

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Liverpool in January 2014**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution
to safer, fairer custody and offender supervision'*

This is the investigation report into the death of a man, who died of heart failure in January 2014, at HMP Liverpool. He was 55 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the clinical care the man received at Liverpool. The prison cooperated fully with the investigation.

The man had been in police custody from 3 January until 6 January 2014, when he was remanded into the custody of HMP Liverpool. At an initial health assessment at the prison, he disclosed no health issues and he did not report feeling unwell.

A lack of accommodation in the prison's first night centre meant that the man and a number of other new prisoners were located on another wing that night. He shared a cell with another new arrival.

At around 9.30am the next morning, the man's cellmate discovered him unresponsive in bed and raised the alarm. Officers and healthcare staff were quick to respond but it was evident that the man had been dead for some time. At 9.45am, paramedics confirmed his death.

I agree with the clinical reviewer that the man's death was not foreseeable and staff at Liverpool could not have prevented it. However, I consider that new arrivals who are not held in the first night centre should have appropriate welfare checks.

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.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

August 2014

CONTENTS

Summary	5
The investigation process	6
HMP Liverpool	7
Key events	8
Issues	10
Recommendations	11
Action Plan	12

SUMMARY

1. The man was arrested on 3 January 2014 and held in police custody at until 6 January, when he was remanded to HMP Liverpool. A nurse conducted an initial health assessment. The man said he was not prescribed medication, he did not disclose any significant medical history and said he did not want to see the prison doctor.
2. There was a high number of new arrivals at the prison that night and there were no spare beds in the first night centre. Some new arrivals, including the man and his cellmate were therefore allocated cells on another wing.
3. That evening the man and his cellmate talked together until around midnight when they went to bed. The night was uneventful, except the man's cellmate said he was woken by his snoring on one occasion.
4. At around 8.00am the next morning, the man's cellmate got out of bed and thought that the man was still sleeping. His cellmate spoke to him at about 9.30am and, when he got no reply, touched his arm to try to wake him. The man's arm was cold and his cellmate realised something was seriously wrong. He pressed the cell emergency bell and shouted for staff.
5. Officers went to the cell immediately. They found the man unresponsive and radioed a code blue emergency. An emergency ambulance was called and prison nurses attended quickly. They found no signs of life and agreed that resuscitation efforts would be futile. Paramedics arrived at 9.40am and at 9.45am confirmed that the man had died.
6. We agree with the clinical reviewer that staff at Liverpool could not have predicted or prevented his death. The staff responded quickly and professionally when he was discovered. However, we consider there is a need for appropriate welfare checks for new prisoners not located on the first night centre. Although this would not have changed the outcome for the man, in other circumstances it could be vital. We make one recommendation about this issue.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff at prisoners at HMP Liverpool, informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. He visited HMP Liverpool on 9 January, met the Governor, visited J wing and spoke to members of staff and a prisoner who had met the man. The investigator interviewed 11 members of staff and one prisoner on 28 February. He wrote to the Governor to give initial feedback on the preliminary findings of the investigation.
9. NHS England commissioned the clinical reviewer to review the man's clinical care at the prison.
10. We informed HM Coroner for Liverpool of the investigation and gave him our preliminary findings about the circumstances of the man's death. The Coroner provided the cause of death. We have sent the Coroner a copy of this report.
11. One of the Ombudsman's family liaison officers contacted the man's partner, his nominated next of kin, to explain the investigation. The man's partner did not raise any concerns.
12. The man's family received a copy of the draft report. There were no factual inaccuracies and an issue raised by the family has been dealt with in separate correspondence. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this is included at the end of the report.

HMP LIVERPOOL

13. HMP Liverpool is a category B local prison for up to 1462 men. Clinical services at the prison are commissioned through Liverpool Community Health NHS Trust and Mersey Care NHS Trust.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Liverpool was in October 2013. The Inspectorate found that the prison received over 70 new receptions weekly. A nurse saw all new arrivals and screened them for urgent medical problems. First night procedures were judged to be good and first night cells were well prepared despite the poor fabric of the building. Inspectors found that night staff were unaware of new arrivals that day.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure prisoners are treated fairly and decently. In its most recently published annual report for the year to December 2013, the IMB said that prison staff provided a generally high standard of professionalism and care for prisoners in sometimes difficult circumstances.

Previous deaths at Liverpool

16. The man's death was the third due to natural causes at HMP Liverpool since the start of 2013. There were no similarities with the previous cases.

KEY EVENTS

17. The man was arrested and held in police custody from Friday 3 January 2014 until Monday 6 January, when he was remanded into the custody of HMP Liverpool. The man did not appear unwell and did not require any medical attention in police custody.
18. During his initial health screen, the man told the nurse that he had no mental or physical health issues, was not taking any medication and did not use illegal drugs or use alcohol excessively. He smoked cigarettes but declined any advice on giving up. He also declined an offer to see the prison doctor that evening.
19. Because of a lack of accommodation in the first night centre, at around 9.30pm, the man and five other prisoners were located on another wing. The man shared a cell with another new prisoner. The man's cell mate said they talked for several hours and then went to sleep some time after midnight. The man's cell mate said that the man did not say anything about feeling unwell. During the night the man's loud snoring woke the man's cell mate for a short while, but otherwise he noticed nothing to concern him.

Events on 7 January

20. At around 8.00am on 7 January, the man's cell mate got up and looked out of the cell observation hatch. He went back to bed and thought that the man appeared asleep on the top bunk. He told the investigator that there was nothing that concerned him at the time. At about 9.30am, he got up and looked out of the observation hatch again. This time he turned the cell light on and saw that the man had not moved. He spoke to him and tapped him on the arm to try to wake him. The man's cell mate said that the man's arm was cold and he realised something was seriously wrong. He pressed the cell emergency bell and shouted and kicked the door.
21. An officer arrived at the cell within moments, followed closely by two other officers. The man's cell mate was distressed and one of the officer's took him to the wing office leaving the other two officers to go into the cell.
22. The officers found the man on the top bunk lying on his back with his head facing towards the cell door. The officer realised that the man was rigid and cold. He could not find a pulse and there was no movement. An officer immediately radioed a code blue emergency (a code blue message is used to indicate a medical emergency when a prisoner is unconscious or has breathing difficulties). In accordance with national guidelines, the control room immediately requested an ambulance. North West Ambulance Service verified they received this call at 9.34am.
23. A nurse was close to the man's cell and heard the request for emergency assistance. He examined the man and also found no signs of life.
24. A nurse (the duty emergency responder) and another nurse arrived at the man's cell with emergency medical equipment. The nurse said that he thought the

man had been dead for some time. The nurses examined the man and noted that blood had pooled in the lower parts of his body and that rigor mortis was evident. They agreed that any resuscitation attempt would be inappropriate and of no benefit to the man.

25. At 9.40am paramedics arrived and examined the man. At 9.45am they confirmed his death.

Liaison with the man's next of kin

26. At 11.15am the prison's family liaison officer, a member of the chaplaincy and the head of safer custody went to the man's partner's home and informed her of his death. They also informed other family members. The family liaison officer kept in contact with the man's family until the funeral on 17 January, at which he represented the prison. In line with national guidelines, the prison contributed towards the cost of the funeral.

Support for staff and prisoners

27. The Governor issued a notice informing staff and prisoners of the man's death and informing them of the support available. All prisoners subject to suicide prevention monitoring were reviewed and offered additional support in case they had been affected by the news of the man's death. The man's cell mate received ongoing support.
28. The Governor held a hot debrief for the staff involved in the emergency response. Most attended but it appears that two of the nurses were unaware of it and we draw this to the Governor's attention. However, we were told all staff were aware of the availability of Care Team support and how to access it and generally felt well supported.

Post-mortem report

29. A post-mortem report concluded that the man died of acute myocardial insufficiency (inadequate functioning of the heart muscle), aortic stenosis and ischaemic heart disease (narrowing of the aortic valve in the heart and disease of the blood vessels supplying the heart).

ISSUES

Clinical care

30. The clinical reviewer concluded that the man died unexpectedly during the night and that staff at Liverpool could not have foreseen or prevented his death. There was no indication during the initial health screen carried out the evening before of any signs or symptoms of underlying health issues. The man did not disclose any pre-existing conditions and normal clinical observations were recorded. On the morning of 7 January, when the man was found, the response from officers, healthcare staff and paramedics was prompt, professional and appropriate.
31. The clinical reviewer was concerned that the room used for initial health screens is not suitable for high quality health assessments. He makes a recommendation about this in his clinical review which the head of healthcare will need to address. We do not include it in this report as the issue is not one directly related to the circumstances of the man's death.

The man's Location

32. A high number of new prisoners arrived at HMP Liverpool on 6 January which caused a shortage of accommodation in the first night centre. The man and a number of other newly received prisoners were located on J wing instead, where he and the man's cell mate shared a cell.
33. First night prisoners are not usually held on J Wing except as an occasional overflow from the first night centre and there is no established routine for monitoring them except at a routine roll count around 5.30am. Standard J wing prisoners are unlocked at around 8.00am but if the first night prisoners have not been unlocked and collected by first night centre staff at the end of their own wing routine, then J wing staff unlock them to allow them time in the open air, but this can be some time later. The man's cellmate raised the alarm at around 9.30am, before any of the first night prisoners had been unlocked.
34. Prison Service Instruction (PSI) 74/2011 says that new prisoners should be allocated to dedicated first night accommodation or other suitable accommodation that meets minimum standards and that there should be arrangements to monitor new prisoners' safety and wellbeing throughout the night. There were no welfare checks on J wing during the night. We consider that night staff should be informed of any prisoners on the wing who are new to custody so that they can be alert to any problems. At a minimum someone should check on their welfare at the standard unlock time in the morning. While it would not have altered the outcome for the man, in other circumstances, particularly for a new arrival in a cell on their own, this could be important. We make the following recommendation.

The Governor should ensure that there are appropriate arrangements, in line with PSI 74/2011, to check the welfare of first night prisoners wherever they are held in the prison.

RECOMMENDATION

The Governor should ensure that there are appropriate arrangements, in line with PSI 74/2011, to check the welfare of first night prisoners wherever they are held in the prison.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible
1	The Governor should ensure that there are appropriate arrangements, in line with PSI 74/2011, to check the welfare of first night prisoners wherever they are held in the prison.	Accepted	<p>The accommodation at HMP Liverpool has been reconfigured so that all first night receptions are located in the first night centre.</p> <p>An additional safety check for all first night prisoners will be introduced to meet this recommendation. This will be structured into procedures and documented for audit purposes.</p>	<p>1 October 2014</p> <p>Head of Safety and Equalities</p>