Investigation into the circumstances surrounding the death of a prisoner at HMP Altcourse on 8 January 2006

Report by the Prisons and Probation Ombudsman for England and Wales

June 2006

This is the report of an investigation into the death of a prisoner. He was aged 31, died in the Healthcare Centre at HMP Altcourse on 8 January 2006.

I would like to extend my sincere condolences to the prisoner's family for their untimely loss.

The man had been remanded into custody on 16 December 2005, and had spent time in prison healthcare and outside hospital following a series of fits. Despite extensive tests carried out at the request of the Coroner, it has not been possible to establish the prisoner's cause of death. The toxicology results indicate that drugs or alcohol did not contribute to his death. Notwithstanding the absence of a formal cause of death, I have judged that all matters properly within my remit have now been covered. Other investigations by the police and Coroner are continuing.

One of my Investigators, conducted this investigation. I am grateful to the North Liverpool Primary Care Trust for undertaking a clinical review into the prisoner's care and treatment. I would also like to thank the Director of Altcourse, and his staff for their help and co-operation during this investigation.

I make four recommendations, the last of which reflects the very good practice demonstrated by the prison's family liaison officer.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2006**

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Summary

At about 4.15am on 8 January 2006, the prisoner was pronounced dead by paramedics in the Healthcare Centre at HMP Altcourse. He was 31 years old. Despite extensive tests, his cause of death is not known.

The man had been remanded into custody at Altcourse on 16 December 2005. He told healthcare staff on his medical reception that he had been hit over the head by police in their custody, after being arrested on 14 December. He stated during his reception screening that he had experienced fits and memory loss in the past, and that he had suffered a fractured skull in October 2003 also whilst in police custody. He had longstanding mental health and alcohol problems, for which he had been receiving appropriate anti-psychotic medication.

On 28 December, the prisoner experienced a series of fits and was taken to the prison's Healthcare Centre for further observation. Later that day, he was taken by ambulance to an outside hospital for further tests which included a head scan and x-rays. He was diagnosed as suffering from viral encephalitis (infection in the brain). He remained in hospital under bedwatch by prison staff until 3 January 2006 when he returned to the Healthcare Centre at Altcourse. On 5 January, he was deemed well enough to return to a normal residential wing.

At about 12pm on 7 January, the prisoner's cell mate, alerted staff that he was having a fit. In view of his recent history, it was decided to locate him in the Healthcare Centre once again so that he could be observed. Whilst in healthcare, the man did not experience any further episodes of fitting and gave no further cause for concern to staff. During the night, he was observed regularly. Staff noted that he was at first snoring heavily and then maintaining a clear, loud and solid breathing pattern.

However, at about 3.45am on 8 January, the night nurse noted that she could not hear the prisoner's breathing. She looked through the open flap of his cell door to discover that his chest was raised and he appeared not to be breathing. His cell was unlocked immediately and Cardio-Pulmonary Resuscitation began. An ambulance was called. During efforts to resuscitate him, he bled from his mouth. Resuscitation attempts continued for about 25 minutes but were unsuccessful.

The clinical review concludes that the prisoner received timely, appropriate and reasonable care and treatment whilst at Altcourse, and that he was referred to outside hospital for prompt investigation and treatment. I hope his family can take some comfort from these findings, and reassurance that he received a level of care equivalent to that which he could have expected in the wider community.

I make four recommendations in my report. The first three relate less to the death of the prisoner and more to issues that could be relevant in future medical emergencies. The fourth highlights the way in which Altcourse liaised with the prisoner's family following his sudden, sad and untimely death.

The investigation process

1. The investigation into the circumstances surrounding the prisoner's death was opened at HMP Altcourse on 9 January 2006. Notices were issued to staff and prisoners informing them about the investigation and giving them the opportunity to meet the investigator. My investigator visited Altcourse on 16 February to speak with members of staff who had cared for him. No prisoners came forward in response to my notice.

2. The Director and his staff produced the prisoner's core record, his Medical Record and a number of other documents for review.

3. North Liverpool Primary Care Trust was commissioned to conduct a clinical review into the care and treatment that he received whilst in prison. A doctor from the North Liverpool Primary Care Trust undertook the clinical review. It is attached to this report as an annex.

4. One of my Family Liaison Officers, contacted the prisoner's sister, the family's nominated representative, by telephone on 1 February. He offered her the opportunity to meet with him and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that the family would like explored and addressed. The family liaison officer and the investigator, met with his sister on 10 February when a number of issues concerning the man's care whilst in prison were raised. I endeavour to address all these issues in this report.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. My final report will be sent to the Coroner to assist him with the inquest into the prisoner's death.

The prisoner

6. The man was born on 6 December 1974. He was 31 years old when he died. He was from a large family and is one of six siblings. He had a particularly close relationship with his older sister, who described him as a quiet, shy boy in his youth who was very protective of his family.

7. He left school at the age of 16 and became an apprentice in horticulture. At about this time, he started to smoke drugs. His sister recalled that he then went on to use heroin. He began to get into trouble when he became involved in petty theft to pay for his habit. For some years, he lived with his older sister and her children.

8. The man also misused alcohol and could be easily provoked under its influence particularly by other members of his family.

9. The prisoner had an outstanding civil complaint against the police from a previous arrest for another offence in October 2003. Whilst in police custody, he sustained a fractured skull and other serious injuries whilst being restrained. This matter was still being dealt with at the time of his death. The prisoner's family has maintained that, since the incident in 2003, he had been suffering from headaches and a degree of visual impairment. The family is of the opinion that the injuries to his head could have contributed to his death.

10. At the time of his arrest for his current offence in December 2005, he was living with his partner at his mother's home address. His mother was his nominated next of kin. He was unemployed but had worked for a double glazing company in the past. The prisoner and his partner had a young son. However, at the time of his arrest, the relationship had broken down and the child had been taken into care. The prisoner did not maintain contact with his partner whilst he was in prison, and there is no record of him using the telephone or requesting a visit from her.

11. This was not the man's first experience of prison. He had previously been at HMP Liverpool and HMP Altcourse for separate offences. Staff at Altcourse found him to be an amenable person.

HMP Altcourse

12. HMP Altcourse is a contracted prison in Liverpool, under the management of Global Solutions Ltd – GSL. It was the first prison to be opened under the Government's Private Finance Initiative.

13. Altcourse's population consists of sentenced and convicted adult males from the Cheshire and North Wales area. It also holds young adults from Cheshire, North Wales and Merseyside. The current operational capacity (maximum crowded capacity) is 1,010. Approximately, one third of the prisoners are on remand.

14. Until 31 January 2005, Primecare Forensic Medical provided the healthcare services at Altcourse under a Service Level Agreement with the prison. On 1 February, this contract transferred to a new provider, Veritas Limited. The Healthcare Centre can accommodate up to 32 in-patients and offers a good range of primary care services.

15. A report of an announced inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) in February 2005 confirmed the widely held view that Altcourse is a very good local prison. The Chief Inspector concluded that Altcourse was "a safe prison with good interaction between staff and prisoners". The report also highlighted that good links had been established with the North Liverpool Primary Care Trust and that a survey of prisoners revealed all aspects of healthcare were highly rated.

Events from 16 December 2005 to 5 January 2006.

16. On 14 December 2005, police were called to his mother's address where he was arrested for threatening to kill his mother and resisting arrest. He appeared at Magistrates' Court on 16 December and was remanded in custody until 16 January 2006.

17. On reception at Altcourse, he underwent an initial medical screen. This established that he had seen his GP in the previous 12 months in respect of a wound to his penis. He was also being treated for a stomach ulcer. The prisoner had a history of mental health problems including psychotic episodes and schizophrenia. He said he was being treated by a Consultant Psychiatrist and was receiving Quetiapine and Diazepam. When asked if he had contemplated self-harm, he admitted that he had attempted this approximately 18 months previously. The initial health screen also indicated that he had suffered from fits in the past. He also told healthcare staff at reception that he had been hit over the head with a baton or a fist during his most recent arrest. However, the health screen determined that he was not suffering from any serious physical problem. The prisoner stated that he had not taken drugs for many years.

18. Following his health screen, he was referred to the prison doctor and the Mental Health In Reach Team because of his history of mental health problems. He was deemed suitable to share a cell with another prisoner. He was placed in a shared cell with another prisoner who was on remand.

19. On 17 December, it was recorded in his medical record that the prisoner was prescribed the appropriate medication for his mental health problems. On 20 December, he was seen by the Mental Health In Reach Team. Confirmation of his current medication was also received by fax from his GP. The prisoner complained at the time of being unable to urinate properly because his penis was split. Examination did not discover anything untoward.

20. On 21 December, he was seen by a Registered Mental Health Nurse (RMN). The medical record indicates that he agreed to comply with his medication regime.

21. The prisoner's cellmate recalled speaking to him on 22 December and being told that he was not getting the right medication for his psychotic illness and that he was getting pains in his head. The prisoner also told his cellmate that the root cause of his problem was that he had been assaulted by police during his recent arrest, when he had sustained a hit to the head with a truncheon. In a subsequent statement to the police, the cellmate said that he had told him that he had not suffered fits prior to being arrested by police on 14 December 2005. However, the initial health screen noted that the prisoner had in fact experienced fits prior to being

arrested in December 2005. During this investigation, it emerged that the man had told staff that he had experienced fitting episodes outside of prison. In a letter sent to his brother before Christmas, he said that he had received a beating by police when he was arrested on 14 December. This letter also contained an apology to his mother for the outburst leading to his arrest.

22. At about 2am on 28 December, the prisoner's cellmate rang the cell bell, having observed him with foam coming out of his mouth. The cellmate, who had some experience of people who suffered with fits, placed him on his side so that he could not swallow his tongue. Healthcare staff entered the cell within 10 minutes, after authority was received from the Duty Operations Manager (DOM). They noted that the prisoner was sitting on his bed talking incoherently. The cellmate was removed from the cell so that he could be treated. The medical record states that at 2.15am he was observed to fit again and was turning blue. He was given oxygen. During the course of being treated, he fitted twice more. At 3am, he was admitted to the Healthcare Centre for further observations. He was then taken by wheelchair as he was unable to stand.

23. The medical record further states that, at about 5.30am, the prisoner experienced a mild fit that lasted for about 30 seconds. Staff reassured him and kept him under observation. At about 8.50am, he vomited a small amount of blood and was seen by a doctor. The record then indicates that at 9.30am he vomited a small amount of partially digested food. By 10am, he was described as incoherent, and at 11.30am he was drowsy and vague. The man had also complained of a headache and stated that he was feeling unwell. Investigations at Altcourse confirmed that he had not taken any additional medication or illicit alcohol. (Whist he was in the Healthcare Centre, the prisoner told a nurse that outside prison he was a heavy drinker and that he had experienced similar episodes of fitting about 18 months previously.)

24. The medical record states that at 12.25pm, following observations and abnormal test results, he was seen by the prison doctor who decided to refer him as an emergency case to a local Hospital for further assessment.

25. At 2pm, the prisoner arrived at hospital under escort and handcuffed in line with the prison's security and operating procedures. He was seen by a doctor at 2.15pm and was described as confused and with a high temperature. The bedwatch log (an observation log completed by the escort officers) states that, at about 3.10pm, he was becoming agitated, distressed and delirious. The escort officers were concerned that he might take out his frustrations on the medical staff.

26. At 4.09pm, the bedwatch log indicates that the escorting officers had to restrain him as he was becoming very agitated and violent towards staff as doctors were trying to treat him. At 4.40pm, he was seen by a doctor who suspected that he might have an infection and that an x-ray and blood tests were required.

27. The prisoner needed intravenous treatment and accordingly his handcuffs were removed. However, in light of his propensity for violence and his behaviour towards staff earlier on, a third officer was deployed to help supervise him. At about 6.17pm, the bedwatch log indicates that the doctors treating the prisoner wanted to sedate him in preparation for a brain scan. They were concerned at his abnormal blood test results which indicated that there might be a problem with his heart. By 6.30pm, his condition was deteriorating. One of the escorting staff contacted the prison control room asking that his next of kin should be contacted in light of his deteriorating condition. An entry in the bedwatch log indicates that the prisoner's condition might have been attributable to a head injury.

28. By 8.30pm, he was intubated, fully sedated and had undergone a chest x-ray and other medical tests. An entry in the bedwatch log at 9.50pm enquired whether his next of kin had been informed of his condition. There was no evidence that this had been done in the prison records. My investigator also found that the prisoner had told his escort officers that he did not want his family told of his condition, although there was no documentary evidence to support this. Since his death, Altcourse has revised its documentation. This now prompts escorting officers to ask the prisoner if they would like their next of kin to be informed in the event of being kept in hospital, and to record the response

29. The prisoner remained fully sedated until 9.50am on 29 December. He was then informed that he might have to undergo further neurological tests in a Neurological Unit. At 3pm, he was transferred under escort to the Neurological Unit where he had a brain scan. Following the scan he was taken back to hospital. He was described by staff as fully compliant.

30. At 9.50am on 30 December, the bedwatch log entry indicates that the scans on him were normal and that he was to be transferred to a normal ward as a bed became available. At 4pm, he was seen by a doctor and told that he would be in hospital for several more days. He had been receiving antibiotic treatment. Whilst in hospital, the prisoner continued to be handcuffed and supervised by two Prison Custody Officers.

31. By 1 January 2006, the bedwatch log indicates that he was becoming increasingly frustrated at the lack of information from medical staff with regard to his condition, although he remained compliant and raised no concerns with his prison escorts.

32. On 3 January 2006, the prisoner was discharged from hospital and returned to the Healthcare Centre at Altcourse. He had been diagnosed as suffering from possible viral encephalitis (an infection in the brain) and was due to be reviewed in three months time. His brain scan was normal. It emerged during the investigation that following his discharge from the hospital, although the prison received notification with detail of the diagnosis, they did not receive a discharge letter which is used to formulate an appropriate care plan. The Healthcare Manager stated that

this was by no means unique to the prisoner's case and that, despite previous attempts to obtain discharge letters from the hospital through the Primary Care Trust, a system for sending letters to the Healthcare Centre had not been implemented. The Healthcare Manager and her staff were frustrated by this. The clinical review concludes that this is a universal problem, although healthcare staff would have been able to contact the hospital at any time if they were concerned.

33. Whilst he was in healthcare, he told a nurse that he had no recollection of the events leading up to his admission to hospital and stated that this was not the first time that he had experienced a loss of memory. The nurse recalled that he had told her that sometime in 2005, whilst outside prison, he had collapsed at a bus stop and was taken to hospital. He described the experience to the nurse as "a bit of a blitz" and had been told by medical staff that he had fitted. She also told my investigator that the prisoner was on a high dosage of Quetiapine. Because of this, his medication was always double checked during its administration. The nurse also said that, during her conversation with the prisoner, he had told her that he had been assaulted by six police officers.

34. He did not suffer any further recurrence of fits and, having been assessed by the prison doctor on 5 January, he was deemed fit to be moved back to a normal residential location. The prisoner returned to the same cell on the wing that he had been sharing with his cellmate. In a statement to police following his death, the cellmate said that the prisoner was subdued and complaining of headaches. The cellmate also said that the prisoner attended the Healthcare Centre in order to receive his medication.

Events from 7 January leading up to the prisoner's death

35. The prisoner's cellmate said that at about 11.30am on 7 January, he and the prisoner were playing cards in the cell when the prisoner began to fit. His eyes were rolling and he was coughing froth and some blood. The cellmate alerted discipline staff who entered the cell. Healthcare staff were then alerted and attended the cell within minutes. After attending to the prisoner, staff noted in the medical record that he was uncoordinated and unable to respond to various commands and was not aware of his surroundings. It was also established that he had bitten his tongue whilst fitting as there was some blood. In view of his previous medical history, he was admitted to the Healthcare Centre once again and placed in a double cell for further observation and assessment by the prison doctor. The cell is located adjacent to the nurses' office.

36. At about 9pm, the Nurse, the Healthcare Assistant, and Prison Custody Officer had reported for night duty. A verbal handover between the day and night staff had taken place and confirmed that the prisoner was back in the Healthcare Centre following a fit earlier that day. The healthcare staff were aware of the prisoner's previous history of fitting. The nurse had been told that he had been on association with other prisoners, had watched television and played snooker. He had also collected his medication between 6pm and 7pm. It was also reported by staff that he had eaten very well that day, and given no cause for concern.

37. At 9pm, prisoners are locked up for the night. Each Prison Custody Officer has a set of sealed keys, but cells must only be opened with the authority of the Duty Operations Manager. (This procedure is designed to ensure that security is not compromised during the night.)

38. During lock up, the nurse toured the Healthcare Centre and looked through the door flap of each cell to assure herself that prisoners were okay. The Healthcare Assistant had asked the prisoner to place his mattress on the floor of his cell in order to prevent further physical injury should he experience a fit during the night. The prisoner complied with the request.

39. Staff told my investigator that regular observation of prisoners in healthcare took place during the night, irrespective of whether prisoners were on specific observation regimes to prevent self-harm. The nurse stated that checks were cursory and consisted of approximately five checks during the hour in which staff look through the cell door flap to ensure that the prisoner is okay. Staff are not required to keep a record unless the prisoner is subject to the formal suicide prevention regime. The prisoner was not the subject on any formal observation regime and consequently the checks on him were not recorded. However, the nurse told my investigator that these quick checks on the prisoner did take place.

40. Staff also told my investigator that during the night he was snoring loudly, and that he gave them no cause for concern. At about 1.00am, the nurse looked again into his cell and noted that he had just been to the toilet. The prisoner was standing with hands on his hips and appeared to be stable on his feet. The nurse asked if he was okay and she received an affirmative response.

41. Later on in the night, the nurse noticed that he had stopped snoring loudly and was maintaining a clear, nice and deep level of breathing. The nurse stated that, in light of this change in his breathing pattern, she lowered the flap to the cell door and left it open so she could hear any change in his breathing pattern. Healthcare staff told my investigator that, at night time, sounds resonate very clearly in the Healthcare Centre.

42. At approximately 3.45am, the nurse was in the nurse's office opposite The man's's cell. She said that she could not hear him breathing and walked across to his cell to look through the open hatch of the door. The prisoner was lying on his mattress. She noticed that his chest was raised and that he might start fitting. After a few seconds of further observation, she then saw that he was not breathing. The nurse shouted to the PCO and her colleague, the Healthcare Assistant, who were nearby and requested access to the cell immediately.

43. The PCO informed the Duty Operations Manager, that healthcare staff needed access to the prisoner's cell and that the sealed pouch containing cell keys would need to be broken. The Duty Operations Manager who was in the Care and Separation Unit at the time, conducting his routine supervisory checks, told the PCO that he would make his way to the Healthcare Centre in order to assess the situation. Whilst the Duty Operations Manager was making his way to the Healthcare Centre, the PCO unlocked the cell and entered it with Healthcare Assistant. The nurse went to get the emergency bag. The prisoner was unconscious, unresponsive and cyanosed [a blue colour to the skin]. He showed no vital signs. His mattress was repositioned on the floor to allow for ease of access and medical treatment. The Healthcare Assistant and the PCO then began Cardio-Pulmonary Resuscitation (CPR).

44. The nurse returned to the cell in seconds with oxygen and a mask. She told my investigator that the prisoner began to vomit and, as he was turned on his side to obtain a clear airway, he suffered two large haematemasis (vomiting blood from the stomach or oesophagus) that resembled ground coffee.

45. Staff confirmed to my investigator that they were up to date in their CPR training. They continued CPR until the paramedics arrived. The nurse quickly put in an airway to administer oxygen. A defibulator was attached to the prisoner that indicated to staff that CPR should continue.

46. During the resuscitation attempt, the Duty Operations Manager arrived in the cell and contacted the control room via radio to request an emergency ambulance. As the Duty Operations Manager, he then left the wing to open the prison for the paramedic team. He also contacted the Duty Director, and informed him of the situation.

47. The ambulance was called at 3.50am, and paramedics arrived in the cell at about 3.58pm to assist healthcare staff with resuscitation. CPR continued for a further 15 minutes. The ambulance was parked on grass close to the Healthcare Centre. Sadly, the efforts to resuscitate the prisoner were not successful and he was pronounced dead at 4.15am.

Events after the prisoner's death

48. At about 4.25am, the Duty Director arrived in the prison and was briefed on the events leading up to the prisoner's death. Altcourse then followed its contingency plan in the event of a death in custody. This included informing the Prison Service's National Operations Unit (NOU), the Coroner, the prison's Independent Monitoring Board, and the police. Staff who dealt with the prisoner were also requested to complete contemporaneous notes. They were offered support by the care team.

49. The incident log indicates that, following his death, the ambulance that had been parked on grass outside the Healthcare Centre sank into the ground and could not be moved. Later on that day it had to be towed away. In the event, this did not have a direct effect on the prisoner's treatment or care, although it could have had serious consequences for him had he been resuscitated and needed to be transferred to hospital. Manifestly, it could also have serious consequences for other patients in the future.

50. Altcourse nominated a governor as the prison's Family Liaison Officer. The decision was taken for the liaison officer together with the chaplain, to visit the prisoner's mother's address. The family was told of his death at about 10.45am. The family are highly critical and suspicious that he died as a result of the police having used excessive force in his arrest. It also became clear that there was a long and acrimonious history between the family and the Police in respect of a previous allegation of improper use of force.

51. After the news of his death had been broken, the family went to view the body at the hospital. They were accompanied and supported by the prison's family liaison officer and the prison chaplain.

52. The funeral took place in late January 2006. The prison offered and paid the cost of the funeral. The chaplain attended the funeral as the representative from Altcourse.

53. Altcourse has maintained contact with the prisoner's family since his death and have given family members the opportunity of visiting the establishment. Arrangements were also in hand to ensure that his property was returned to his family. The prison's family liaison officer endeavoured to answer any questions or concerns and the family have been most appreciative of his efforts and the sensitivity of the prison in this matter.

54. On 10 February 2006, my Family Liaison Officer and the investigator visited the prisoner's sister at her home address. It was clear that the family remained deeply concerned and mistrustful of the way in which he was arrested by police in December 2005. In conjunction with a previous

incident involving the police, they believe that he may have sustained injuries that could have contributed to his death. However, this issue is outside the remit of this particular investigation and remains the subject of a separate police inquiry.

55. The family also raised some issues in respect of the prisoner's time at Altcourse. First, the family wanted clarification on whether he was receiving his medication for his mental health problems, and whether any change in his medication was a factor in his untimely death. The family was also concerned that he might have been discharged prematurely from hospital and that, whilst in the care of the prison, normal and frequent observations on him were not maintained. Lastly, the family wanted to know whether he had been bullied whilst in prison and had therefore sustained any further injury that caused him to suffer from fits. (My investigator has found no evidence to suggest that the prisoner was bullied.)

56. Staff who dealt with the prisoner were asked if they had received the appropriate care and support following his death. Whilst most staff are satisfied with the level of support they had been given, this was not universal. My investigator established that a staff debrief for those involved in the prisoner's care had not taken place.

Clinical review and post mortem

57. The clinical review undertaken by the North Liverpool Primary Care Trust has determined that the man's care appears to have been comprehensive and thorough during his stay at Altcourse. His chronic and acute health problems appear to have been managed in an appropriate and timely manner. The review states that he received his anti-psychotic medication from 19 December. He was also given Diazepam, prescribed for his anxiety, although this was stopped two days after his arrival at Altcourse. The review states that stopping this medication abruptly could have lowered the threshold for seizures. However, it is noted that it was 10 days after this medication was stopped before he was observed fitting.

58. In regard to the prisoner's discharge from hospital, the clinical review states that this was reasonable, particularly as he was returning to a 24-hour healthcare facility within the prison. The review highlights that no formal discharge letter was received by prison healthcare and that this is often the case. However, the review states that prison healthcare staff would have been able to contact the hospital at any time if they were concerned.

59. Following further observations where no further fits occurred, he was deemed fit to return to a normal location. The review goes on to state that whilst he was in the Healthcare Centre on the night preceding his death, the man was observed at the appropriate frequency.

60. The clinical review notes that the prisoner had a previous history of fits and, although these are recorded in his general practice notes, this does not appear to have been investigated at any time prior to his detention at Altcourse. As such, it is impossible to relate this to recent alleged episodes of head injury. The clinical review concludes that the history of fits should have been the subject of further investigation in primary or community services. These issues are also subject to a separate, ongoing investigation by the police.

61. A post mortem was carried out and extensive tests were made on the prisoner's brain at the request of the Coroner. However, the cause of death is unascertained and will never be known.

Issues considered during the investigation

The prisoner's history of fits

62. The prisoner's psychiatric history was noted when he entered Altcourse and he continued to receive the appropriate anti-psychotic medication. It was documented that he had suffered episodes of memory loss. He also admitted to members of staff that he had suffered from fits in the past, although this was not known to his family. The clinical review also notes the history of fits, including a head injury following a fit in August 2005. Although these are recorded in his general practice notes, this does not appear to have been investigated at any time prior to his detention at Altcourse.

63. The prisoner was prescribed Diazepam for anxiety although this was stopped two days after his arrival in Altcourse. The clinical review states that stopping this medication abruptly could have lowered his threshold for seizures, although it was 10 days after this medication was stopped before he was observed fitting.

64. The clinical review observes that the history of fits should have been the subject of further investigation in primary or secondary services in the community and is not a reflection on his care in prison. The prisoner's healthcare in the wider community is outside the scope of the Ombudsman's investigation.

65. The medical record does not show that the man entered prison with any obvious physical injury, although he had told his cellmate and a nurse that he had been assaulted by police during his arrest in December 2005 and sustained a bang to his head.

Information sharing between the hospital and prison healthcare

66. On 3 January 2005, the prisoner was discharged from hospital back to the Healthcare Centre at Altcourse. He had been diagnosed with possible viral encephalitis and was due to be reviewed in hospital in a further three months. However, during the investigation the Healthcare Manager was concerned that a formal discharge letter was not received by Altcourse. This would have been useful in confirming and determining an appropriate and continuous plan of care for him. However, the clinical review concludes that this did not contribute to the prisoner's death, and it seems to be a continuing source of frustration to healthcare staff when they refer a prisoner for treatment to an outside hospital.

The Director and the Healthcare Manager should continue their efforts with the North, South and Central Liverpool Primary Care Trust to ensure that formal discharge letters are received every time

a prisoner returns from hospital, to ensure continuity of treatment and the formulation of an appropriate care plan.

Emergency access

67. In the event, the ambulance was not required to take the prisoner to hospital. However, the vehicle had been parked on soft ground outside the Healthcare Centre and became bogged down in the ground. Although this did not have a bearing on the events surrounding the death of this man the inability to transfer a patient to hospital for immediate and potentially life-saving treatment could have serious consequences in similar circumstances. (Or could have done in this instance, had he been resuscitated.)

The Director should ensure that staff direct ambulances attending the establishment to an appropriate hard standing in order to prevent vehicles from becoming bogged down in soft ground.

Alleged injuries sustained during arrest

68. Although the prisoner had stated during his medical screen that he had received an injury to his head during his arrest in December, the post mortem indicated that this was not a contributory factor to his death. However, he had also sustained a fractured skull and other injuries in October 2003 during a previous arrest. In view of this, the Coroner had requested further tests on the prisoner's brain in order to determine whether this could have been a cause of death. However, following investigations the cause of death will remain unknown. The circumstances of his arrest in October 2003 are being investigated as a civil complaint by the family against the Police.

Post incident de-brief

69. The investigation highlighted the need to provide adequate debriefing to staff following a death in custody in line with Prison Service Order 2710. This enables timely discussion and early identification of potential learning opportunities.

The Director should remind senior colleagues of the importance of a timely formal debrief of key staff following a death in custody or other serious incident.

Family liaison

70. It was clear that Altcourse has dealt with the man's family in a very sensitive and compassionate way, and has provided both comfort and reassurance to the family during a traumatic time. The efforts of the prison's Family Liaison Officer, should be highlighted as an example of good practice.

The Director should commend the Family Liaison Officer, for the way in which he broke the news of the death of the prisoner to his next of kin and the high level of sensitivity, professionalism and compassion that has been displayed and commented on by members of the family since his death.

Recommendations and good practice

1. **The Director and the Healthcare Manager should continue their efforts with the North, South and Central Liverpool Primary Care Trust to ensure that formal discharge letters are received every time a prisoner returns from hospital to ensure continuity of treatment and the formulation of an appropriate care plan.**

2. **The Director should ensure that staff direct ambulances attending the establishment to an appropriate hard standing in order to prevent vehicles from becoming bogged down in soft ground.**

3. **The Director should remind senior colleagues of the importance of a timely formal debrief of key staff following a death in custody or other serious incident.**

4. **The Director should commend the Family Liaison Officer, for the way in which he broke the news of the death of the prisoner to his next of kin and the high level of sensitivity, professionalism and compassion that has been displayed and commented on by members of the family since his death.**