

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a man at hospital in August 2012, while in
the custody of HMP Liverpool**

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 report of an investigation into the death of a man, a prisoner at HMP Liverpool, who was found hanging in his cell on 31 July. He died in August at hospital. He was 45 years old. I offer my condolences to his family and friends.

Two investigators carried out the investigation. A clinical reviewer conducted a review of the clinical care the man received at Liverpool. The prison cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was remanded into custody on 25 July 2012. He had a history of drug and alcohol misuse and began a detoxification programme. At around 2.35pm on 31 July, his cell mate and another prisoner discovered him hanging in his cell. Prison and healthcare staff tried to resuscitate him and a nurse managed to obtain a pulse. He was taken to hospital, where he was placed on life support.

When the man arrived at the prison, he said that he had no thoughts of self-harm. However, assessing the risk a prisoner poses to himself involves balancing the prisoner's demeanour and behaviour against known risk factors. I am concerned that staff did not assess him with sufficient rigour. Greater weight should have been given to his known risk factors, including the circumstances of his alleged offence and his withdrawal from drugs and alcohol. It is also clear that his self-enforced isolation and lack of interaction with staff or other prisoners were not identified and acted upon. Consideration of the suicide and self-harm monitoring procedures might have offered the opportunity to put in place greater support during his early days.

The investigation also identified some deficiencies in the emergency response. Nevertheless, in spite of delays in starting the resuscitation attempts, nurses worked skilfully and were able to regain the man's pulse. Sadly, it proved too late to save him.

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

April 2013

CONTENTS

Summary

The investigation process

HMP Liverpool

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded into custody to HMP Liverpool on 25 July 2012, charged with two offences of grievous bodily harm. One of the alleged offences was against his long term partner.
2. During his first reception health screen, the man disclosed he had epilepsy and was alcohol and drug dependent. He was prescribed tegretol for his epilepsy as well as methadone (a heroin substitute) and librium (medication for alcohol withdrawal) as part of a detoxification programme. He did not disclose any suicidal intentions and was moved to a shared cell in H Wing, the substance misuse and stabilisation unit. Between 25 and 27 July, medical staff reviewed him regularly to monitor his alcohol withdrawal symptoms and increased his methadone dosage.
3. After lunch on 31 July, the man went to education but returned to his cell shortly afterwards. His cell mate returned a short time later but found the door locked and the cell in darkness. Another prisoner looked through the observation panel and shouted to officers that he could see him hanging.
4. Two officers immediately went into the cell and found the man hanging from a noose made from a bed sheet. They cut him down, called for healthcare assistance and began chest compressions to try to resuscitate him.
5. The nature of the emergency was not initially communicated to other staff who attended, but after a short delay, a code blue (an emergency code to indicate that a person is not breathing) was called. Healthcare staff took over the resuscitation attempt and managed to regain the man's pulse, but he was unable to breathe unaided. Paramedics arrived at around 2.55pm and took over his treatment. They took him to hospital at 3.15pm, where he was placed in a drug-induced coma and attached to a life support machine. The prison's family liaison officer contacted his family, who went to the hospital. His life support machine was switched off and he died the next day.
6. The man's alcohol detoxification was managed well, but we are concerned that prison staff did not take account of potential triggers of self-harm during his reception screening. There is no documented record to show that the nature of his alleged offence which involved his partner, his withdrawal from drugs and alcohol or a previous suicide attempt were considered when assessing any possible suicidal ideation. All of these are known factors which increase the risk of suicide and self-harm. Additionally, there is no evidence of any interaction between him and prison officers on the wing.
7. When the man was found the wrong call sign was used to summon help and an emergency code was not used in the initial call. A log of events and actions taken during the emergency was completed however this document was not made available to the investigator at the time of investigation. His cell mate was not offered support when he was taken to hospital or after he died. We have made recommendations about these issues. However, we commend the skills of two nurses who successfully managed to regain his pulse.

8. The Coroner's inquest took place on Monday 25 February 2013 during which further information came to light. A copy of CCTV footage was produced by the prison, which recorded the sequence of events from when the man was unlocked from his cell for education, to the arrival of paramedics. This evidence was not made available to the PPO at the time of this investigation.

THE INVESTIGATION PROCESS

9. Notices announcing the investigation were issued to staff and prisoners at Liverpool, inviting anyone with relevant information to contact the investigator. No one came forward.
9. The investigator carried out the investigation, assisted by a colleague. She visited Liverpool on 10 August, where she met a member of the senior management team, the chair of the Independent Monitoring Board (IMB) and a Prison Officers Association representative (POA). She also spoke to the prison's family liaison officer, viewed the man's cell and interviewed his cell mate.
10. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care that the man received at Liverpool. He reviewed the medical records and interviewed medical staff with the investigator on 30 August.
11. The investigator reviewed the man's records and returned to HMP Liverpool on 15 November, with a colleague, to interview several members of prison staff. She gave preliminary feedback after the interviews. The investigation was subsequently completed by her colleague. We are sorry for the delay in issuing this report, which was caused by staffing changes during the course of the investigation.
12. One of the Ombudsman's family liaison officers contacted the man's sister on 23 August 2012, to explain the investigation process. She also wrote to update her on the progress of the investigation on 13 February 2013. His family had no specific issues they wished to be considered as part of this investigation and will receive a copy of this report.
13. The Coroner received an initial copy of this draft report and the inquest took place on 25 February 2013.

HMP LIVERPOOL

14. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,184 prisoners. A Health Trust delivers healthcare at the prison. There is a primary mental health team, an in-reach team (for those with a diagnosed severe and enduring mental illness), and a clinical psychology service which delivers specialist therapy and counselling.

Her Majesty's Inspectorate of Prisons (HMIP)

15. Her Majesty's Inspectorate of Prisons carried out a full unannounced inspection in December 2011. The inspection found some progress had been made at the prison since the last inspection, but it was very slow.

16. The Inspectorate considered that safer custody policies were reasonable, but were not effectively implemented on the wings and a worrying number of officers were not trained in the suicide and self-harm prevention procedures. The Inspectorate was also concerned that prisoners had to be at the prison for three months before they could be considered for enhanced status (which entitles them to increased privileges, including time out of the cell and additional visits).

Independent Monitoring Board (IMB)

17. Each prison has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community, to help ensure that proper standards of decency are maintained. In its annual report for 2010/2011, the IMB expressed concerns about staffing shortages and the impact of further budget cuts on the delivery of the regime. The IMB were satisfied that staff were vigilant and professional about safer custody procedures.

Previous deaths at HMP Liverpool

18. Since January 2011, there have been ten deaths at Liverpool of which five were self-inflicted. We repeat a previous recommendation to Liverpool about the use of emergency codes.

KEY EVENTS

19. The man appeared at Crown Court on 25 July 2012, where he was charged with two offences of serious assault, one of which was against his long-term partner. He was remanded into custody and taken to HMP Liverpool. He had been in prison before and his last custodial sentence had been at Liverpool in 2002.
20. At a reception health screen, the man told a nurse that he was dependent on alcohol and drugs. He also explained that he had been diagnosed with epilepsy for which he had been prescribed tegretol (200mg). He said he had no thoughts of self-harm and she described him as orientated and relaxed. A locum GP saw him and noted opioid drug dependence and chronic alcoholism. He began a detoxification regime for alcohol (librium – 30mgs daily) and was prescribed 10mls of methadone for his first night. This was gradually increased to 80 mls each day and his medication for alcohol withdrawal was to be gradually reduced over the next seven days. Prison staff requested his medical records from his GP.
21. During the reception process, an officer conducted a first night interview using a proforma which asked several standard questions including whether the man had alcohol or drug withdrawal symptoms. The proforma did not include any questions about self-harm or suicide and there is no indication that the officer discussed this with him. The clinical reviewer notes that he was admitted to hospital in 2011, “after a suicide attempt that was related to alcohol abuse” but this was not noted in his record at reception so it is unclear whether reception staff were aware of this information.
22. The man went to the substance misuse and stabilisation unit on H wing at about 6.30 pm and was assigned a cell on the top landing, sharing with a cellmate. His alcohol detoxification regime was monitored, with withdrawal assessments completed twice daily on 26 and 27 July. During his final assessment on 27 July, he did not display any obvious signs of alcohol withdrawal. On that day he saw the GP, who recorded that he denied any suicidal intent.
23. The man’s cellmate said that on the first night, the man wrote a letter to his partner but he was concerned she might not receive it because of the nature of his alleged offence. He talked mainly about his partner and was anxious about the breakdown of their relationship. He gave no indication to him of suicidal intentions. For the first few days, he only left his cell to collect his medication and food and did not appear to interact with any other prisoners. He was very concerned about whether the two letters he had written to his partner would be posted. He told him that he was upset as he felt he had lost everything and likely to receive a long prison sentence. He made no telephone calls and did not receive any visits.
24. On 28 July, the man and his cellmate moved to another cell together on the same landing. At that time, he met a prisoner he knew. His cellmate said this was the only other person he ever saw him talk to. The cellmate reported that on 28 or 29 July, at about 8.30am, the man said he had been given three tegretol tablets in the morning. He told him that he had taken all three tablets at once although he

knew they should have been taken individually at intervals over the course of the day. He had received his methadone and librium at the same time.

Events of 31 July

25. There is a record that on the 31 July the man saw a substance use worker from the Counselling, Assessment, Referral, Advice and Throughcare services (CARATs) team. This team provides drug misuse intervention services for prisoners. He was noted to be reluctant to engage but gave no indication of suicidal ideation.
26. At approximately 1.30pm, two officers went to H wing to unlock prisoners for work and education. Officer A explained to the investigator that by 1.50pm, all the cells had been opened to allow prisoners to attend activities and then re-locked. The CCTV footage records that both the man and his cell mate left their cell at 1:52pm. The officers remained on the wing for returned prisoners who were not required for work or education (prisoners return to the wing if there are too many for classes or other activities which are organised on a first come first served basis). Between 1.50pm and 2.20pm, returning prisoners were locked into their cells individually as they arrived.
27. Officer A said his normal practice was to lock empty cells and then when prisoners returned he would unlock the cell and let them in. He said he did not know if this was standard practice among other officers however we would expect this to be done. The officer does not recall the man returning to the wing.
28. Another officer explained that when prisoners go to education or work, they are 'ticked' on a list and if they return because they are not required, they should hand staff a note to explain the reasons. This note is not retained. The CCTV footage shows the man returning to his cell at 1:59pm and the cell being locked by an officer at 2:00pm. It is unclear which officer locked his cell.
29. The cellmate explained he had left the cell when he and the man were unlocked for education. He was also sent back but had remained on the wing, talking to another prisoner on the second landing when the man also returned from education. He spoke briefly to him but did not notice anything unusual in his demeanour. He remained with his friend for a short time while the man returned to his cell on landing five.
30. It appears from CCTV footage that a male with a bag, possibly a workman, entered the man's cell at 2:20pm and the man left. This male then left the cell at 2:23pm and locked him back in his cell.
31. The cellmate said he returned to his cell to find the door locked and the cell in darkness. He explained that he is partially sighted so he asked another prisoner to look through the door observation panel. The prisoner saw the man hanging and called for help from officers on the landing. This is recorded on CCTV at 2:42pm.

32. The officers became aware of a commotion outside the cell and responded immediately. Officer A reached the cell first and unlocked the door. He went in with Officer B and saw the man hanging at the back of the cell from a bed sheet. Officer A lifted him up to support his weight while Officer B cut through the sheet with his cut-down tool, which all officers carry. They then placed him on his back on the floor and checked for a pulse in both his wrist and his neck but could not find one. The officers took it in turns to give chest compressions. Two more officers were also at the cell. It is unclear which officer had called for healthcare, however it is recorded that a Senior Officer (SO) had called a code blue (used in an emergency to signify breathing difficulties).
33. A Principal Officer (PO) was on G Wing when he heard a code blue call at around 2.35pm and he immediately went to H Wing. He said that when he arrived, two officers were performing cardiopulmonary resuscitation (CPR). He radioed to ask the control room to call an ambulance but was told a call had already been made. A couple of minutes later, two nurses arrived and took over emergency aid at which point the two officers left the cell. The PO estimated that it took around 15 minutes for the ambulance to arrive.
34. Nurse A said she was in the outpatient unit when she received a call as Hotel 7 to attend H wing as soon as possible. She asked her colleague to go with her. She was not aware of the reason for the call but assumed if it was urgent that Hotel 1 (the nurse designated as the emergency response contact) would be there and would have asked for assistance. The walk to H wing took about two to three minutes. As she arrived, she heard a code blue called. She then radioed the control room and asked for Hotel 1 to attend with the emergency equipment urgently. She also checked that an ambulance had been called and was told that this had been done.
35. When the nurses took over CPR from the officers Nurse A said the man was warm but unresponsive. His eyes were fixed, he was not breathing and he had no pulse.
36. The emergency response nurse (Hotel 1) arrived about two minutes later with the emergency bag. The nurses administered oxygen and attached the defibrillator to the man. There were four cycles of the defibrillator and no shockable rhythm indicated, so nurses continued with chest compressions and managed to regain his pulse. However, he was still not breathing independently so they continued to give him emergency aid until paramedics arrived about twenty minutes later, at around 2.55pm. (This is recorded on CCTV footage at 3:02pm). He did not require further CPR, as his pulse had returned, but he continued to receive oxygen while the paramedics transferred him to the ambulance.
37. The ambulance crew left the prison at about 3.15pm and took the man to hospital. Two officers accompanied him but no restraints such as handcuffs or an escort chain were used. The escort officers noted in their log that after he arrived at the hospital he had started to breathe independently at 3.27pm and doctors put him into a drug-induced coma at 3.35 pm.

38. The prison immediately appointed a family liaison officer (FLO), who went to the man's sister's home, as she was his nominated next of kin. One of the prison chaplains accompanied him. She was not at home, but he explained what had happened to other members of his family and had a brief telephone conversation with his sister, who was at work. He had a further telephone conversation with her the following day to explain the circumstances to her in more depth. Another officer took over as the family liaison role two days later and kept in contact with the family.
39. Nurse A held a debrief for healthcare staff involved in the emergency response. A further debrief was held by prison managers for all staff involved, including nurses, but some staff had already gone off duty by that time.
40. Prison staff checked prisoners subject to suicide and self-harm monitoring in case they had been adversely affected by the incident. The cellmate said that he was placed in a cell with another prisoner for a short time, but shortly afterwards was taken to the segregation unit where his clothes were removed for forensic tests. This is normal procedure and there is no evidence to suggest anyone else was involved in the man's death. However, he was not offered any support following the death of his cell mate.
41. The man remained in hospital and hospital staff told his family that his prognosis was poor. They explained they would attempt to bring him out of his drug-induced coma but warned that this could result in his death.
42. On 4 August, hospital staff told the man's family they intended to remove the medical equipment supporting him and that he was not expected to recover. This was postponed in accordance with the wishes of some family members. After a review, the hospital removed the life support and he died the following afternoon. In line with national guidance, the prison offered financial assistance towards the funeral expenses.
43. The man's cellmate learnt of his death from another prisoner. He told the investigator that no prison staff had spoken to him or offered him support since he had been found.

ISSUES

Clinical care

Detoxification

44. The man was identified as dependent on drugs and alcohol when he arrived at Liverpool. He was prescribed methadone and placed on alcohol detoxification. The clinical reviewer considered that his reception medical screening was appropriate and his drug and alcohol misuse were correctly identified. He says:

“A full history of his drug and alcohol history was obtained. Alcohol intake was assessed and a tailored detox programme was instituted with regular assessments of his physical withdrawal. His methadone dose was identified as well as the method of pickup in the community. He was referred to the prison drug services as well as the CARAT [drug support services] team. He was seen daily for his methadone prescription and was seen by the CARAT team on 31 July. The methadone maintenance programme was appropriate.”

We are satisfied that his healthcare needs were adequately met during his time at HMP Liverpool.

Assessment of risk

45. Prison Service Instruction (PSI) 64/2011, which gives guidance on the management of prisoners at risk of harm, lists a number of potential triggers for self-harm and suicide. These include early days in custody; substance misuse; previous self-harm; and violent offences, especially against family members or partners. As the man was at Liverpool for only a few days before his death, there were few entries in his prison record. Healthcare staff assessed his mental state and asked him about self-harm or suicide on his arrival at the prison and two days later. When questioned, he said he had no thoughts of harming himself. During his relatively short time at the prison, staff recorded no concerns about him.
46. We have considered whether staff should have started, or at least considered self-harm prevention procedures on the man's arrival. We have been critical in the past when prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk related information. He had a history of drug and alcohol misuse. He had been charged with a serious violent offence against his partner and placed on an alcohol detoxification programme. In addition, he had attempted suicide in the past, although reception staff might not have known this. All these factors are significant indicators of risk of self-harm and suicide. Set against these, he said he had no thoughts of self-harm or suicide when asked directly.
47. Staff judgement is fundamental to the suicide and self-harm prevention system, which relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. It is not an exact science. However, the man had a number of known risk factors when he arrived at

Liverpool and we are concerned that staff relied so heavily on his own assurances that he had no thoughts of killing himself rather than making an assessment taking into account all the factors. There is no evidence that any consideration was given to beginning suicide and self-harm procedures. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk.

48. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged. We consider that more weight should have been given to the known risk factors in comparison to the man's presentation, including the circumstances of his alleged offence and his detoxification. Prison staff should have then considered conducting the initial assessments of the suicide and self-harm procedures to determine whether he required monitoring or support under its provisions.

The Governor and Head of Healthcare should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide. Where there are significant risk factors and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.

Wing staff's knowledge of the man

49. The man did not leave his cell for the first few days after his arrival and had little interaction with other prisoners. He was preoccupied with his partner and upset that he had 'lost everything' and was likely to receive a long sentence. We acknowledge that H Wing has a transient population however it is unacceptable that there is no evidenced interaction between him and prison officers on the wing. Staff described a procedure for checking prisoners as they go to work or education and receiving them back if not required. On the day that he died, staff were not aware he had returned to his cell from education and no evidence has been found to substantiate which staff member opened and locked his cell. It is clear that prison staff on the wing had little knowledge of him.

The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by good quality entries in their case notes. The Governor should also ensure that staff adhere to the procedures for registering prisoners as they leave their cells and arrive back from education and work.

Emergency response

50. When the man was discovered hanging, officers used the wrong call sign to summon healthcare staff. They initially called a member of the healthcare department but not the one designated as the emergency response. They did not initially use an emergency code but did so in a second call. Use of such a code informs staff not only that there is an emergency but also of its nature and

enables better preparation, including taking the correct emergency equipment. While reacting in stressful situations, it is understandable that mistakes can be made. However, the incorrect call sign and lack of an emergency code resulted in a delay of several minutes in obtaining emergency equipment. It is unclear which officer was responsible for these calls. A quick response is vital in increasing chances of successful resuscitation.

The Governor should ensure that all staff use the appropriate call signs and emergency codes to request healthcare staff on discovery of a serious incident.

Support for the man's cell mate

51. After the man was taken to hospital, his cell mate was placed in a cell with another prisoner for a short period. He then went to the segregation unit where his clothing and possessions were removed for forensic tests. He said he was told by a police officer who interviewed him that the man's ventilator was to be switched off and that he heard about his death from other prisoners. As well as sharing a cell for the duration of their time at Liverpool, he was one of the prisoners who found him hanging. PSI 64/2011 states that, in the event of a death in custody "Appropriate care and support must be offered to the cell mate and any other persons directly affected by the death..." We are not satisfied that prison staff offered appropriate support to him.

The Governor should ensure that following a death in custody, the prisoner's cell mate and those who are known to have had close personal relationships with the prisoner, are informed of the death personally and offered appropriate support.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all the known risk factors of a newly-arrived prisoner are fully considered when determining their risk of self-harm or suicide. Where there are significant risk factors and self-harm prevention procedures are not started, decisions and reasons should be clearly documented.
2. The Governor should ensure that all prisoners have a named officer who should be aware of their individual needs, whom they can approach for assistance and who will make regular checks on their well-being, backed up by good quality entries in their case notes.
3. The Governor should ensure that staff adhere to the procedures for registering prisoners as they leave their cells and arrive back from education and work.
4. The Governor should ensure that all staff use the appropriate call signs and emergency codes to request healthcare staff on discovery of a serious incident.
5. The Governor should ensure that following a death in custody, the prisoner's cell mate and those who are known to have had close personal relationships with the prisoner, are informed of the death personally and offered appropriate support.