge letter it was written that the man had been told that it was suspected he might have lung cancer. He was seen on the following three days by healthcare staff and prescribed pain relief for back pain. On 28 April, a doctor noted that a malignant tumour had been diagnosed while the man was an inpatient. (A malignant tumour is a cancerous growth that tends to spread into nearby normal tissue and travel to other parts of the body.)
31. The clinical reviewer writes: "I am impressed with the care the man received while in prison." He does not raise any concerns regarding the timing of the man's diagnosis, and I am satisfied it was appropriate.

Informing the man about his condition and treatment

32. The man was aware that he was suffering from chronic heart disease and diabetes when he entered prison. When he was admitted to hospital in April, he underwent medical tests to determine the exact nature of his presenting medical conditions that included shortness of breath. These tests revealed that the man was suffering from cancer.
33. On 28 April, the man saw a doctor for a full physical examination. The doctor wrote that the man had been diagnosed with lung cancer and secondary cancer in the bones. The doctor noted that he had counselled the man about his cancer and he would arrange for Macmillan Nurses to become involved in the man's care.
34. The clinical reviewer noted that healthcare staff should continue with their good practice of supporting patients with a terminal illness and communication with outside agencies. I am satisfied that the man was informed of his diagnosis in a timely manner.

The man's medical appointments and treatment of the prisoner

35. The clinical reviewer raises a point around the diabetic care the man received. While he acknowledges that his diabetes was well managed, it is unclear if an annual diabetic review was completed. Although the man was only at Liverpool for a short time the clinical reviewer comments:

“On 15 March the man had blood tests done by Glycolated Haemoglobin (HbA1c) which would indicate diabetic control over previous three months was not done. It is good practice to have one as it helps to monitor diabetic control.”

36. It was noted that the man missed his outpatient appointment for a bronchoscopy on 3 May. His medical record noted that he was too late for the appointment. A nurse wrote in his medical notes on 4 May that :

“A catalogue of events contributed to this. A DPSM (Developing Prison Service Manager) was late coming to healthcare to check the cuffs so he left late. He then had to go to some dept for breathing tests which he did, late. Due to him being so SOB [short of breath] he took along time to do the tests. The prison officers then had to get him to another building for his bronchoscopy. They were already later but then got later as they had to wait a while to find a wheelchair to move the man. When they arrived at the unit they were late and waited to find if he could still be seen. Half an hour later they were told they could not hence an appt. in two weeks time.”

37. It is important that prisoners leave the prison in good time to attend outpatient appointments. The DPSM was late in checking the man's security arrangements which had a knock-on effect of delaying his arrival at the hospital and his medical tests, prior to the bronchoscopy. I note the clinical reviewer's observations that Liverpool should review their procedure of hospital outpatient appointments. I therefore make one recommendation for the attention of the Governor

The Governor should ensure that all security arrangements for prisoners out patient appointments are completed well in advance of their departure to hospital

38. However, I am disappointed that when the officers arrived at the hospital a wheelchair was unavailable to move the man to the several clinics for his tests and around the hospital. This caused further delays in getting the man to the unit for his bronchoscopy.
39. The man was admitted to the medical assessment unit at a hospital on 6 May as his breathlessness had deteriorated and there were abnormal sounds when the nurse manager examined his chest. Three days later, at 04.58am the man's condition had deteriorated and his family were at his bedside. All medical treatments had ceased and he was being kept comfortable. He died at 6.57am.
40. The clinical reviewer assesses: “The man was assessed properly and decision was to observe regularly was made. He was seen regularly by nursing staff and when necessary by medical staff.” I am satisfied that the man was looked after well while at Liverpool.

The man's pain relief and medication

41. When the man arrived at Liverpool he was prescribed medication for his chronic diseases. He was seen at a hospital prior to being arrested. The hospital suspected renal stones and he was prescribed co-codamol for pain relief. Following his discharge from hospital on 22 April, The man was prescribed Hyoscine to relieve the congestion in his lungs. At the beginning of May, the man was prescribed Fortisip and nutritional supplements as his appetite had diminished. (Fortisip is a ready-made milkshake style drink meant for consumption by people who cannot consume enough solid food to maintain a balanced diet.)
42. The man's medical record does not indicate that he was prescribed an opiate based medication for pain relief. However, his pain was being controlled by co-codamol and he received oxygen regularly to assist with his shortness of breath.

Record keeping

43. The clinical reviewer comments:

“Though record keeping is generally good, records at important time (period 30 March to 5 April 2011) is missing, it needs improvement. Provider staff are required to keep good records and update regularly.”
44. It is disappointing that there were no notes made in the man's medical record at a critical time in his care. In light of the clinical reviewer's comments, I would ask the head of healthcare to ensure all healthcare staff make concise and regular entries into patient's medical records.

Liaison with the man's family

45. An officer was on bedwatch duty on the evening of 8 May. In a statement, the officer notes that at 1.50am on 9 May, hospital staff asked for the man's next of kin details as his condition had deteriorated and they should be called to his bedside. The officer telephoned the night orderly officer for the details and passed them to the ward sister.
46. The man's sister, brother and other family members arrived at the hospital at 4.50am. They were joined at 5.40am by more members of the man's family, so there were ten relatives in the room. Following enforcement of hospital rules that only two visitors were allowed by a patient's bedside, the man's family took turns to be at his bedside.
47. At 6.40am, hospital staff asked all visitors to leave the man's room so he could be washed and shaved. The officer received a telephone call from the duty governor and took the call outside the room. When he returned all the visitors were at the man's bedside and a nurse told him

that the man had died. The officer and his colleague left the room to give the man's family some private time with him.

48. The man's sister was his nominated next of kin and a member of the prison staff acted as the family liaison officer. He visited her at her home after her brother's death to offer support and assistance. The prison contributed towards the man's funeral expenses.

The man's location

49. The man was only a prisoner at Liverpool for two months. His first week of custody was spent in the healthcare unit while staff assessed his chronic heart disease and diabetes. Later, he moved to the vulnerable prisoner unit. Within three weeks, the man was admitted to hospital and spent two weeks as an inpatient. Following his discharge from hospital, he returned to the healthcare unit at Liverpool, for observation and nursing care.
50. On 6 May, the man was re-admitted to hospital following deterioration in his condition. I judge that the man was appropriately admitted to hospital and the healthcare unit when his condition gave cause for concern.

Compassionate release

51. No application for compassionate release was made on the man's behalf. I do not believe that an application for compassionate release would have been appropriate given the man's very recent conviction and the late diagnosis of his terminal illness.

Palliative care plans

52. Following the man's diagnosis, a doctor noted that Macmillan Nurses (specialists in nursing patients with terminal illnesses) should become involved in the man's care and the Liverpool care pathway implemented. (This plan sets out the pathway for those suffering a terminal illness and includes their nursing, spiritual and emotional care.) Furthermore it was written in his medical record, that the man would be placed on the gold standards framework. (This framework works alongside the Liverpool care pathway in caring for those with a terminal illness.)
53. The clinical reviewer noted the arrangements for a referral to the Macmillan Nurses for support and the implementation of the care pathway was in a "timely manner". I am pleased to see that palliative care plans were implemented when it became clear that the man was suffering from a terminal illness.

Restraints, security and bed watch

54. The man was restrained by an escort chain during his last admission to hospital. Two officers were on bed watch duty during the night of 8 May. When they reported for duty, one of the officers noted a decline in the man's condition from the day before. The man was sleeping and seemed unwell. An improvement was noted in his condition at 1.15am on 9 May, when he gave the officers 'the thumbs up' sign following treatment. However, this did not last long and the man rapidly deteriorated.
55. During the early hours of 9 May, the officers kept in regular contact with the night orderly officer updating him on the man's condition. They asked for the duty governor to be contacted as the officers felt that the man's restraints should be removed at 3.00am.
56. When all of the man's relatives came into his room the officers noticed a change of atmosphere and felt there was some ill feeling between the family members present. Later, the officers observed that some of the family members were arguing outside the hospital entrance.
57. At 5.40am, one of the man's relatives asked one of the officers "to take the cuffs off". The officer explained that he was unable to make this decision and was waiting for authorisation from the duty governor. At 6.10am, the officer received a telephone call from the night orderly officer who informed him that the duty governor had authorised the restraints to be removed, which he did immediately. Due to the large amount of visitors the officers remained in the man's room although they were at a distance. They both left the room to give the family privacy when the man died.
58. The investigator spoke to the officer who told her that both he and his colleague felt uncomfortable being present in the man's room whilst his death was imminent. However, for security reasons and in response to the amount of people in the room, their presence was necessary to ensure the man's dignity. I note the sensitive and professional manner in which both officers responded to a difficult situation.
59. The removal of restraints can only be authorised by a senior prison staff member or in emergency situations (such as if hospital staff demand their removal to enable them to provide treatment). It was noted that hospital staff did not ask the officers to remove the restraints. I am concerned that the removal of restraints did not happen earlier than 50 minutes before the man died. The officers had telephoned the night orderly officer for the restraints to be removed at approximately 3.00am. In accordance with protocol, the duty governor had to be contacted for authorisation and at 6.10am, the man's restraints were removed. Whilst I mindful of the time of day and the situation the officers found themselves in, an earlier response to authorisation of the removal of restraints would have been preferable.

CONCLUSION

60. Following a two week admission to hospital in April, it was suspected that the man had lung cancer. On 28 April, medical tests revealed that he had been diagnosed with lung cancer with secondary cancer in his bones. The man was readmitted to hospital when his health deteriorated on 6 May. He died three days later.

61. The clinical reviewer judges that the man medical care was “well managed” at Liverpool. However he does note that record keeping should be reviewed to ensure entries are regularly made in patients’ records. In conclusion, the clinical reviewer says that the care afforded to the man was satisfactory and equal to that which he would have received in the community. I agree with clinical reviewer, and am satisfied that the man’s care was appropriate.

RECOMMENDATIONS

The Governor

The Governor should ensure that all security arrangements for prisoners out patient appointments are completed well in advance of their departure to hospital

Accepted – “Discharge of escorts to outpatient’s appointments should always be progressed at the earliest opportunity in order to attend the appointment on time. The operations manager will monitor and record the discharge time of outpatient’s appointments from reception and refer these to the healthcare manager to identify any issues. Additionally, a notice will be issued to staff reminding them of the need to ensure such appointments are not delayed except in the most severe circumstances”.