

**Investigation into the circumstances surrounding
the death of a man
at Fazakerley Hospital in September 2005
whilst a prisoner at HMP Altcourse**

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

February 2006

This is the report of an investigation into the circumstances surrounding the death of a man on 1 September 2005. The man who died had been transferred to Fazakerley Hospital on 31 August, following concerns on the part of the healthcare team at HMP Altcourse about his neurological state. The man suffered a cardiac arrest whilst undergoing an endoscopy to establish the extent of his bleeding oesophageal varices. Sadly, staff at the hospital were unable to resuscitate him.

I would like to express my sincere condolences to the man's family and friends for their loss.

This investigation has been undertaken by my Deputy Ombudsman, Miss Emma Bradley, a qualified clinician. I would like to thank the Director of HMP Altcourse and his staff for their participation in the investigation process.

I am concerned that there is no formalised system for documenting injuries to prisoners sustained prior to coming into custody and make one recommendation relating to this. However, the commitment to ensuring effective, appropriate and sensitive family liaison shown by Altcourse and revealed by this investigation is commendable.

Stephen Shaw CBE
Prisons and Probation Ombudsman

February 2006

Contents

Summary

The Investigation

Background

HMP Altcourse

Events between 19 August and 1 September 2005

Events following the death of the man

Issues considered during the investigation

Recommendations

Good Practice

Annexes

Annex 1 Clinical Records

Annex 2 Prisoner Escort Record (PER)

Annex 3 Leaflet on Meeting funeral costs

Summary

The man who died was 44 years old when he died on 1 September 2005, having been transferred from HMP Altcourse to the Hospital. He was on remand having been charged with a number of offences including criminal damage, obstructing a police officer and theft.

The man had arrived at Altcourse on 19 August with injuries that were known to have been sustained whilst in police custody. The man was admitted to the healthcare centre, where his condition gradually deteriorated. The man was subsequently transferred to the local hospital for further investigations. Sadly, whilst undergoing an endoscopy, due to bleeding oesophageal varices, he suffered a heart attack from which he did not recover.

The post mortem initially raised questions about possible injuries to the brain that might have been caused by trauma. However, the Consultant Forensic Pathologist, concludes that the delay between the man's arrest and the onset of neurological symptoms do not make it possible to relate one to the other. The Consultant Forensic Pathologist therefore concludes that the man's death was due to natural causes.

This report draws attention to family liaison in the aftermath of the man's death. An initial decision was made to ask the police to contact the man's family but this was speedily rescinded. Unfortunately, the message does not appear to have been received by the police officers who were first asked to take on this responsibility. Thereafter, Altcourse managed its relations with the man's family particularly well.

The Investigation

The investigation was opened on 16 September 2005 by my Deputy Ombudsman, Miss Emma Bradley. Miss Bradley visited Altcourse and met with two senior managers, Family Liaison Officer, and with the Head of Healthcare. Notices were issued for staff and prisoners and subsequently published. These outlined the scope of the investigation and invited anyone who believed they had information relevant to the investigation to make themselves known. No responses to the notices were received.

Miss Bradley made contact with the Coroner and has received a copy of the Post Mortem to assist with the investigation.

Having reviewed all the available paperwork and discussed the case with the prison's Liaison Officer, Family Liaison Officer, and Head of Healthcare, it was apparent that no formal interviews were required.

Background

The man who died was born on 10 April 1961 in Lancashire. At the time of his arrest, he lived in North Wales. The man had last been in custody in 1985.

The man had little contact with his family and struggled with personal relationships. He had a brother who lived in North Wales and a sister living in Oxford. Both his parents died about eight years ago. The man was estranged from his partner with whom he had two sons. His eldest son acted as a “go-between” him and his former partner. At the time of his arrest, the man was unemployed.

The man was arrested late in the evening of 17 August 2005 by North Wales Police. During the arrest, he sustained a number of injuries that resulted in him being sent to the local hospital by the custody sergeant on his arrival at the Police Station. The man returned to the police station in the early hours of 18 August where he was charged with a number of offences including criminal damage, obstructing a police officer and theft.

The man was seen by the Forensic Medical Examiner (FME) after he admitted to having a mental health problem. The FME, considered the man fit to be detained and interviewed. He was later seen by a forensic nurse at the Police Station who also considered him fit to be detained.

The following day, 19 August, the man appeared at the Magistrates' Court where he was remanded into custody. The man was taken by the court escort services to HMP Altcourse, arriving at about 3.00pm.

HMP Altcourse

HMP Altcourse opened in December 1997 under the management of Group 4 (now Global Solutions Ltd – GSL). It was the first design, construct, manage and finance prison under the Government's Private Finance Initiative.

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 and the remaining two thirds are convicted and sentenced or awaiting sentence.

Until 31 January 2005, Primecare Forensic Medical provided the healthcare services under a Service Level Agreement. 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.

The report of an announced inspection by Her Majesty's Chief Inspector of Prisons 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 a good interaction between staff and prisoners."

Events between 19 August and 1 September 2005

The man was taken from the Magistrates' Court to HMP Altcourse on the afternoon of 19 August, arriving at reception (known at Altcourse as Admissions) shortly after 3.00pm. The Prisoner Escort Record makes no note of the injuries known to have occurred during the man's arrest or his subsequent review at the local Accident and Emergency Department. The medical warning box is ticked, but no further information is supplied.

The man was received into custody by the admissions staff at Altcourse. He was seen by the officers, his photograph was taken and personal information obtained. The man was then seen by healthcare for completion of his first reception health screen.

It was noted by healthcare that the man had bruises to his face and top of his body, possible fractured ribs, and poor vision. He told them these had been received on 17 August. The man also complained of chest pain and general aches in his body. He stated that he had mental health problems (psychosis) and was receiving medication for this. The man also advised the healthcare worker that he was receiving methadone daily (this is not supported by any documented history of drug misuse). The man told healthcare that he was a "binge drinker", but was unable to say exactly how much. On concluding the health screening, the healthcare worker felt it was appropriate to admit the man to healthcare for a period of observation.

Accordingly, the man was admitted to healthcare that evening, and a plan of care was drawn up to observe and maintain his physical health needs. On admission, the man's blood pressure and pulse were taken again, and a more detailed physical examination undertaken and documented in the clinical record.

Over the next 48 hours, the man appeared to settle, requiring occasional analgesia for his aches and pains. No problems or concerns were noted in his nursing records. Following further examination and review by the medical officer, it was planned to discharge the man to ordinary location.

However, late in the evening of 21 August, the man became agitated and was seen to be staggering around his cell. He was complaining of a headache for which he was given painkillers. The man then settled until 5.00am when he was heard calling for help. The night nurse attended the cell and noted that the man had fallen between the beds. He got himself up and back into bed on his own and again settled down.

The man was again reviewed by the medical officer on 22 August. His behaviour that day was noted to be "odd and demanding ... appears to see himself as helpless but will perform ADL's [activities of daily living] with encouragement". The man was restless at the start of the night shift, but eventually settled and appears to have had a problem-free night.

On 23 August, contact was made with the Medical Centre in Liverpool, from where the man stated he was receiving a maintenance methadone prescription. The staff at the medical centre advised Altcourse that he had been removed from their books

on 12 August, although the reasons for this removal are not noted in the clinical record.

On 25 August, the man was assisted with a shower and hair wash. He was reported to have been behaving bizarrely, but able to have a lucid conversation at times. Clinically, the man was noted to be "chesty".

Over the next 48 hours, the man was noted to have been settled with no problems. His mobility was improving and he was taking food and fluids.

During the evening of 27 August, the man began vomiting and feeling generally unwell. The man was seen and examined by a nurse. His blood pressure and pulse were recorded and noted to be within normal limits. However, his left ankle appeared very swollen and he was having difficulty swallowing. The duty doctor was contacted who advised an injection of Stemetil to stop the sickness, and a routine urine test. The injection was given according to the verbal instructions of the doctor. The man's blood pressure and pulse were checked again at 9.00pm. They were again found to be within normal limits and the man appeared settled.

During the night, the man was incontinent. His bed was changed by the night staff and he was reassured.

On 28 August, the man remained dependent on nursing staff for a number of daily living activities. He was not tolerating food and fluids well and complained of discomfort on swallowing. However, the man did appear cheerful in mood. That night he slept for long periods and there was nothing of significance reported.

On 29 August, the man was seen by the duty medical officer who questioned whether he should go to the local hospital for assessment. However, it was decided he should remain where he was at present and be monitored. The man was given help with mobilising, washing and dressing by the healthcare team.

On 31 August, the prison medical officer, contacted the medical senior house officer at the hospital who agreed to review the man in hospital. The doctor was unsure of the man's exact diagnosis, but felt his neurological signs were deteriorating and needed further investigation. A comprehensive referral letter is available in the clinical record.

An escort risk assessment was completed and instructions given that the man should remain double cuffed at all times, although an escort chain could be applied to facilitate treatment. The man was taken to hospital by car, accompanied by two custody officers, during the afternoon. He arrived at the hospital at about 4.00pm.

On arrival at hospital, the man was seen promptly by the nurse and an attempt was made to take blood for investigation. They were unable to obtain any samples. At 5.30pm, the doctor came to see the man and it became apparent he would need to be admitted to the Medical Assessment Unit. Later that evening, he was taken to the x-ray department before returning to the ward.

A comprehensive bed watch log shows that the man was seen regularly by nursing staff for neurological observations to be carried out. The following day, the man was seen and examined by a number of clinical staff.

At 1.00pm, the man was sitting in his chair having his lunch when he complained of feeling dizzy and began coughing up blood. Hospital staff responded promptly and sited an intravenous drip and arranged for a Magnetic Resonance Imaging Scan. Permission was given to remove the closeting chain for the scan. At 4.00pm, the man was taken for the scan. Following the scan, the doctor came and spoke to the man and the accompanying officers about what was going to happen to him. The man required an endoscopy as he was bleeding internally. He went for his endoscopy at 6.00pm.

During the procedure, the man suffered a heart attack. The hospital staff immediately started to try and resuscitate him. Sadly, this was unsuccessful and the man was pronounced dead at 7.07pm.

Events following the death of the man

Immediately following the man's death, the escorting staff notified the prison of what had occurred. Initially, North Wales Police were contacted and asked to inform the man's brother of his death. Within five minutes of this instruction, the police were phoned back and asked not to inform the next of kin as the Director wished the Chaplaincy team to go and break the news. This second instruction appears to have been ignored and 15 minutes later North Wales Police called to say the man's brother had been notified.

The Family Liaison Officer (FLO) for the prison made contact with the man's brother. The FLO asked the deceased's brother if he wished to visit him to see him in the Chapel of Rest. The prison was prepared to make the necessary arrangements for him to travel from his home town to the man's location if required. The man's brother said he had not had much contact with his brother and did not wish to visit him in the chapel at the hospital.

The FLO later met with the man's brother and his son, and offered them the opportunity to visit the prison. They declined this offer. The FLO also explained about the available financial support to help with meeting the costs of the funeral. This was reinforced by leaving with them a brief leaflet about the provision of reasonable funeral expenses to support the family.

Staff returning to the prison from the hospital were seen by the care team who had been called in and were waiting for them to return. All other elements of the contingency plan for managing deaths in custody were adhered to and actioned in a timely and appropriate manner.

The post mortem report concluded that the primary cause of death was haemorrhage as a result of ruptured oesophageal varices. There was a delay in releasing the man's body for burial in order to allow further examination of the brain and upper cervical cord. A report by another Doctor on this further examination notes that his principal finding was haemorrhagic infarct in the medulla and he could not exclude trauma as a causative factor. However, the Consultant Forensic Pathologist, notes that in his view the delay between arrest and the onset of neurological factors do not make it possible positively to relate one to the other. The doctor believes the cause of death was one of natural causes.

Issues considered during the investigation

The man was received into custody with injuries sustained during his arrest. There is some question about how these occurred and I understand this is subject to a police investigation. I am concerned that there is no note on the Prisoner Escort Record regarding these injuries and no copies of the police custody documents, including the examination by the Forensic Medical Officer, were forwarded to the prison. It is difficult to see how prison staff can be expected to care effectively for prisoners if they are not provided with important and relevant information.

On the man's arrival at Altcourse, no note was made on his prison custody documents of his injuries until he was seen by healthcare staff. This was at least eight hours after he had left police custody and some time after he had arrived at Altcourse. Whilst it is known that the man received these injuries whilst in the custody of the police, in other situations the failure to record the nature and extent of the injuries could leave prison staff open to accusations of abuse.

The Director should remind staff that, if a prisoner arrives in custody with obvious injuries, a note should be made on their Prisoner Escort Record and countersigned by the escort staff and receiving officer.

The records kept by the bed-watch staff are clear, concise and contemporaneous. They give a full picture of the man's time in the Hospital with regard to the care and treatment he received from both escorting officers and the hospital staff. Furthermore, the log kept after the prison was contacted regarding the man's death is again well kept. The standards of record keeping are to be commended.

The Family Liaison Officer role is clearly defined and taken seriously by the prison. It was noted during my investigator's visit that the guidance on the role of the FLO was widely published. In addition, the man's FLO is to be commended for his commitments to ensuring families are given appropriate information in a timely and sensitive manner.

The leaflet for families on assisting with funeral expenses is considered good practice.

The initial decision of the prison was to ask the police to break the news of the man's death to his family. This was quickly retracted as the Director required the prison to undertake this task personally. Sadly, it seems this message was not relayed to the police officers already on their way to the man's brother by their control room. Whenever it is feasible to do so, I believe it is always better for a prison to break the news of a death in prison custody, and welcome the Director's decision to retract the initial instruction.

Recommendation

The Director should remind staff that, if a prisoner arrives in custody with obvious injuries, a note should be made on their Prisoner Escort Record and counter signed by the escorting officer and receiving officer.

HMP Altcourse accepted this recommendation and have reminded staff of the above information

Good Practice

The leaflet for families on assisting with funeral expenses is considered good practice.