Investigation into the circumstances surrounding the death of a man at HMP Liverpool in November 2006

Report by the Prisons and Probation Ombudsman for England and Wales

November 2007

This is the report of an investigation into the death of a man in November 2006 at HMP Liverpool. The man, who was 35 years old, was found hanging from the bars of his cell. He was serving an 18 month sentence imposed at Liverpool Crown Court just over a month earlier.

I wish to offer my sincere condolences to his family and friends for their loss.

The investigation was conducted on my behalf by one of my investigators. I would like to extend my thanks to the Governor and his staff at HMP Liverpool for their assistance.

In addition to my investigation, a clinical review was undertaken by the Primary Care Trust into the medical care that the man received.

Both this report and the clinical review show that there were a number of possible suicide and self-harm indicators concerning the man that were not seen as such by staff at Liverpool. As a consequence, he was not considered for increased levels of support and observation.

Although it is unlikely that he was aware of the birth, the man became a father for the fourth time on the day of his death.

I make four recommendations.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2007**

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SUMMARY

The man was remanded to HMP Forest Bank on 24 June 2006 from the Magistrates' Court. As a drug user, he was offered a detoxification regime. However, he refused this preferring to 'detox' himself using illicit Subutex.

The man was not happy to be at Forest Bank, possibly because of a conflict with a local drug gang. He spent much of his time at Forest Bank away from normal location, either because he asked for protection or due to breaches of prison discipline.

After a Crown Court appearance in September, the man was re-allocated to HMP Liverpool. He had been prescribed Citalopram, an anti-depressant medication, at Forest Bank and this was continued at Liverpool, along with Tramadol for pain relief. Over time, the Citalopram dosage was increased while the Tramadol was reduced.

The man ran up a drug debt, and was concerned for his own safety as he was unable to repay it. He asked for Vulnerable Prisoner (VP) status for his own protection on 18 October. He remained off the normal wings until 22 November when he said he was happy and that the threat had passed.

While the man had not previously expressed any direct intention to self-harm, on 15 November he told a nurse that the previous week he had been feeling low and had made a noose which he had hung from the bars of his window. On 21 November, he made a threat to throw himself off the five's landing if he was not taken off the VP wing.

About 11.40 am on 29 November 2006, the man's cell mate returned from education and saw him hanging from the window bars of their shared cell, B4-10. Officers immediately entered the cell, cut him down and started attempts at resuscitation. Despite their efforts, and those of the paramedics and a doctor who arrived a short while later, the man was pronounced dead at 12.00 noon.

An inquest into the man's death was held in October 2009, the verdict of which was death by misadventure.

THE INVESTIGATION PROCESS

1. One of my investigators opened the investigation at HMP Liverpool on 4 December 2006. The Governor and his staff produced the man's core record and a number of other documents for examination. Notices were distributed around the establishment notifying staff and prisoners of the investigation. As part of the investigation process, a number of staff and prisoners were formally interviewed.

2. My investigator liaised with the investigating officer from the local Police, who was conducting an enquiry on behalf of Her Majesty's Coroner.

3. Her Majesty's Coroner was contacted to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report was sent to the Coroner to assist with his enquiries into the man's death. The verdict from the inquest held by the Coroner was one of 'death by misadventure'.

4. One of my Family Liaison Officers contacted the man's family to tell them about my investigation. She and my investigator met with the man's parents on 24 January 2007. My investigator summarised the progress of the investigation to date, and what he had discovered of the events surrounding their son's time at Liverpool and his death. My Family Liaison Officer explained her role and noted the concerns that the family had.

5. The man's parents told my staff that, prior to his arrest; their son had been on the run from a drug gang. They were concerned that his death was somehow related (whether his apparent suicide was assisted by someone, or if he was driven to it out of fear). The man's parents also wanted to know if their son was on any medication for depression, and whether it was possible to determine the time of his death.

6. My investigator said that a number of letters addressed to a mental health nurse, and apparently written by the man, had been found in his cell after his death. In the letters, he wrote of his long term problems being the cause of his low mood, as well as feelings of paranoia about his health.

HMP LIVERPOOL

7. HMP Liverpool was constructed in 1855 and replaced a much older prison situated in the centre of the city. There are eight wings, all of which have been refurbished and provided with integral sanitation. The prison serves the courts of the Merseyside area.

8. Liverpool is the second largest prison in England and Wales judged by population, and has a very high throughput of prisoners.

9. The most recent reported inspection of HMP Liverpoll by HM Chief Inspector of Prisons was published in November 2004. She wrote that, while there had been improvements since the previous inspection, her main concern was that Liverpool was not a safe prison. She found that drugs were readily available on the wings and bullying was rife. The findings of HM Chief Inspector's subsequent visit in February 2007 have not yet been published.

10. Prior to the death of the man who is the subject of this report, there had been 11 apparently self-inflicted deaths at Liverpool prison since April 2004.

KEY EVENTS

11. The man was released from HMP Forest Bank on licence on 3 March 2006. That licence expired on 2 May 2006. On 24 June 2006, the man was remanded into custody by the Magistrate's Court, again to Forest Bank, charged with dangerous driving and related matters. The accompanying Prisoner Escort Record (PER) form showed the identified risk categories for him as drugs, violence, concealed weapons and self-harm (historic).

12. During the reception process at Forest Bank, a First Reception Healthscreen was completed. The man told the nurse that he was prescribed methadone and using eight 'bags' of heroin a day. He also said that he did not have any mental health problems and denied having self-harmed in the past.

13. The man's probation officer was contacted by the prison. It was established that he had not been attending the Drug Intervention Programme based at the probation offices for four weeks, and was not therefore on prescription for methadone. On 26 June, the man was offered a detoxification regime using Britlofex. He refused, saying that it did not work for him and that he was using illicit Subutex on the wing.

14. The man returned to the Magistrates' Court in July and was further remanded into custody to await trial. He was also charged with new offences, including one count of armed robbery. The same day he was sentenced to three months imprisonment for criminal damage.

15. The man put in an application on 6 July to see a doctor. He wrote, "I need some medication. I need to see the doctor ASAP 'cos I'm expecting 10 years and my head is battered. I've done my detox on my own and now I'm doing double jail 'cos I can't sleep at night which isn't fair on my padmate. Please can I see a doctor before I lose it."

16. The man was seen by the doctor on 12 July and prescribed a course of Citalopram, an anti-depressant. The doctor noted that the man was not feeling like he would self-harm. He saw the doctor again on 25 July, this time complaining of pain in his hip. He was prescribed an analgesic, Tramadol.

17. On 28 July, it was noted in the man's personal record that he had been given a warning slip for being abusive to staff. On 8 August, he spoke to a member of staff and said that he had been hit whilst on the wing and that he would be assaulted again when his cell was next unlocked. The man was then on D wing. There is no record of him showing any injury and no injury form was completed.

18. Later that afternoon, the man pressed his cell bell and told the member of staff who answered that he would go on basic (the lowest level of privileges) if they did not move him off the wing. (Being on basic regime

would mean that he would not be let out of his cell for association.) He was offered a move to A wing, which he refused. He said there was a price on his head and he asked to be treated as a Vulnerable Prisoner for his own protection. There was no space available that day, so he was kept locked in his cell for his own safety.

19. The man was moved to B wing on 10 August. On 12 August, a review stamp was placed in his record underneath of which is written, “troubled young man”.

20. On 23 August, the man was taken to the Care and Separation Unit (CSU) (the segregation unit). The reason given was “threatening and abusive towards staff by threatening to assault staff and by handing out an unauthorised article during the course of a visit.” He had handed his visiting girlfriend a gold ring and then made threats to slash staff during the search procedure afterwards.

21. During the afternoon of 25 August, the man made a telephone call and was overheard to say, “I had phoned my solicitor and told him if he doesn’t get a shipout [transfer] soon I will cut a screw from ear to ear”.

22. The man was seen by a doctor in the CSU. It was noted in his medical record that the Tramadol alone was not helping the hip pain and paracetamol was added to his medication. Additionally, it was noted that the Citalopram was not helping his depression and the dose was increased to 30mgs per day.

23. The man remained on the CSU until 4 September, when he was reallocated to HMP Liverpool after an appearance at the Crown Court. His medical record noted that he was fit for normal location, work and any cell occupancy. He was referred to see the doctor to prescribe his current medication. The doctor recorded that the man was a polydrug misuser, including the misuse of Subutex. The doctor also noted the currently prescribed drugs. The doctor did not physically assess him that evening, as the man declined to see him.

24. On 26 September, the man was seen by a doctor. The doctor took the man’s recent medical history and spoke to him about his depression and drug misuse. The man told him that the Citalopram was not working. The doctor noted that the man maintained good eye contact. He also recorded that the man refused to acknowledge the possibility that he might not be depressed, and that his problem was the fact that he was in custody. He started to get angry and irritated. He then left the room saying that he wanted to see another doctor.

25. The doctor noted on 4 October that the man had requested an extension of his opiate analgesics (Tramadol). The doctor wrote that the Tramadol would and should be weaned off to non-opiates like paracetamol or Nefopam, but that the Citalopram was to be extended.

26. A second doctor saw the man on 6 October. The man told him that he had received five to ten years of anti-depressants from his GP and that he found Prothiaden most helpful. It was agreed to wean him off the Citalopram and slowly increase Prothiaden. He also told the doctor about pains from past multiple broken bones. The man pressed for opiate medication, but the doctor continued the Tramadol reduction programme.

27. On 7 October, there was a note in his personal history sheet saying that there have been no adverse comments regarding the man. He appeared to be conforming to the wing regime, although his attendance at work needed to be monitored. Three days later, it was noted that the man did not attend the morning workshop and this occurred again on 12 and 16 October. He was issued with a final warning before being placed on basic regime. He was told that he must attend work or education. The man said that he had a medical condition. He added that some days he was 'ok' and others he was not, and on those days he did not go to work. He was told that he needed to obtain a sick note for any absences.

28. On 18 October, the man approached a Senior Officer (SO) and told him that he had incurred a drug debt of £80 which he could not pay. It was due in two days' time. The man said that he feared for his safety and requested Vulnerable Prisoner (VP) status. The SO relayed the information to the duty governor. It was decided that VP status was to be a last resort and that the man was to be moved to F wing. (Being given VP status means that the prisoner is separated from the general prison population. Even though many prisoners on VP are not sex offenders, the perception tends to be that they all are. As a result, there can be ramifications if the prisoner returns to the normal wings, and even after they leave the prison or transfer to another establishment.)

29. The man declined to move to F wing saying that it was too close to G wing, where he was located when he first came to the prison, and where he initially had problems over his drug debt. The SO contacted B wing for a vacancy, but they refused as the man was a convicted prisoner. (The main part of B wing is for remanded prisoners only.) The duty governor then agreed to give the man VP status as he was clearly at risk given the history of the prisoner to whom he owed the debt.

30. A note in the medical record notes that the man did not attend his appointment during morning surgery on 20 October.

31. On 25 October, the man refused to go onto K wing, again saying that he feared for his life. (K wing is the area of the prison used to house VP status prisoners.) He was being held at the time on a section of B wing that was being used as a K wing overspill.

32. At the end of October, the man returned to court and was sentenced to 18 months imprisonment.

33. On 1 November, during a single cell review, the man said that he was happy to share with “someone of the same nature as him and also on VP.” The following day, he was ordered to relocate to K wing, but he refused and was taken to the CSU. He remained there until he moved to K wing on 17 November.

34. A written note by a Staff Nurse says that the man was seen on 4 November and no problems were identified. The man’s parents visited him around this time and found him to be anxious and withdrawn. He told them that “everyone thought he was a ’nonce’”, meaning a sex offender. The SO had previously warned him about the possible implications of VP status.

35. The man asked to see a nurse whom he had met during a previous sentence. On 15 November, this nurse noted in the medical record that he remained low in mood, but that “the predominant features of this gentleman is that of an angry man who is currently at odds with the wing staff and the GP.“ In the man’s personal history record the nurse added that he had no concerns about the man’s mental health but that he remained low in mood. The man said that he felt better than the previous week, when he had a noose hanging from the window bars. He also said that he had no current thoughts of suicide.

36. On 16 November, a prisoner on K wing spoke to the wing SO. He told him that another K wing prisoner had said that the man was intending to apply for VP status with the sole intention of getting onto the wing to stab him. The SO submitted a security information report (SIR) about the allegation.

37. On 17 November, the man arrived on K wing and the staff explained what was expected from him in terms of behaviour. The officer ended the history sheet entry by adding “no problems”.

38. The following day, a Governor wrote in the SIR that an entry was to be made on the man’s history sheet about the possible threat, and that any VP issue was to be managed on the K wing overspill (B3) until further notice.

39. The man had been on K wing for a few days when he was pointed out to the prisoner whose allegation had led to the SIR. By that time the two of them had spoken and the man was not concerned about his safety.

40. On 21 November, an officer made an entry on the man’s history sheet with a time in the margin of ‘1300 – 1600’. He wrote that the man had been agitated and performing all day, saying that his head was ‘done in’ and demanding to be taken to B1 (level one on B wing). The officer added that the man was prepared to listen to reason and had so far not carried out his threat to throw himself off the five’s. (Although the five’s landing is the topmost level in the prison, there is a safety net across the open middle section for the very purpose of preventing anyone falling.)

41. According to the officer, the man said that he was not suicidal. He also refused a Listener (a Listener is a prisoner who has volunteered to be trained by the Samaritans to provide a similar role as that organisation within the prison), saying that he would only do that to further his exit from K wing. The officer concluded his entry by writing, 'staff please observe closely.'

42. A third nurse was asked to review the man after he threatened to throw himself off the topmost landing. She wrote in his medical record, "States wants to go back to B1 to be on his own before his trial. Spoken to [the nurse who the man met during his previous sentence] (Dual Diagnosis) who reviewed him last week. Said no mental health issues, he is just behavioural. Wing staff aware, SO will review inmate again as he is to stay on the wing."

43. The same day, the man put in an application form on which he asked to 'sign off the numbers'. (This refers to an individual wishing to come off Vulnerable Prisoner status and return to the main population.) The application is politely worded, starting with 'please' and ending with 'thanks' and does not give the impression of someone who is agitated. The form is not timed and I have been unable to establish at what stage during the day he wrote it.

44. The deputy governor saw the man regarding his application. The man said that he was now willing to return to normal location as the risk of harm had reduced and there had been no recent threats. On 22 November, he was moved to B wing, cell B4–10, with a view to moving to F wing in the future.

45. On 27 November, an entry was made on the man's history sheet saying, "this inmate is under threat from [named] prisoner who resides on K wing, instructions from the Governor, this inmate is to be managed on B wing." (This entry reversed the identities of the potential assailant and the potential victim.) The same day the man received a cell mate.

46. On the morning of 29 November, the man put in two application forms. On one he wrote, "Need to see the Governor ASAP, Thank you. It's about something I discussed with him a week or so ago. Ok." On the other, he asked why he had not got his canteen the day before. (Prisoners can pre-order certain goods, for example stamps, sweets, food, tobacco and additional toiletries, once a week from the prison shop or 'canteen'. The items are paid for out of their own spending account.)

47. An officer had overheard another officer talking about the man's canteen application in the wing office, and had heard him confirm that the man had had his canteen on K wing. When the man pressed the cell bell a little while later, the officer who overheard the conversation responded. He explained to the man that he had received his canteen whilst on K wing. He told my investigator that the man accepted this was the case.

48. The man's cell mate left to go to education classes at about 9.30 am. As he left the man said to him, "I'll show the bastards." The cell mate thought that he meant he was going to cause trouble in some way, perhaps by attacking an officer. He told my investigator that, although he had only known him for two days, he never thought that the man intended to harm himself.

49. When the cell mate returned to the wing at about 11.40 am, he was talking to some other prisoners. When he got to his cell he looked in through the open flap and saw the man at the rear of the cell. He was hanging from the window. The cell mate ran along the landing and shouted for a named officer.

50. Two officers responded immediately. The first officer radioed for further assistance. Upon reaching the cell, the officers entered and the second officer took hold of the man's body to support it and take the weight off the ligature which was made from a torn bed sheet. The first officer climbed onto the table that was next to the man and tried to cut the sheet using his ligature knife. However, he found that there still was not enough slack. A prisoner was at the cell door. He asked for and was given permission to enter the cell. He helped support the man's body, enabling the first officer to cut through the sheet. The man was laid on the floor and the first officer felt for a pulse. When he could not feel one, he started Cardio Pulmonary Resuscitation (CPR).

51. Other officers arrived and a prisoner who was trained in first-aid was given permission to enter the cell. The prisoner started mouth to mouth.

52. Healthcare staff arrived in response to the 'code blue' emergency call. (Liverpool uses a colour code system to quickly convey the basis of a particular medical emergency. Code blue indicates breathing difficulties.) They took over CPR and applied an automatic external defibrillator which indicated that no shock was to be given.

53. A doctor arrived at the cell at 11.55 am from an incident he had been attending in the sports hall. The paramedics who had been called by the prison control room arrived a few minutes later. CPR had been performed for about 20 minutes and the doctor still found no cardiac output. At 12.00 noon the doctor pronounced the man dead.

54. When the cell was searched after his death, a number of handwritten sheets of paper were found, apparently written by the man and addressed to the mental health nurse. They are not dated, but at least one seems to have been written after he came off K wing on 22 November. He wrote about feelings of paranoia, depression and anxiety. He also wrote about killing himself.

55. Some months after the man's death another letter written by him was found by the prison. It is not dated but it was written whilst he was on B

wing. In the letter the man writes that he knows he will be found guilty at his trial. Although he does not specifically mention an intention to end his life the tone of the letter implies it. The Coroner has asked the Governor at Liverpool to investigate why the letter did not come to light until some time after the man's death.

ISSUES CONSIDERED DURING THE INVESTIGATION

56. When the man was first remanded into custody on 24 June 2006, he was sent to Forest Bank. He was not happy to be there, possibly because of the conflict, his parents told my investigator, he had had with a drug gang prior to his arrest. On 8 August, the man told staff that there was a price on his head and asked to be put on protection. I believe that he was concerned for his safety whilst at Forest Bank, and that a lot of his behaviour whilst he was there was designed to get a move and/or be separated from the general population.

57. Whilst at Forest Bank, the man was prescribed anti-depressant medication, Citalopram. That medication was continued and the dosage increased at Liverpool, and eventually replaced with Prothiaden. However, throughout his time in custody he denied any thoughts of self-harm or suicide. The man was seen by the nurse who he met during his previous sentence, on 15 November. During that meeting the nurse decided that the man was in a low mood, but that he was an angry man at odds with the wing staff and the GP. The medical record does not contain the additional information about him saying that he felt better than the previous week, when he had a noose hanging from his window bars. That information only appears on his personal history sheet. During a second interview with my investigator, the nurse explained that he believed that the man had placed the noose there to be seen by the staff rather than having any suicidal intent.

58. On 21 November, an officer heard the man threaten to throw himself off the five's landing. My investigator has not been able to interview that officer as he has been off sick with an unrelated injury. The officer correctly wrote about the man's threat in his history sheet, and requested that he be seen by healthcare. A nurse saw the man a short while later. He denied any suicidal intent and expressed his wish to leave K wing. The nurse also took advice from the nurse who the man met during his previous sentence, who repeated his diagnosis of behavioural problems rather than mental health issues. It seems that, at the time, the whole incident was thought of as the man trying all avenues to get what he wanted, rather than as a suicide threat.

59. The clinical review concludes that the man had multiple self-harm risk factors including drug abuse, history of depression, change of anti-depressant medication and reduction in opiate analgesics. In view of his admission to having a noose hanging in his cell, and the threat to throw himself off the landing, I believe that he should have been referred for a psychiatric assessment. I also think that the opening of an ACCT document should have been considered to monitor the man until that assessment took place.

    The Governor should consider whether any refresher suicide and self-harm training is required by staff to ensure they give

appropriate and timely consideration to presenting risk factors and threats of self-harm.

60. Prisoner medical records at Liverpool are computerised, although hand written notes are still made on separate paper medical record sheets. This risks a breakdown in communication amongst healthcare professionals and is confusing. The practice of supplementing the computerised medical records with handwritten notes should be discouraged.

    The Prison Health Partnership should ensure that all staff requiring access to medical records are trained in the use of the computerised system and required to use it.

61. The handling of the allegation by a prisoner that the man was intending to stab him, while not related to the man's death, highlights a potentially serious communication breakdown. At the time the prisoner made his allegation, the man was already on VP status but on the B wing overspill. A decision was made not to allow him onto K wing and for a note to that effect to be placed in his file. The man was actually moved onto K wing the day after the other man made his allegation and the note was not placed onto the man's file until five days after he had left K wing. Even then, the whole meaning was transposed to indicate that he was at risk from the man who had actually said he was under threat.

    The Governor should review as a matter of urgency, the procedures for dealing with and the timely communication of any action to be taken after threats of violence against prisoners.

62. The governor the man referred to in his application dated 29 November, and whom he wanted to see urgently, is believed by all those interviewed to be the wing governor. The acting wing governor at the time of the man's death was an SO. My investigator has not been able to speak with him directly, although he has given a statement to the police. I understand that he had not previously spoken to the man about any particular matter. He told the police it is common practice for prisoners to say that a governor has been involved in whatever matter the application is about in order to add weight to it.

63. In respect of the man's claims to have been under threat over a drug debt, I judge that staff listened to his concerns and made appropriate decisions to ensure his safety. I have found no evidence to suggest that his death was other than self-inflicted.

64. Wing and medical staff reacted swiftly and professionally when the man was discovered hanging. I believe that special praise should be extended to the prisoner on scene and to the other prisoner who provided help to staff during the first few difficult minutes.

The Governor should send letters of commendation to the two prisoners involved in the attempt to resuscitate the man.

65. RECOMMENDATIONS

1. **The Governor should consider whether any refresher suicide and self-harm training is required by staff to ensure they give appropriate and timely consideration to presenting risk factors and threats of self-harm.**

2. **The Prison Health Partnership should ensure that all staff requiring access to medical records are trained in the use of the computerised system and required to use it.**

3. **The Governor should review as a matter of urgency, the procedures for dealing with and the timely communication of any action to be taken after threats of violence against prisoners.**

4. **The Governor should send letters of commendation to the two prisoners involved in the attempt to resuscitate the man.**