Investigation into the death of a man at Fazakerley Hospital, while in the custody of HMP Liverpool, on 18 April 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the death of a 57 year old man at Fazakerley Hospital, Liverpool, on 18 April 2009. The man was a prisoner at HMP Liverpool, and had been in poor health for some time. I would like to offer my condolences to his family and friends for their loss.

One of my investigators conducted the investigation on my behalf. I thank the Governor of Liverpool and his staff for their co-operation and assistance.

I commissioned Liverpool Primary Care Trust (PCT) to conduct a clinical review into the standard of healthcare the man received whilst in custody. As the inquest into the man's death was heard relatively quickly, the clinical review was not available at the time of issuing the draft report. A copy of the review is now attached as an annex to this report along with the recommendations.

In light of the man's poor health, he had been admitted to the prison's healthcare centre and located in a shared cell. On the evening of 18 April, his cellmate alerted staff that he had collapsed. The staff quickly intervened and an ambulance was requested. After administering treatment in his cell, the ambulance staff conveyed him at 7.00pm to Fazakerley Hospital, where an emergency medical team continued resuscitation. Sadly, at 7.22pm he was pronounced dead. The post mortem examination concluded that the man had suffered a heart attack because of severe ischaemic heart disease.

I am satisfied that he was well cared for and his physical needs met during his time at HMP Liverpool, I endorse one recommendation made by the clinical review in relation to training for healthcare staff. I am also pleased to highlight four areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

The man was remanded into custody on 29 March 2009 after breaching the conditions of an order imposed on him. This was not his first time in custody. He was 57 years old.

When he arrived at HMP Liverpool, a nurse assessed him and completed a health screen. During this interview, it was established that the man had previously suffered a stroke which had resulted in disability to his left side. He was taking a variety of medications to manage his condition, and this was also recorded. Due to his physical disability and difficulty in climbing stairs, the nurse arranged for him to be located on the ground floor. The man declined the offer to see the doctor following the nurse's assessment. However, the doctor made an entry in the medical record that the man had been observed and was stable with no signs of acute problems.

Following the reception process, the man was located on K wing which is for vulnerable prisoners. Over the next few days, he completed the induction process during which he was allocated two members of staff as his personal officers. (These officers would be his main point of contact should he have any concerns during his time on the wing.) The man spent two weeks on K wing. While he was there, he kept to himself and mixed very little. This might have been because of anxiety over his disability.

A nurse at Liverpool runs a monthly Older Prisoners Clinic, together with a Nurse Consultant, from Liverpool PCT. On 8 April, the nurse assessed the man at the clinic. He appeared anxious and told the nurse that he had been unable to shower for the last two weeks on K wing. The nurse looked into this and established that the showers on K wing were on the first landing and so he would have to negotiate a flight of stairs to reach them. There is no evidence to suggest that he had voiced his concerns to wing staff prior to speaking with the nurse. Due to his obvious physical needs, the nurse arranged for the man to be admitted to the healthcare centre for a few days to enable him to attend to his personal hygiene and reduce his anxiety.

He settled into the regime on the healthcare centre which he found suited his physical needs better. He was located in a shared cell that had disabled access toilet and washing facilities. The man was reportedly able to move well around the unit. He would laugh and joke with other prisoners and staff, who described him as a jovial character. He attended court during his time at Liverpool and it was reported that on his return to the prison he appeared quite down and upset.

On 18 April 2009, the man spent the morning associating with other prisoners and talking to staff. While locked in his cell over the lunch period, he received a letter from his solicitor. His cellmate later said that, after reading the letter, the man began to cry and was inconsolable despite the best efforts of his cellmate to console him. For the remainder of the afternoon, he remained in his cell and slept for most of that time.

At 6.25pm, the man attempted to get up from his bed before collapsing back. His cellmate alerted staff who quickly came to the cell. On assessing him, they asked for an ambulance and administered cardio pulmonary resuscitation. Other medical staff who had heard the emergency call attended and also tried to resuscitate him. At 6.45pm, the ambulance and paramedics arrived and took over treatment.

The paramedics were able to establish a pulse before transferring the man by emergency ambulance to Fazakerly Hospital at 7.00pm. On arrival at the hospital, he was taken immediately to the resuscitation room where efforts to revive him continued. Despite the efforts of the medical staff, he was pronounced dead at 7.22pm.

The prison had some difficulty contacting his next of kin on the evening of his death but did so the following morning. There have been continuing efforts to trace a blood relative. Managers also held a debrief for staff who had been involved in the efforts to revive the man the previous evening.

I endorse one recommendation made by the clinical reviewer in relation to training for healthcare staff, and highlight several instances of good practice.

THE INVESTIGATION PROCESS

1. My investigator opened the investigation on 21 April 2009 when he contacted HMP Liverpool to arrange for documentation to be provided. Notices were issued to staff and prisoners informing them of my investigation, and inviting anyone who had relevant information to come forward. My investigator received no responses to the notices.

2. My investigator visited Liverpool on 12 May. He spoke with healthcare staff and to a prisoner who had shared a cell with the man.

3. In accordance with my terms of reference, I commissioned Liverpool PCT to conduct a clinical review into the care and treatment the man received while in custody. This review was completed by a doctor. The doctor's review is attached as an annex.

4. The man had named a close friend as his next of kin and one of my Family Liaison Officers telephoned her on 14 May but there was no answer. The FLO has attempted to make further contact but been unsuccessful. Efforts by the Coroner's officer, and the prison have continued in trying to trace a blood relative of the man.

5. The investigator wrote to HM Coroner to inform him of the nature and scope of the investigation. The Coroner told my investigator that the cause of death had been established and it was clear that it was natural causes. As such, the Coroner said that he was intending to hear the inquest into the man's death on 16 June 2009. My investigator was also in contact with the Coroner's officer, during the investigation, and I would like to thank him for his assistance. The inquest was held on 16 June and concluded that the man died from natural causes.

HMP LIVERPOOL

6. HMP Liverpool was built in 1855 to replace a much older and more cramped establishment in the centre of the city. There are eight wings, all of which have been refurbished and provided with an integral sanitation system.

7. Liverpool is one of the largest prisons in England, accommodating around 1,400 prisoners. It holds category B and C convicted male adults as well as remand and unconvicted male adults. One of the wings is K wing, which is the designated vulnerable prisoners unit, where the man who died was initially located.

8. The most recent inspection of Liverpool by HM Chief Inspector of Prisons, Dame Anne Owers, was an unannounced follow-up inspection in February 2007. In relation to healthcare and, in particular, in-patient facilities, Dame Anne concluded that:

> "… The in-patient unit was staffed by a team of nurses and healthcare officers. The team leader was a general nurse and a principal officer. She was supported by two senior officers, both of whom were registered mental health nurses. Prisoners each had a named nurse who coordinated their care. Each patient was discussed at a weekly multidisciplinary ward round meeting. A plan was devised and then discussed with the individual patient. One of the cleaners was the wing representative and attended the general prisoner forum meetings. He then fed back to the other patients at a group meeting organised by one of the nurses. Patients were able to undertake education on the wing and attend work or gym activities as their condition allowed. Prisoners admitted direct to the unit from reception underwent a modified induction to the prison dependent on their condition ..."

9. The Independent Monitoring Board's report for the year 2007/2008 contains no matters relevant to the man's circumstances.

10. Prior to this death, there had been 18 deaths at Liverpool prison attributed to natural causes since April 2004 (when I first became responsible for their investigation). No matters arising in those cases are of direct significance to this death.

KEY FINDINGS

Events from 21 March to 18 April 2009

11. The man was remanded into the custody of HMP Liverpool on 21 March 2009 after breaching the conditions of his sex offender order. He was 57 years old and had been released from a previous prison sentence in 2006. On his arrival at Liverpool, he was assessed as part of the reception procedures by a nurse who completed a health screen.

12. During the health screen, the nurse established that the man had suffered a stroke in 1993 which had resulted in weakness on his left side and his walking with a limp. The man also said that, prior to being remanded, his blood pressure had been monitored monthly. The nurse recorded that, due to the man's limited mobility, he would need a cell on the ground floor. When asked whether he had ever tried to harm himself, he told the nurse that, following his stroke, he had been diagnosed with reactive depression. He said that during this period he had felt suicidal but no longer felt like this and had no thoughts of self-harm.

13. The nurse noted the medication that the man had brought into prison. Due to his ongoing medical problems, the nurse referred him to the doctor but he declined to be seen. However, the doctor made a note on the man's medical record:

> "… Received today in HMP Liverpool with medication for his heart condition. Patient observed stable and shows no signs of acute problems. Stated he is fine in himself and controlled well by his meds. Meds represcribed as per confirmation. Review as needed ..."

14. Due to the nature of his offences, he asked to be placed on the vulnerable prisoners unit and was subsequently moved to K wing. His wing history record (Page 16) indicates that he attended the induction on K wing, and completed it on 23 March.

15. During his induction, staff explained the Group Officers Scheme. This is a scheme at Liverpool in which two named officers are allocated to each prisoner to whom they can go to if they have any problems. The man signed a compact to say that he understood how the scheme worked. (Most prisons have a personal officer scheme in which a certain number of prisoners on a wing are allocated to a named member of staff. This staff member is their principal point of contact for any concerns, and the personal officer also completes any sentence planning or report documentation required.) The system at Liverpool ensures that all prisoners are informed on induction, and two members of staff are allocated to ensure that there is usually someone on duty.

16. The man's personal officer for the short period that he was on K wing, recorded in his wing history record that he was a quiet individual. On 27 March, he attended Bootle Magistrates Court where he was remanded until 16 April.

17. The following week, a nurse assessed the man in the Older Prisoner Clinic. She was assisted by a nurse consultant from Liverpool PCT, who attends the prison to conduct the monthly clinic. The nurse told my investigator that all prisoners over 55 years of age are referred to her when they come into custody. This was the first contact that she had with the man.

18. During his assessment, the nurse recorded that he had no acute illness but was anxious. The man told the nurse that he found it difficult to attend to his personal hygiene due to the weakness on his left side, and he was becoming quite anxious about this. He said that he had not managed to shower for two weeks. The man had been located on the second landing, which is the ground floor, as the initial health screen advised. However, the showers are located on the landing below, which meant that he would have to negotiate one flight of stairs in order to access them. As part of the plan to deal with this, the nurse recorded that staff should look into whether a bath could be provided in the healthcare centre. The nurse was to speak with the wing staff regarding the man's condition and need for assistance. The nurse spoke with staff in the healthcare in-patients unit later that morning and they were happy for the man to be admitted for a couple of days until he felt better.

19. The nurse also spoke with the disability advisor, regarding the man's inability to climb stairs, to maintain his personal hygiene, and his problems collecting his meals. It was recorded that these matters were to be discussed with wing staff the following day.

20. Despite him saying that he had not showered for two weeks while on K wing, there is no indication that he had previously mentioned his difficulties to wing staff. As previously mentioned, the man had been told what to do if he had any concerns and who to speak with. He was very self-conscious about his disability, and this may have inhibited him from asking for help.

21. The man was admitted to the healthcare centre later that afternoon. He settled in well to the regime there and appeared to be more settled. He mixed with other prisoners and took his medication as prescribed. Although he still had some difficulty moving around the unit, he managed to eat his meals without assistance but needed help to collect them. In-patients in healthcare are able to eat their meals in a dining area rather than their cells. My investigator was told by nursing staff that he would always do this and socialised well.

22. He continued to progress in the healthcare centre, and it was apparent that the ability to use the disabled facilities and tend to his personal hygiene contributed to a brighter outlook. On 16 April, he returned to court and again was remanded into custody. His cellmate, described him as being "jovial" and "optimistic" for the majority of the short time that he knew him. However, he mentioned that, following this court appearance, the man was upset and appeared to have a lot on his mind. The man's cell mate told my investigator that the man also spoke to him about his personal situation outside prison which had been causing him concern.

23. On Saturday 18 April 2009, the man spent time in his cell with his cell mate as well as around the unit. Nursing staff recalled him laughing and joking during the morning. In a statement made following his death, his cell mate said the man had received a letter from his solicitor over the lunch period that had upset him. He said that the man began crying and, despite trying to reassure him, his mood did not change. During the afternoon, he remained in his cell lying on his bed and slept for most of the time.

24. At around 6.25pm that evening, a healthcare assistant (HCA) and staff nurse were on evening duty in the healthcare centre. They were alerted by the man's cell mate to a problem with the man. The cell occupied by the man is directly opposite the nursing station where they were located. When they went to the cell they found the man lying slumped across his bed. His cell mate said that the man had appeared to get up to go to the toilet and fallen backwards onto the bed.

25. In a statement, the staff nurse said that the man's face was a 'bluish' colour and he had been incontinent of urine. She immediately used her radio to ask the control room to call an ambulance. While the staff nurse made the call the HCA removed the man's cell mate from the cell and collected the emergency response bag and an oxygen cylinder. (The bag is held in the treatment room and contains the equipment required in a medical emergency.) The HCA then began assisting the staff nurse to administer cardio pulmonary resuscitation (CPR).

26. Having heard over the radio network that there was a medical emergency in the healthcare centre, a registered general nurse (RGN) went to the cell and helped to set up the defibrillator. (An automated external defibrillator or AED is a portable electronic device which measures electrical activity in the body and advises on the action to be taken.)

27. The ambulance arrived at 6.45pm, with two more paramedics in a rapid response vehicle. They took over administering first aid to the man. The paramedic staff used their own defibrillator that had a monitor attached. CPR continued and a paramedic identified a pulse. He was then transferred to the ambulance and taken to Fazakerley Hospital at 7.00pm. Two members of staff accompanied him on the ambulance, but no restraints were used as the prison managers had been told by healthcare staff of the seriousness of his condition.

28. The man was taken straight into the hospital's resuscitation area and attempts to revive him continued. The prison staff remained outside the room. At 7.22pm, an escorting officer was told by a member of the resuscitation team that the man had been pronounced dead.

Actions after the man's death

29. After his death was reported to the prison, the prison chaplain along with a governor and a principal officer went to tell the man's cell mate. He was offered the opportunity to speak to a Listener (Listeners are volunteer prisoners who are trained by the Samaritans to offer confidential support to fellow prisoners in

30. Following a death in custody, regardless of cause, the cell would normally be sealed to preserve the scene for any police involvement. Due to the cell mate's physical disability, his cell in the healthcare centre had a special bed and other equipment. As a consequence, it was not feasible for him to be moved following the man's death, although healthcare staff did look for another suitable location. The cell mate was asked not to disturb any of the man's belongings as the police would need to view the cell.

31. The chaplain reassured the cell mate of further chaplaincy support if he needed it. After visiting him, the chaplain and a governor who is a prison Family Liaison Officer, left the prison to visit the friend that the man had named as his next of kin. Unfortunately, there was no answer at the address and, despite trying another address, no one could be contacted. On return to the prison at 12.30am, the governor and deputy governor discussed the difficulty contacting the next of kin.

32. A mobile telephone number was available. Due to the lateness of the hour, it was considered inappropriate to call at that time, but instead the governor would return to the address the following morning. The governor, along with a member of staff from the prison chaplaincy team, returned the following morning and initially there was no answer. However, the man's friend arrived home shortly afterwards and they were informed about the man's death.

33. A debrief was held at the prison later that morning attended by all staff involved the previous evening. The purpose of the debrief was to give staff the opportunity to discuss how they felt and to identify any immediate learning points. The debrief was chaired by the duty governor. He thanked all the staff concerned for their part in the delivery of care to the man and the speedy response to take him to hospital as quickly as possible.

34. As no relatives had been identified, the Coroner's officer, police and prison continued to attempt to identify further next of kin before releasing the man's body and opening the inquest. My investigator spoke with the Coroner's officer, who told him that it was believed the man had a daughter from a previous marriage. The coroner's officer had asked the local council to assist in trying to trace her mother via the electoral roll.

ISSUES

Clinical care

35. The health screen carried out when the man entered custody identified his physical problems and ensured that this information was passed on to the residential wing so that he could be suitably located. The Older Prisoners Clinic provided him with the opportunity to discuss his concerns regarding access to facilities, and meant medical staff could readily identify the need for him to be located in the healthcare centre. At this clinic, the nurse sees all prisoners aged 55 and over who may have untreated problems, or like the man, had felt unable to discuss them. This is also highlighted by the clinical reviewer in her report as being good practice. **I consider the provision of this service to be excellent practice on the part of the Primary Care Trust and the prison.**

36. In her report, the clinical reviewer says of the screening process at Liverpool. If a prisoner fails to attend the second healthcare screening, he is offered a further two appointments. After three non-attendances no further appointment is made but the prisoner is encouraged to attend at a later date. This active encouraging of attendance is to be commended.

37. During the clinical review it was found that some nursing staff were unsure how to use the defibrillator so did not apply the defibrillator pads immediately. Another member of staff arrived soon after the man had been discovered and was able to apply the pads and administer a shock when directed by the defibrillator. During the review, the doctor was told that all trained nursing staff undergo annual Intermediate Life Saving (ILS) training. However, HCAs currently do not undergo ILS, nor do they have Basic Life Support Training. The doctor makes the following recommendation which I endorse:

All staff on the Healthcare Unit should have at least Basic Life Support Training and ideally Intermediate Life Support Training.

All staff should be aware of how to use the Defibrillator.

38. The facilities in the healthcare centre enabled the man to manage his personal needs independently. The professional attitude of the staff in dealing with a group of prisoners with varying mental and physical illnesses has ensured that there is a relaxed atmosphere with a sense of community. This enabled him to settle in quickly and become less anxious about his own physical disability. **I should be grateful if the Governor would share my observations with the clinical staff.**

Group Officers Scheme

39. During the induction process, the Group Officers Scheme was explained to the man and two members of staff were allocated to him. On entering prison, many prisoners feel isolated and procedures are often not thoroughly explained. However, the Group Officers Scheme at Liverpool ensures that, as part of their induction, prisoners are allocated two members of staff as key workers in the first few days in custody. **This ensures greater availability of staff to prisoners and should be seen as another example of good practice.**

Transfer to hospital

40. In many of my reports, I have had to comment in strong terms on the inappropriate use of restraints when escorting sick or dying prisoners. In this man's case, the views of medical staff were sought by prison managers before making a decision on their use. As a result, he was not subjected to the indignity of being restrained and emergency treatment was able to continue unhindered. **I commend HMP Liverpool for ensuring that the views of healthcare professionals were considered before making a decision on restraints.**

Family liaison

41. The initial actions of the governor and chaplaincy staff in trying to notify the man's listed next of kin at the earliest opportunity were commendable. I also acknowledge the governor decision not to telephone due to the lateness of the hour but instead to return the following day.

42. While I agree that the governor's decision not to telephone at the late hour was appropriate in these circumstances, some families have been upset when they have not been told of a death as soon as possible (even when it is very late). There are no easy answers to this dilemma. In such situations, the prison needs to ensure that equal consideration is given to the need for next of kin to be informed, and the chances of them hearing from a third party, and how the shock of the news at a late hour could be managed.

43. The continued efforts of the prison, police and Coroner's officer in trying to establish a link with a family member is commendable. **This was only possible due to the good working relationship between the different organisations and again should be seen as good practice.**

Conclusion

44. The man who died had not been in good health since suffering a stroke. On his reception into custody, his physical problems were identified, but he did not wish to be treated any differently because of them. However, after being on a residential wing for two weeks, when he was seen in the Older Prisoners Clinic he admitted that he was not coping well with his personal hygiene and welcomed the opportunity to move to the healthcare facility.

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45. His cellmate described him as a jovial character, but said he did have concerns about his ongoing court case. On 18 April 2009, there was initially no sign that he was unwell and his death came as a shock to his cellmate and to staff.

46. I consider that every effort was made to resuscitate him, and that staff in the healthcare centre had cared for and supported him very well.

RECOMMENDATIONS

1. All staff on the Healthcare Unit should have at least Basic Life Support Training and ideally Intermediate Life Support Training.

   All staff should be aware of how to use the Defibrillator.

GOOD PRACTICE

1. All prisoners aged 55 and over are seen in the Older Prisoners Clinic. I consider the provision of this service to be excellent practice.

2. The Group Officers Scheme at Liverpool ensures that prisoners are allocated two members of staff as key workers in the first few days in custody as part of their induction. This should be seen as another example of good practice.

3. The continued efforts of the prison, police and Coroner's officer in trying to establish a link with a family member is commendable. This was only possible due to the good working relationship between the different organisations.

4. I commend HMP Liverpool for ensuring that the views of healthcare professionals were sought and taken into account in taking a decision on the use of restraints.