Investigation into the circumstances surrounding the death of a man at HMP Liverpool in February 2010

Report by the Prisons and Probation Ombudsman for England and Wales

September 2010

This report considers the circumstances surrounding the death of a man at HMP Liverpool in February 2010. He was found hanging in his cell around 5.20am. He was 53 years old.

I offer my sincere condolences to the man's family and all those who knew him.

The investigation was conducted by two investigators on my behalf. I would like to thank the governing Governors for their co-operation. I also extend thanks to the liaison for the Ombudsman's office. In addition, I thank the clinical reviewer who conducted a review of the man's clinical care. She was appointed by the local Primary Care Trust.

The man had served a number of custodial sentences in the past, some of them at Liverpool. After being remanded into Liverpool in August 2009, he remained on the same wing until his death. The members of staff who were involved with him did not think he was at risk.

This is the 15th apparently self-inflicted death at Liverpool since 2004, when the Ombudsman's office began investigating all deaths in custody. Before the man's death, the last such death occurred in February 2009.

Despite the tragic outcome, there was little to suggest that the man was at risk of suicide. I have looked into the immediate response, communication, clinical issues and post-incident care for staff. I make two recommendations and endorse a further five recommendations made by the clinical reviewer.

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

Jane Webb
Acting Prisons and Probation Ombudsman **September 2010**

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SUMMARY

The man appeared at Magistrates' Court and was remanded to HMP Liverpool on 8 August 2009. He was seen by a nurse for an initial health screening, and then by a locum doctor. It was noted that, before being remanded into custody, he was drinking heavily on a daily basis. He was prescribed Chlordiazepoxide (commonly known as Librium) for alcohol withdrawal, and referred to the prison's drug dependency unit (DDU). The doctor who saw him also noted that he suffered from epilepsy and chronic pain, and prescribed medication in relation to these matters. He said he had no thoughts of suicide or self-harm.

A cell sharing risk assessment (CSRA) was completed, and the man said he would not share a cell with a prisoner from a minority ethnic group. He was located on the fifth floor of B wing, which usually accommodates prisoners for around one week from their arrival whilst an induction programme takes place.

Two days after his arrival at Liverpool, the man saw a psychiatrist who diagnosed alcohol dependency syndrome and recommended that he continue the course of Librium. He noted that he did not suffer from depression or psychosis.

On 14 August, the man moved to cell B4-26. This is on the fourth floor of B wing, which usually accommodates remand and unsentenced prisoners. He began sharing a cell with a prisoner around the same age. The next day, his personal officer introduced herself to him and noted that he had "no problems or concerns".

The man's prescription charts indicate that he did not take any medication after 18 August, though he had been collecting it as scheduled until that point. His reducing course of Librium was due to run until 20 August, and his medications for epilepsy and pain relief were prescribed on an ongoing basis.

A court hearing was held at Crown Court on 21 August. The man did not attend court, but took part in the proceedings via video link. His case was adjourned until 16 October.

On 30 August, when the man had failed to collect his medication for 12 days, a 'refusal of treatment' form was completed. This listed his ongoing prescription medication and contained a short, pre-printed disclaimer indicating that a member of the healthcare team had advised him to continue taking it, but that he did not wish to do so. He signed the form and printed his name.

The man was offered an appointment for a secondary health screening on 21 September, but he did not attend. A further court hearing was held on 16 October, with him again contributing via video link. His trial was scheduled to start on 15 February 2010. On the same day as the court hearing, he was

sent an appointment letter, again inviting him to attend a secondary health screening on 19 October 2009. However, he again chose not to attend.

Between August and October, there were no recorded staff concerns that the man would kill or harm himself. He was described in his wing history record as having no problems and, during interviews after his death, members of staff described him as generally quiet but not withdrawn or vulnerable.

On 5 November, a Senior Officer (SO) received information from the prison's security department that, during a telephone call to his sister, the man had said he was going to "end it". The SO spoke to him in the wing office during the same day, and was reassured that he did not mean what he had said during the call. The man attempted to telephone his sister but he was not able to reach her. He spoke to her from the wing office the following day in the SO's presence, and reassured her about his well-being. The SO thought the situation had been resolved, and monitored him informally over the next few days.

During interview with my investigator, several members of B wing staff reported that the man began to seem increasingly tense and nervous in late December 2009 and throughout January 2010. He made numerous telephone calls to his solicitor and was frustrated by feelings that some of the paperwork did not properly represent their discussions.

The man's cellmate moved out of the shared cell on 29 January, having been informed three days earlier of his daughter's death. The move was not due to any problems with the man, but instead because he thought he would be able to cope better in a cell on his own after receiving such traumatic news. The man remained in the same cell.

On the evening of 31 January, the man had separate, short conversations with two members of staff, one around 5.00pm and the second around 8.00pm. There was no cause for concern. As he was not subject to any special monitoring during the night, his cell was next checked during the morning roll count (a process involving counting all the prisoners).

When the man's cell was checked around 5.20am, he was found hanging from a ligature which had been fashioned from a bed sheet and run over the top of the toilet door. Several officers and two nurses arrived very quickly and started cardio-pulmonary resuscitation (CPR). Despite continuous and uninterrupted efforts until the paramedics arrived, he could not be resuscitated. He was pronounced dead by a paramedic at 5.45am.

I have investigated issues around the immediate response, clinical care, communication between departments, and post-incident care for staff. I make two recommendations and endorse a further five recommendations from the clinical reviewer.

THE INVESTIGATION PROCESS

1. One of my senior investigators opened the investigation on 1 February 2010 and visited HMP Liverpool on 4 February. He met the following people:

   - the PPO's liaison officer and the Safer Custody manager
   - the Head of Safer Custody
   - the Safer Custody administrative officer
   - the prison chaplain
   - the prison family liaison officer
   - the Chair of the Prison Officers' Association
   - the coroner's officer from Liverpool Coroner's Office

2. The various people present at the meeting explained the background to the man's imprisonment and the circumstances of his death. Night staffing was discussed in brief terms. The liaison officer explained that there had been a single incident in November 2009 which had raised some concern about the man's well-being, but that at the time of his death there had been no known issues around suicide or self-harm.

3. The liaison officer facilitated access to all of the records regarding the man's remand period in custody.

4. One of my family liaison officers (FLOs) having been unable to speak with the man's sister directly, wrote to her to explain the purpose of the investigation and offer his family the opportunity to raise any questions or concerns. The family did not raise any specific concerns to the FLO.

5. On 8 June 2010, the investigator met the man's two sisters at the Coroner's Court. They asked why he was checked at 5.20am on 1 February 2010, and if this was in response to any specific concerns. They also wondered why SO A did not take any formal action as a result of his conversation with him on 5 November 2009. Finally, his sisters were concerned that the prison's healthcare department did not appear to have his community medical notes, and that after he stopped taking his medication and signed a disclaimer, there was no further clinical intervention.

6. The issues that the man's sisters have raised are covered in this report, which I hope helps them better understand the events leading to his death. The family received a copy of the draft report, however raised no further questions in relation to the findings of the investigation.

7. The investigator retuned to Liverpool in March 2010 with an Assistant Ombudsman. They conducted recorded interviews with ten members of staff. Transcripts of these interviews were produced and are annexed to this report.

8. A prisoner who shared a cell with the man during much of his time at Liverpool, was released before the investigator conducted interviews. The investigator wrote to him at his release address but received no reply.

9. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the man's clinical care whilst in custody. (The purpose of a clinical review is to examine the medical care that a prisoner received whilst in custody, which should be of an equivalent standard to what might have been expected in the community.) She consulted his medical records from his time at Liverpool and, with the investigator, visited the prison on 18 March to talk to members of the healthcare staff. Her findings are summarised in this report and the full clinical review is included as an annex.

10. My investigator was informed by a Detective Sergeant (DS) of Merseyside Police of an ongoing investigation concerning the man's solicitor. The DS said an allegation had been made that the man had made a telephone call to a receptionist at his firm of solicitors, around January 2010, and that during this call he threatened to kill himself. At the time of writing this report, the police investigation was ongoing.

HMP LIVERPOOL

11. Liverpool is one of the largest prisons in the estate, with a maximum operational capacity of 1359. It serves courts from the Merseyside area, and holds remanded, unsentenced and convicted adult male prisoners. There are eight residential units, including those for drug support, vulnerable prisoners, detoxification, and resettlement. One of the units 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.

12. Healthcare services at Liverpool are provided by the local 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.

Performance

13. The Ministry of Justice produces quarterly performance figures for all prisons in England and Wales. Every establishment is given a rating between 1 and 4 based on 34 agreed performance indicators. The most recent figures available at the time of writing are for quarter 3 of 2009-2010 (October, November and December 2009). For this period, Liverpool received a rating of 2, indicating that the prison required development to meet the agreed standards. This was a drop in performance from the previous quarter, at which time the prison received a rating of 3.

14. HM Chief Inspector of Prisons inspected Liverpool in September 2009. Her report found that the support for people at risk of suicide or self-harm was variable. The quality of education and employment was good, though access to these activities was a problem for some prisoners. She noted problems with violence and bullying, the availability of drugs, and the reception and first night procedures. Relationships between prisoners and staff were, however, generally good.

Previous deaths at HMP Liverpool

15. The Ombudsman’s office has been responsible for investigating deaths in custody since April 2004. Prior to the man’s death, 14 other apparently self-inflicted deaths have been investigated. Three occurred in 2004, five in 2005, four in 2006, and one in 2008. The most recent death, before that of the man, was in February 2009.

16. The man was located on B wing, which usually accommodates remand and unsentenced prisoners, at the time of his death. Before his death, the last apparently self-inflicted deaths on B wing occurred in August and November 2006.

17. Another prisoner died at Liverpool on 18 February 2010, just over two weeks after the man's death. Although he was a remand prisoner, he was located on K wing (for vulnerable prisoners) rather than B wing. At the time of writing, the investigation into this death is ongoing.

18. Aside from the method used (hanging by ligature is the most common form of self-inflicted death in prisons) there are few similarities between the man's death and the deaths of other prisoners at Liverpool. The man who took his life on B wing in November 2006 had been convicted and sentenced. The man who took his life in August 2006 was a remand prisoner like the other man, though the circumstances were quite different. In that case, the prisoner had been at Liverpool for little more than one month, and was identified from the outset as being a risk to himself. The man had been at Liverpool for several months and was not thought to be a risk of suicide or self-harm.

KEY FINDINGS

19. The man appeared at Magistrates' Court on 8 August 2009 and was remanded to HMP Liverpool.

20. An initial health screening was completed at 1.45pm by Staff Nurse A at Liverpool. She noted that the man was slightly unkempt in appearance but he had no concerns about his physical health. She also recorded that he was drinking two to three litres of alcohol daily (the type of alcohol was not specified at this point). She noted that he had not harmed himself in the community or whilst in custody, though this information would have been based primarily on his own account.

21. Staff Nurse A referred the man to the duty doctor, whom he saw at 2.00pm. The clinical record indicates that he saw Staff Nurse B. However, in conversation with my investigator, Nurse B explained that the man had actually seen a locum doctor who did not have any access to System One (the computerised medical system used by Liverpool), and so used her information to record the details of his appointments. Thus, whilst the clinical record shows that he was seen by Nurse B, he was in fact assessed by a locum doctor.

22. The doctor recorded that the man suffered from epilepsy and chronic pain in his left knee, and had suffered a head injury in 2001. He noted that the man had no thoughts of suicide or deliberate self-harm. The doctor prescribed Phenytoin (to treat epilepsy) and Diclofenac (an anti-inflammatory and analgesic drug). He also prescribed a 13-day course of Chlordiazepoxide (commonly known as Librium) for alcohol withdrawal, and referred him to the drug dependency unit (DDU). The doctor did not mention the Librium prescription in the main clinical record, but recorded it on the separate, handwritten prescription chart along with the other medications.

23. The man saw an alcohol support worker with the DDU at 2.25pm. He told him that, for the last six weeks, he had been drinking two to three litres of cider daily, and had received Librium whilst in police custody.

24. A cell sharing risk assessment (CSRA) was completed upon the man's arrival. This is intended to identify any risks associated with prisoners sharing a cell. Officer A, who completed the form, noted that he said he would not share a cell with a prisoner from a minority ethnic group. He also wrote that he had a previous conviction for a racially aggravated offence, and so was not to share a cell with a prisoner from a minority ethnic group. Officer A assessed him as a medium risk, meaning that the situation would need to be reviewed regularly. A separate section of the form covers health-related issues, though Nurse A did not identify any concerns in this area.

25. Following these initial processes, the man was located on the fifth floor of B wing, in cell B5-25. This floor is usually used to accommodate

prisoners for around one week from their arrival. During this time, an induction process takes place to familiarise prisoners with various aspects of the regime. Since he had served a number of previous custodial sentences, some of them at Liverpool, it is likely that he already had a reasonable understanding of prison life.

26. On 10 August at 9.50am, the man saw a psychiatrist. The psychiatrist wrote in the clinical record that the man had alcohol dependency syndrome, and recommended that he continue with his course of Librium. He also mentioned that the man had epilepsy, but noted that he did not suffer from depression or psychosis.

27. At 10.20am on the same day a general practitioner working at Liverpool made a note in the clinical record of the man's prescription medication. In conversation with my investigator on 18 March 2010, he explained that he had not seen the man at this time, and was merely noting in the record the medicines that had been prescribed two days earlier by the locum doctor. Although an appointment had been made for the man to see him on 10 August 2009, the clinical record states that he did not attend.

28. The man moved to B4 landing on 14 August. Whilst the fifth floor is used for inductions, the fourth floor usually accommodates remand and unsentenced prisoners. He was located in a shared cell, B4-26, with a prisoner of a similar age. The following day, Officer B wrote in his wing history record that she had introduced herself as his personal officer and that he had "no problems or concerns". A personal officer is a named prison officer from the wing on which the prisoner is located, and someone to whom the prisoner can direct concerns and queries. Personal officers are also responsible for making regular notes in their prisoners' wing history records.

29. On 17 August, SO B conducted a cell sharing risk review. No issues were raised further to those identified on 8 August, and the man remained a medium risk.

30. The man's prescription charts show that he did not take any medication after 18 August. His reducing course of Librium was due to run until 20 August. Nurse C told the investigator that it is not particularly unusual for prisoners to stop taking Librium before the end of the course, because their alcohol withdrawal symptoms may have subsided. However, the Phenytoin for epilepsy and the Diclofenac for pain relief were supposed to continue on an ongoing basis. The man did not have any of his medication in his own possession, and so was required to collect it each day. His prescription chart shows that he last collected his medication on 18 August.

31. A court hearing was held via video link on 21 August. This means that the man did not leave the prison to appear in court, but he was able to see the court proceedings on a video screen and to contribute as

required. Similarly, the people in the court would have been able to see him on a screen. The hearing was at Crown Court, and the case was adjourned until 16 October.

32. On 30 August, a 'refusal of treatment' form was completed regarding the man's medication. The form listed the medication offered (Phenytoin and Diclofenac) and included the following pre-printed statements:

> "It has been explained to me by a member of the healthcare staff, that it is advisable that I avail myself to this treatment.
>
> "I don't wish to avail myself to the treatment."

33. Underneath these statements, the man signed the form and printed his name. The remainder of the form, which provides space for the details of the member of staff witnessing the prisoner's signature, was not completed.

34. Officer B wrote in the man's wing history record on 30 August: "The man has kept a very low profile since arriving on B wing. No problems or concerns." This was a sentiment echoed during interviews that the investigator conducted with members of B wing staff. The officer said the man was "a very quiet individual who was very polite to staff". She added that he did not associate very much with other prisoners, saying:

> "He would stand outside his cell … and just watch the world go by, and just made sure he had plenty of cups of tea and that was it really, to be honest, and occasionally he'd come and speak to staff and just have a general chit-chat about soaps [meaning the television programmes] and that was it. He was very much a loner."

35. Officer B said that although the man spent much of his time alone, he did not seem particularly withdrawn, and she had no concerns around self-harm or suicide.

36. During interview, Officer C recalled the man in a similar way. He said:

> "He was a very, very quiet man on the landings. He would always speak to you when he needed to speak to you and he wasn't one of them that would just stand there all day talking to you. If he needed you or he needed to speak to you or needed your advice then he would come and see you. But he wouldn't be one of them that would just stand there and just talk about the time of day or anything like that. He was mostly very, very quiet I thought."

37. Officer C also described the man as an "old timer", someone who was respectful towards members of staff and who had a good understanding of the prison regime.

38. On 7 September, a further cell sharing risk review was carried out. He remained a medium risk, and continued to share his cell.

39. An appointment slip was sent to the man on 18 September from the healthcare unit, inviting him to attend a secondary health screening on 21 September. (A secondary health screening is similar to the initial health screening completed when prisoners arrive at the prison, but usually takes longer and is more detailed.) A note was made in his clinical record that he did not attend for this appointment.

40. On 26 September, Officer B wrote in the man's wing history record that there were "no problems or concerns to report". This is consistent with the view expressed during interviews that he was polite and well-mannered to members of staff, and that his behaviour did not cause any concern or alarm.

41. The man's risk in terms of cell sharing was reviewed again on 6 October. By this point, he had been sharing his cell with another prisoner for almost two months. He remained a medium risk and continued to share his cell. In terms of his relationship with his cellmate, the officer (who was personal officer to both prisoners) said:

> "I do know that when I spoke to both of them … individually … I'd asked them if they were getting on fine and they'd both say yes, fine. But there didn't seem to be much communication between them. They weren't laughing and joking when you'd open the door. They'd be both sat watching the telly, the man would be lying on the bed and [his cellmate] would be sat by the table by the door. But they never seemed to argue … there never seemed to be an atmosphere but they didn't seem to be the best of buddies."

42. On 16 October, a further court hearing was held at Crown Court, again with the man contributing via video link. His case was adjourned, with a trial scheduled to commence on 15 February 2010. Also on 16 October, an appointment slip was sent from the healthcare unit, giving him another opportunity to attend a secondary health screening on 19 October. However, he did not attend this appointment either.

43. Officer B noted in the man's wing history record on 4 November that he had "gone to labour as and when required". During interview, she confirmed that this could refer to either work or education, and that he had been attending education classes.

44. On 5 November, SO A wrote in the B wing observation book that he received information from the security department that, during a telephone call to his sister, the man had said he was going to "end it". The SO wrote that he interviewed him, who assured him that he had made an "off the cuff" remark and would call his sister to explain that he was fine.

45. During interview with my investigator, SO A explained that his understanding of the situation was that the man's sister had telephoned the prison after he made the comment during a call. She had been transferred to the security department and had outlined her concerns, and the security department had alerted B wing to the situation. The SO said he then asked for the man to be brought to the wing office, and they had a conversation about the concerns. Initially, the SO approached this in a general way and asked if there was any reason for people to be worried about his well-being, but he said this was not successful. Eventually, he had to tell the man that his sister had telephoned the prison. It was at this point that he reassured the SO of his well-being, and said he would call his sister to clarify the situation.

46. The SO suggested that the man make the telephone call from the wing office and, although this was attempted, there was no reply. Another call was placed later the same evening, but again his sister did not reply. The SO said the man managed to speak to his sister from the wing office the next morning, whilst he was present in the room. He said that during his conversations with him he did not have any concerns about his well-being. He added that he wanted to ensure he spoke to his sister to reassure her, but he also wanted to see and hear how he presented when speaking to her.

47. My investigator asked SO A if he would have taken any further action if he thought the man was at risk to himself. He said he would not have hesitated to open an Assessment, Care and Custody and Teamwork (ACCT) document in these circumstances. (ACCT documents are designed to help manage and support prisoners who are at risk of self-harm or suicide.) He thought the matter was resolved and that the opening of such a document was not necessary. He told my investigator that he informally monitored the man for a few days afterwards, and was satisfied that the situation had been managed appropriately.

48. On 21 November, Officer B wrote in the man's wing history record that he was causing no problems or concerns. On 27 November, an appointment slip was sent to him from the healthcare unit, inviting him to attend for a flu injection on 30 November. He did not attend the appointment. A further appointment slip was issued on 4 December for an appointment on 7 December. This was another opportunity for the injection. There is nothing in the clinical record to show whether or not he attended this appointment.

49. Nothing of significance was reported until 13 January 2010, when the man was dismissed from his education classes. This followed a security information report (SIR) on the same morning which stated that he had used a computer in one of the classrooms for "inappropriate literary composition". The document appeared to be a personal account relating to the alleged offences with which he had

been charged. A note was made in his wing history record by an officer which simply stated: “Sacked education.”

50. Three days later, Officer B wrote the following in the man’s wing history record: “The man has got an ongoing problem with getting in contact with his brief [meaning his solicitor]. He is attending education on a daily basis.” It appears that at this point, she was not aware that he was no longer attending education classes, having been dismissed.

51. The issue of the man having problems contacting his solicitor was also mentioned by members of staff during their interviews with my investigator. Officer B said that shortly after Christmas 2009, the man became more preoccupied with his forthcoming trial and seemed tense and nervous about it. He also made numerous telephone calls to his solicitor and was frustrated by some of the paperwork which he felt did not represent what he had told her over the telephone. Officer C recalled that the man had problems reaching his solicitor by telephone, and said that they would often leave his cell door open for periods of time to allow him to use the telephone.

52. The man’s cellmate moved out of B4-26 and to another cell on 29 January 2010. Three days earlier, the cellmate had been informed of the death of a close family member, and felt that he would cope better in a cell on his own. The man remained in the same cell as the sole occupant.

53. On 30 January at 10.57am, Officer B wrote the following in the man’s wing history record: “The man has been very stressed of late due to his trial starting soon. He has attended work when required.” She wrote a further entry at 11.01am, stating: “The last entry was inputted by mistake. He has been sacked from education.”

54. Officer B mentioned during interview that the man remained tense about his trial at this point and dissatisfied with the situation regarding his solicitor.

31 January – 1 February

55. On 31 January, Officer D was working on B wing. During interview with my investigator, he remembered having a brief conversation with the man before locking his cell door around 5.00pm. The conversation was not about anything in particular; the officer recalled that he was checking that the man was generally okay, as he would with any other prisoner, before locking his cell for the night. At that time, he had no concerns about his well-being, and did not notice anything unusual about his presentation or demeanour.

56. During the night, each of Liverpool’s residential wings is staffed by either a prison officer or an officer of operational support grade (OSG). On the night of 31 January, an OSG began his shift on B wing at

8.00pm. He explained during his interview with my investigator that one of his first duties was to complete a roll check – essentially, to count the prisoners on the wing and ensure that the number was consistent with the previous count.

57. The OSG recalled that upon arriving at cell B4-26 he realised that it was a double cell but that there was only a single occupant: the man. He remembered having a brief conversation with him, asking him if he was alone in the cell and whether he was okay to be alone. He answered, "Yes I am, thank you." Although he was not able to recall the specific time of this exchange, the OSG believed it took place a few minutes after 8.00pm.

58. During his interview, the OSG explained that part of his job is to patrol the wing overnight, paying particular attention to prisoners who have been identified at risk of self-harm or suicide, those known to have attempted escape, and those in the highest security category. As the man was not in any of these categories, the OSG had no cause to specifically check his cell until the time of the next full roll check, around 5.00am.

59. The OSG told my investigator that he began the roll check shortly after 5.00am on 1 February. The roll check involves counting every prisoner and confirming that they are present in the cell. He said that, in order to do this, it is necessary to switch on the cell's interior light using a switch located outside the cell, and look into the cell through the observation panel. He recalled arriving at the man's cell at 5.18am and, upon switching on the light, saw him hanging from the toilet door, which was opened out into the cell.

60. The OSG used his radio to contact the night manager, SO C, who had the radio call sign 'Oscar'. (All members of staff in the prison with a radio have a unique call sign depending on their role, and the night manager is known as Oscar.) He said over the radio that he needed Oscar's help on B wing as soon as possible, but did not elaborate on the nature of the situation. He explained that during the night, the radios are switched to a 'talk-through' mode which enables all members of staff with a radio to hear all radio communications, whether specifically intended for them or not.

61. Officer E was working on A wing, which is adjacent to B wing. Upon hearing the OSG's radio message, which he recalled as happening around 5.20am, he made his way to B wing. He initially thought the situation was not urgent, but the wings are close together, and so he reached B4 landing in under one minute. He asked the OSG what had happened, and was told that a prisoner was hanging in his cell. He looked into the cell himself, and used his own radio to make it clear exactly what had happened. He recalled that by this point, SO C had arrived on B wing and was climbing the stairs to join them.

62. SO C and the Acting SO were in the central office at the time of the initial radio message. Nurse C was in the central surgery, located close by. SO C said that upon hearing the radio message, he asked the OSG what was wrong, and received a message that he was required on B wing immediately. He said that, although the actual nature of the situation had not been made clear, he assumed it would be serious. SO C, the Acting SO and Nurse C ran to B wing. Whilst en route, the SO radioed Officer F, who was located on B1 landing, to go to B4. He was also aware that Nurse D, a registered mental health nurse, located in the healthcare unit radioed Nurse C to ask if her assistance was required. The SO estimated that he, the Acting SO and Nurse C arrived at B wing within a minute.

63. SO C recalled that as he was climbing the stairs to B4 landing, Officer E made him aware that the situation involved a prisoner found hanging in his cell. As he reached the landing, he was able to see into the cell through the observation panel. He immediately opened the cell door and radioed the prison's control room to request an ambulance. He then used his anti-ligature knife (a piece of equipment carried by operational staff and often referred to as a 'fish knife' due to its shape) to cut the ligature. As he did so, Officer E took the man's weight. It appeared that the ligature had been made from a torn bed sheet and had tied to a pipe near the floor of the cell and run over the top of the toilet door.

64. The man was laid on his back on the floor of the cell, with his head nearest to the door. Nurse C asked for a bag containing the emergency medical equipment. The nearest of these was located on A wing, and the SO asked the Acting SO to retrieve it. The nurse said the man showed no signs of life, and he began chest compressions whilst waiting for the emergency bag to arrive. The Acting SO said it took him only around 25 seconds to leave the landing, retrieve the bag and return, and the nurse recalled it arriving very quickly. At the same time, Nurse D also arrived.

65. Nurse D attached an automated external defibrillator (AED) to the man. (This is a device that monitors the heart rhythm of a patient and administers a shock if appropriate.) Both nurses recalled that the AED did not detect a heart rhythm and advised that chest compressions should continue. Nurse D attempted to use an ambu-bag (a piece of medical equipment involving a tube that can be inserted into a patient's airway) but said this proved impossible because the man's airway was obstructed. Both nurses and Officer E continued with chest compressions until the paramedics arrived.

66. Officer F was instructed to keep a log of events. He noted that members of staff were initially called to the man's cell at 5.27am, although this would appear to be an estimate as he had not been asked to start a log at the time of the initial radio message. His log notes that the ambulance was called at 5.29am and arrived at 5.37am.

67. Both nurses recalled that when the paramedics arrived they attached their own equipment to look for any signs of life. Officer F’s log records that they retired and pronounced the man dead at 5.45am.

68. Police officers arrived at the prison at 6.15am, and at 6.35am four officers went into the cell with SO C. The SO was already aware of an envelope on the top bunk bed, but was conscious of the need to maintain the scene for the police. He recalled that one of the police officers opened the envelope, which contained a letter. The officer made the SO aware of its content, but the letter itself was taken by the police as evidence.

69. The investigator obtained a copy of the letter from the police. It was four pages long, addressed to the man’s sister, and dated 31 January 2010. He outlined his version of events regarding the alleged offences, and wrote about problems he was experiencing with his solicitor. In particular, he thought his solicitor was misrepresenting him in the statements that she was writing. He then went on to write about his possible sentence and how he felt he would not cope well in prison for a long period of time. At the end of the letter, he wrote that he did not have to time to finish it because he needed to post it, and signed his name. Underneath, he wrote: “Tell my mum I love her and I’m sorry for what I’ve done but there is no way out.”

70. A meeting known as a hot debrief took place at 7.35am. It was chaired by the Head of Operations and the duty governor. The members of staff who had been directly involved attended the meeting. Notes from the hot debrief show that members of staff were told that the care team would be available to speak to them. The immediate response after the alarm was raised was discussed. The general feeling was that everyone concerned had acted quickly and efficiently. The meeting was concluded at 8.05am.

71. The Head of Safer Custody and the prison chaplain left the prison at 8.30am to inform the man’s family of his death. There was a delay because his nominated next of kin, his mother, was not at home and it eventually transpired that she was in hospital. They were able to inform his sister of his death shortly after 11.00am.

ISSUES

Immediate response

72. It would appear that, following the OSG's discovery of the man during the roll check, the response was swift. Officer E said he arrived at B4 landing less than a minute after the initial radio message. SO C said that he, along with the Acting SO and Nurse C, also arrived within a minute.

73. Nevertheless, the initial radio message lacked clarity. The SO, an experienced night manager, said he assumed that such a radio message at that time in the morning would be about something urgent, and he ran from the central office to B wing. This was an implicit understanding, though, rather than a direct response to a clear message. Conversely, Officer E did not initially think the situation was urgent, and although he immediately made his way to B wing, he might have attempted to get there more quickly had he realised the nature of the situation.

74. Liverpool uses specific radio codes so that emergency situations can be identified as such by all members of staff. A 'code red' message over the radio indicates severe loss of blood, whilst a 'code blue' means that someone is suffering from breathing difficulties or requires resuscitation. Although the OSG used his radio to ask for assistance, he did not use the recognised radio code to alert other members of staff to the nature of the situation.

75. In this instance, the radio message did not impede the response and there was no delay. However, the benefit of a clear, unambiguous radio message for such a situation is obvious.

Members of staff should use the established radio codes to inform others of the nature of medical emergencies.

Clinical issues

76. The man did not have a great deal of contact with the healthcare unit at the prison. Routine assessments were made by several members of staff upon his arrival on 8 August 2009. Medication for epilepsy, pain relief, and alcohol withdrawal was prescribed. He was seen by a psychiatrist on 10 August and, other than when collecting his medication he did not have any further contact with the healthcare unit.

77. Despite this limited contact, the clinical record is unnecessarily confusing. On 8 August, the man was seen by a doctor but the entry is recorded in the name of a staff nurse. There is nothing within the entry to suggest that it was written by someone else, and this only became clear after conversation with the nurse whose name was used. This is not good practice. The clinical record should accurately reflect

appointments with the patient and provide a clear audit trail. It is also unacceptable for members of staff to make entries in the computerised record under another person's details. This is a practice which is confusing, unclear and potentially dangerous. The clinical reviewer, who was appointed by the local Primary Care Trust (PCT) to examine the clinical issues, agreed that it was "very difficult to identify who had seen the man and for what reason. It was also difficult to ascertain who had prescribed the medication and when".

78. The man was prescribed medication for epilepsy and pain relief on an ongoing basis. However, he only took this until 18 August. A form indicating refusal of treatment was not completed until 30 August, some 12 days later. The form is handwritten and the spaces for the member of staff to fill in their details are blank. Since there is no corresponding entry in the computerised clinical record, it is impossible to identify who completed this form with him, and what was said to him at the time.

79. It is, of course, entirely the choice of individual prisoners as to whether they take medication which is recommended and prescribed. However, as prisoners are quite literally a captive audience, 12 days seems a long time to wait before a refusal of treatment form is completed. There is no evidence of what, if anything, was done in the interim, particularly considering that the man was taking medication for epilepsy and to stop would increase the risk of fits.

80. The clinical reviewer also found that the procedures for following up missed appointments were unclear, as were the follow-up procedures for patients prescribed medication for substance misuse.

81. The man's family asked whether it is usual practice for the prison to obtain community medical records for prisoners. The investigator spoke to the clinical Head of Healthcare at Liverpool about this issue. She told him that it was not standard practice to request medical records for all prisoners, but that this was done as and when required based on their clinical needs. She went on to say that most such cases involved very complex mental health needs.

82. I endorse the following recommendations made by the clinical reviewer in relation to clinical care:

The head of healthcare should ensure that record keeping is improved, making it clear who has made the clinical entry.

Clinical staff should ensure that all consultations and discussions with patients are recorded.

The head of healthcare should consider changes to the policy for reviewing patients prescribed medication for alcohol misuse.

The head of healthcare should review the policy for follow-up of patients who do not attend for secondary health screening.

The head of healthcare should review the policy for the management and follow-up of patients who refuse prescribed medication.

Communication

83. On 5 November 2009, some three months before the man took his life, SO A addressed the issue of him making comments during a telephone call which gave his sister cause for concern. The issue itself appears to have been dealt with well. The SO spoke to him, witnessed him speaking to his sister over the telephone, and monitored him informally for a few days afterwards. As an experienced officer and someone very familiar with the ACCT process, the SO felt that such a formalised arrangement was not necessary. There is no reason to believe that this was anything other than an appropriate decision.

84. SO A recorded the concerns about the man and his actions in the B wing observation book. This is a document that contains a record of all noteworthy occurrences on the wing. However, a note was not made in the man's own electronic wing history record. This would have been a useful and easily accessible record should there have been any further related incidents attended to by a different member of staff. There is nothing to suggest that the lack of such an entry adversely affected the outcome, but it would be sensible, good practice to ensure that such events are logged in the wing history record.

The Governor should remind staff that relevant information about prisoners should be recorded in the wing history record

85. Merely recording information in the wing history record does not compel staff to readily access it. On 13 January 2010, the man was dismissed from education classes and an entry (albeit very brief) was made in his wing history record. It appears, however, that Officer B did not notice that this information had been entered. On two subsequent occasions, she wrote that he was attending education as required. Whilst I do not make a recommendation, the Governor should remind all staff of the importance of the wing history record as a source of valuable information about prisoners.

Post-incident care for staff

86. The minutes from the hot debrief meeting on 1 February indicate that members of staff in attendance were made aware of the support that they could expect to receive from the prison's care team.

87. The members of staff who work overnight generally work for seven nights in a row. This is followed by seven rest days. When the

overnight staff finished their shifts early on 1 February, they would not return to work for an entire week. During his interview with my investigator, SO C said he telephoned a number of staff members at home to check on their well-being, though he himself was at home at the time, and the calls were not made in an official capacity. This was commendable behaviour on the part of the SO, who was keen to ensure the well-being of his colleagues. However, being the night manager directly involved in the immediate response to the man's death, the responsibility of checking on his colleagues' welfare should not have been left to him alone. During interview, he said that in the week that followed the death, nobody else from the prison contacted the night staff at home.

88. It would appear that whilst the care team is available for support, the onus is on individual staff members to make contact. In situations such as this, particularly when members of staff are not in the prison for several days afterwards, it might be useful for someone from the care team to make the initial contact. I do not make a formal recommendation in this area, though I believe it is worth consideration.

CONCLUSION

89. The man had served a number of previous prison sentences when he was remanded into Liverpool on 8 August 2009. He was familiar with the prison and some of the members of staff.

90. Routine medical assessments were carried out and the man was prescribed medication for alcohol withdrawal, epilepsy and pain relief. He was not thought to be at risk of harming himself. He stopped taking his medication on 18 August and later signed a form to say he did not wish to continue with the treatment.

91. The man was described by wing staff as quiet, and someone who preferred to spend much of his time alone. However, he was polite and respectful to staff, did not cause any problems, and was not thought to be at risk of harming himself.

92. On 5 November, SO A received information that the man had talked about taking his life during a telephone call to his sister. After speaking to him and asking him to call his sister, he thought the situation was resolved.

93. Nearly three months later, at 5.20am in February 2010, the man was found hanging in his cell. Members of staff responded quickly and although resuscitation was attempted, he could not be saved.

94. My recommendations relate to radio call signs and the proper recording of information. I also endorse recommendations from the clinical review.

RECOMMENDATIONS

1. Members of staff should use the established radio codes to inform others of the nature of medical emergencies.

   The recommendation was accepted. The Governor will issue a notice to staff highlighting the issue, and it will also be included in the induction training for staff members who carry radios.

2. The Governor should remind staff that relevant information about prisoners should be recorded in the wing history record.

   The recommendation was accepted. The Governor will issue a notice to staff. All entries will be recorded on the P-NOMIS computer system and subject to quality checks by managers.

3. The head of healthcare should ensure that record keeping is improved, making it clear who has made the clinical entry.

   The recommendation was accepted. All entries on the medical computer system will include the date, time and the identity of the author. This will be subject to regular management checks.

4. Clinical staff should ensure that all consultations and discussions with patients are recorded.

   The recommendation was accepted. All consultations with patients will be recorded on the medical computer system and this will be subject to regular management checks.

5. The head of healthcare should consider changes to the policy for reviewing patients prescribed medication for alcohol misuse.

   The recommendation was accepted. A 'whole systems alcohol service' is under development. A project lead has been appointed.

6. The head of healthcare should review the policy for follow-up of patients who do not attend for secondary health screening.

   The recommendation was accepted. Nurses will hand deliver appointments to patients. They will also speak to patients who do not attend and either re-list them or document the reasons for non-attendance.

7. The head of healthcare should review the policy for the management and follow-up of patients who refuse prescribed medication.

   The recommendation was accepted. All refusals of medication will be discussed with the patient, a disclaimer will be signed, and this will be documented on the clinical record.