

**Circumstances surrounding the death in April 2007
of a man who was a prisoner at HMP Liverpool**

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

September 2007

This is the report of an investigation into the death of a man, a prisoner at HMP Liverpool, who died from apparently natural causes on 20 April 2007 at an outside hospital. He was 34 years old.

I would like to add my personal condolences to those already expressed to the man's family on behalf of this office by one of my Family Liaison Officers.

This investigation was undertaken by one of my investigators. He and I would like to thank the Governor of HMP Liverpool and his staff for their assistance. A doctor was asked by Liverpool Primary Care Trust to undertake a review of the man's clinical care, and we also much appreciate his help.

I endorse the recommendations made in the clinical review and ask the Primary Care Trust and prison to develop an action plan to address these in a timely manner.

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 the investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman

September 2007

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SUMMARY

The man was born in 1972. He was 34 years old when he died on 20 April 2007 at an outside hospital. The man died from natural causes as a consequence of an intercerebral and subarachnoid haemorrhage, caused by a ruptured berry aneurism. This was a sudden, unavoidable and fatal condition that was unrelated to his previous health issues.

The man had been received into custody at HMP Liverpool in February 2007 from Liverpool Crown Court. He had a history of mental health problems and self-harm. During his first health screen, it was also noted that the man had a drug addiction problem.

Around 4:30pm on 19 April, the man returned to his cell after attending a visit with his partner. According to his cellmate, the man made himself a cup of tea and then sat down in his chair. Approximately five to ten minutes later, the man got up from the chair and then fell to the floor. The cellmate immediately went to assist him and helped him onto the bed. After at least another ten minutes had elapsed, another prisoner looked into the cell through the observation hatch and the cellmate asked him to get help.

An Officer A responded and asked his colleague, Officer B, to request assistance from healthcare. Staff from healthcare came to the cell a couple of minutes later. After making an assessment, they radioed the control room asking for the prison doctor to attend. When the prison doctor arrived at the cell an ambulance was requested. When the paramedics arrived, they carried out a further assessment of the man's condition. As the man's condition remained unchanged, he was transferred to the ambulance and taken to an outside hospital.

After he arrived at the hospital, the man was put onto a ventilator machine to assist him with his breathing. As the doctors diagnosed that he would not recover, permission was sought from the man's family to switch off his ventilator. This was agreed and the man passed away during the early hours on 20 April 2007.

The clinical review carried out on behalf of the Primary Care Trust concludes that the man's clinical care was appropriate and equivalent to that available in the community. I have endorsed the five recommendations in the clinical review.

THE INVESTIGATION PROCESS

1. The investigation was opened on 25 April 2007 when my investigator issued notices announcing the investigation to staff and to prisoners. The notices included an invitation to those who wished to submit information relating to the man's death to make themselves known to my investigator. No prisoners or staff came forward as a result. My investigator also studied all relevant prison records relating to the man. These included his main prison record, medical records and statements made by staff.
2. The Liverpool Primary Care Trust identified a doctor to carry out a review of the man's clinical care. I am grateful to him for undertaking the review so promptly.
3. My investigator contacted Her Majesty's Coroner 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 will be sent to the Coroner to assist him in his enquiries into the man's death.
4. One of my Family Liaison Officers contacted the man's family. This gave them the opportunity to discuss the purpose of the investigation and to raise any concerns or questions that they would like explored and addressed. The family wanted to know the sequence of events after the man was taken ill and they also sought clarification on the cause of his death. The clinical reviewer and my investigator have explored these points and I hope that this report provides the family with answers to their questions.
5. My investigator visited Liverpool on 1 and 23 May and discussed aspects of the man's treatment with staff and the clinical reviewer.

HMP LIVERPOOL

6. 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. Liverpool is the second largest prison in England and Wales judged by population, and has a very high throughput of prisoners.
7. The report following the most recent unannounced inspection of Liverpool by HM Chief Inspector of Prisons, Ms Anne Owers, was published in November 2004. Ms Owers wrote then 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.
8. The report following Ms Owers's subsequent visit in February 2007 recorded progress in these areas. Ms Owers's follow-up report also reflected the challenges that still faced those managing the prison. Nevertheless, the inspection found that healthcare had improved considerably and that some primary care services were models of good practice. Provision of healthcare within Liverpool is the responsibility of the Liverpool Primary Care Trust.

KEY EVENTS

9. On 26 February 2007, the man was admitted to outside hospital after he had taken an overdose of heroin. Whilst at the hospital, the man escaped from the ward and climbed onto the roof. He then told the medical staff that he intended to throw himself off. After he came down from the roof, the man was seen by a psychiatrist who was aware of his previous history and felt that this behaviour was consistent with his previous diagnosis of emotional personality disorder. The psychiatrist felt that, providing precautions were taken, the man would be safe in the custody of the police. The man was discharged from the hospital on 27 February and was kept overnight in police custody.
10. The man arrived at HMP Liverpool on 28 February, after being remanded in custody at court. During his first healthscreen, it was noted that the man had a drug addiction problem and that he had been prescribed medication to control his anxiety and depression. The man was identified as an ongoing suicide risk and, as he was showing marked signs of withdrawal from drugs, an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support regime was started. (ACCT is used to monitor and support those prisoners who are felt to be at risk of suicide or self-harm.) After his healthscreening interview, the man was transferred to the prison's Drug Dependency Unit. Whilst he was on the Drug Dependency Unit, the man undertook a methadone detoxification programme.
11. On 1 March, the man was seen by the prison doctor who took a detailed medical history. The doctor had concerns regarding the man's agitated state and because he was hearing voices.
12. On 7 March, the man had a mental health assessment. It was noted that he did not voice any suicidal ideas and was quite positive about his future. He moved from the Drug Dependency Unit onto K Wing on 20 March.
13. On 17 April, the ACCT document was closed when the medical assessment identified that the risk of self-harm had abated and that the man had come to terms with his situation.
14. My investigator interviewed the man's cell mate. He said that he had known the man for a number of years. The cellmate reported that he had witnessed the man having fits on a number of occasions, and confirmed that the man had also complained of severe headaches for which he was given paracetamol. My investigator also interviewed Officer A who was one of the man's personal officers and who shared responsibility with other staff for managing prisoners on the landing. Officer A confirmed that he had known the man for a number of years as he had been in custody on more than one occasion. Officer A recalled that on 19 April he had seen the man throughout the day and also whilst he had been on duty in the visits hall during the early afternoon. He said that the man seemed to have had a good visit with his partner.

15. When asked to elaborate on what happened on 19 April, the man's cellmate recalled that the man had gone for his medication at lunchtime and had had a visit with his partner during the afternoon. The man returned to the cell he shared with his cellmate on K Wing (K3.14) around 4:30pm after the visit. The cellmate said that the man was in a happy mood. The man made himself a cup of tea and sat down in his chair.
16. Approximately five to ten minutes after sitting down, the man got up to change the channel on the television so that he could watch the programme, *Deal or No Deal*. As the man turned away from the television he fell to the floor, clutching his head and holding his right leg out. His cellmate immediately went to assist him. From previous experience, the cellmate thought that it was a continuation of one of the man's headaches and that he would snap out of it. The cellmate said that if he had realised that it was more serious he would have sought assistance immediately.
17. The man was still conscious after he fell to the floor, but did not respond to his cellmate who then helped him onto the bed. As the man's movements were quite forceful, he slid back onto the floor of the cell. The cellmate ensured that the man's head was supported so that he did not hit it. He continued to talk to the man who still did not respond. The cellmate was not sure how much time then elapsed but it was over ten minutes later when another prisoner looked into the cell through the viewing hatch. The cellmate asked the other prisoner to seek assistance immediately as the man had collapsed. Officer A responded. Officer A asked the man's cellmate how long the man had been ill and then asked his colleague, Officer B, to summon staff from the healthcare centre. Officer A then unlocked the cell door and stayed until assistance arrived from healthcare.
18. The Primary Care Manager arrived at the cell a couple of minutes later. After making an assessment of the man's condition, she asked one of the officers to go to the surgery and fetch her colleague, a nurse. She also told the officer to instruct the nurse to bring the emergency bag. The Primary Care Manager then maintained the man's airway and radioed the control room asking for the prison doctor to attend. This call was logged in the Governor's journal as being made at 5:40pm. Once the nurse arrived, the man was given oxygen. When the prison doctor arrived at the cell, the Primary Care Manager withdrew to call an ambulance. The call for the ambulance was made by the Prison Control Room at 5:50pm and a paramedic arrived at the prison at 5:55pm. When the paramedic reached the man's cell, the Primary Care Manager did a handover. Another two paramedics then arrived and a further assessment was carried out. The man's condition remained unchanged, and he was transferred to outside hospital in an ambulance which left the prison at 6:30pm.

19. Whilst the man was in hospital a bedwatch was carried out. Initially the security risk assessment called for three members of staff on bedwatch duty and for the man to be handcuffed. Around 8:00pm, after the man's condition was diagnosed, a further risk assessment was carried out. The restraints were then removed and the escort was reduced to two staff.
20. An officer, who was one of the staff on bedwatch duty, said that when he arrived at the hospital the man was unconscious. He was on a ventilator and was not restrained. The officer noted that an anaesthetist and doctor were with the man at all times. Due to the man's condition, the officers kept a respectful distance between themselves and his bed. The officer recalled that at around 10:25pm he had a conversation with a senior nurse. The nurse informed him that the man's family had been contacted due to the seriousness of his condition. The officer updated the prison with this information. The nursing staff also informed the officers that they would be asking the family if they could switch off the ventilator as the man would not regain consciousness.
21. The man's family and partner arrived soon after. They were met by hospital staff who took them immediately to his bedside. The officer and his colleague withdrew a little further to take up post at the nurses' station. The officer said that at one point the man did attempt to breathe for himself but this only lasted seconds. This set off an alarm at the nurses' station and resulted in the nurses having to reset the ventilator which then continued to assist the man with his breathing. The officer drew attention to the fact that there was always a member of medical staff with the man even when his family were in attendance.
22. At around 12:30am on 20 April, the man's ventilator was switched off and he passed away peacefully after a few minutes. The senior nurse then told the officers on bedwatch duty that the time of death was 12:35am. The man was moved to another room and his family were left alone to spend some time with him.
23. The prison appointed a family liaison officer. He made contact with the man's family shortly after his death. The prison family liaison officer maintained contact with the family and assisted with the arrangements and expenses for the funeral. A chaplain at the prison attended the man's funeral and delivered a eulogy at the request of the family.
24. The post mortem report records the man's death as being due to natural causes, as a consequence of intercerebral and subarachnoid haemorrhage, caused by a ruptured berry aneurism. A berry aneurism is a weakness and swelling in the circle of arteries at the centre of the brain. Subarachnoid haemorrhage occurs when the swelling bursts.

CLINICAL REVIEW

25. A review of the man's medical care was undertaken by a doctor on behalf of Liverpool Primary Care Trust. From the medical records, it was clear that the man was seen regularly by healthcare staff and, when necessary, referred to secondary care services. The clinical reviewer reports that the care provided to the man whilst in prison was of good quality. His clinical review concludes that there are no circumstances indicating that death could have been anticipated or prevented, but makes recommendations for improvements to clinical practice.
26. The clinical reviewer says that, although he would not recommend that medical summaries be sought for new prisoners from their General Practitioners (GPs), he does recommend that the medical record from previous sentences should be requested. The clinical reviewer also recommends that all contacts between medical staff and their patients should be recorded fully in the medical record.

The prisoner's medical records from previous sentences should be requested.

Salient points should be entered on the medical record for all consultations both with the General Practitioner (GP) and other health workers.

27. The clinical reviewer notes that, since the man's death, considerable work had gone into improving the record of medical information. He recommends that all staff, including the mental health workers, should use the computerised record keeping system.

System 1 should become the preferred method of recording contacts and should be used by all health workers including those from Merseycare.

28. The reviewer draws attention to the need for medical staff to confirm promptly the medication which has been prescribed to a prisoner by his GP.

It would have been desirable for confirmation of medications to have been available from the patient's GP at the earliest opportunity.

29. The clinical reviewer says that the use of standard detoxification regimes should not prevent tailoring of the regime to individual patients especially in complex dual diagnosis patients like the man.

Hypnotics (drugs that induce sleep) should only be used if absolutely necessary and in the light of possible drug interactions.

30. The clinical reviewer judges that during the man's time in HMP Liverpool he was treated attentively, caringly and promptly. The clinical reviewer says that any concerns he raises about record keeping and the appropriateness of the detoxification regime had had no bearing on the man's sudden, unheralded and unavoidable death. The clinical reviewer reports that there is usually no warning of a berry aneurism and it often happens to perfectly fit young men and women though it becomes more common over the age of 50. It is more likely to happen to heavy drinking smokers with high blood pressure but is not apparently associated with any higher risk from substance abuse. The clinical reviewer adds that it is important to note that the man's blood pressure when he arrived at Liverpool was normal.
31. The clinical reviewer concludes that the man's tragic early death was entirely due to natural causes.
32. The clinical reviewer draws attention to the good practice employed by HMP Liverpool:
 - Considerable efforts have been made to improve record keeping since the man's death. All healthcare staff are now trained in the use of the computerised record system and use it routinely in their work.
 - The effort made throughout to ensure that the man came to no further harm and received the support that he needed. The quality of social and medical care given to the man was of high standard, and probably beyond that which he would have had in the community.
 - The man's prompt referral to hospital when it became necessary, with excellent co-operation between healthcare and the prison administration which ensured a speedy transfer.

CONCLUSION

33. The man arrived at HMP Liverpool on 28 February 2007 and died from natural causes nearly two months later.
34. I appreciate that the loss of a loved one is always distressing. I hope that this report clarifies the circumstances which led to the man's untimely death.
35. In light of the findings of the clinical review, and my own investigation, I conclude that the man's medical care was entirely satisfactory. I have endorsed the five recommendations from the clinical review. These will need to be addressed by the Liverpool Primary Care Trust in partnership with the Governor of HMP Liverpool.

RECOMMENDATIONS

Medical

- 1. The prisoner's medical records from previous sentences should be requested.**

Accepted - This is already in place.

- 2. Salient points should be entered on the medical record for all consultations both with the General Practitioner (GP) and other health workers.**

Accepted – This is now in place.

- 3. System 1 should become the preferred method of recording contacts and should be used by all health workers including those from Merseycare.**

Accepted - HMP Liverpool is working with Merseycare to allow this to happen. Further training has also been arranged for staff.

- 4. It would have been desirable for confirmation of medications to have been available from the patient's GP at the earliest opportunity.**

Accepted – This is now done at the recommendation of the full time Reception General Practitioner.

- 5. Hypnotics (drugs that induce sleep) should only be used if absolutely necessary and in the light of possible drug interactions.**

Accepted - There is now more input from the Pharmacy on a regular basis and more agencies are going to attend Drugs and Therapeutics meetings.

Good Practice

- 1. I commend the work to improve record keeping at Liverpool since The man's death**
- 2. The man was a vulnerable prisoner who appeared to be supported throughout his stay at Liverpool. The quality of social and medical care given to him was of high standard, and probably beyond that which he would have had in the community.**
- 3. I also commend his prompt referral to hospital when it became necessary.**