Investigation into the circumstances surrounding the death of a man in July 2004 at Fazakerley Hospital whilst a prisoner at HMP Liverpool

Report by the Prisons and Probation Ombudsman for England and Wales

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Introduction

This is the report of an investigation into the circumstances of the death of a man at Fazakerley Hospital in the summer of 2004 whilst a prisoner at HMP Liverpool.

Since 1 April 2004,as the Prisons and Probation Ombudsman I have had the responsibility of investigating the deaths of people in prisons, probation hostels and immigration holding centres.

I wish to extend my thanks to the Governor and staff at Liverpool for their help and co-operation during this investigation. I am also grateful to the Liverpool Primary Care Trust for preparing a clinical review of the man's care.

This published version does not include the original annexes. This material was extensive and included the original SIO report.

Stephen Shaw CBE
Prisons and Probation Ombudsman

Summary

The man was remanded in custody by Liverpool Magistrates Court a week before his death in July 2004 for an alleged assault on his partner. He had been excluded from an Approved Premises for infringing the rules concerning alcohol and could not provide a suitable alternative bail address.

During the reception process, he made a telephone call to his partner during which she made it clear that she had had enough. He did not make any further calls.

Over the next few days, he was aware that prison staff were trying to locate a hostel place for him. His cellmate told my investigator that the man did not give any indication that he intended to harm himself.

On the morning of the incident, his cellmate was taken from the cell to attend a video court link between 10:00 and 10:30 am. The evidence indicates that the cellmate was the last person to see him before he was found hanging.

The cellmate returned to his cell, which was locked. He could not see the man through the flap in the cell door and went to speak with a friend in another cell. He returned a few minutes later and, still not able to see the man in the main cell area, looked into the toilet area. He saw the man's back; it appeared as though he was looking out of the window. After obtaining no response to banging on the door, the cellmate became concerned and alerted staff on the landing.

An Officer entered the cell at approximately 11:40 am and found the man hanging from a ligature attached to the toilet area window. With the help of other staff he was cut down and CPR was commenced. Paramedics arrived and a pulse was eventually found, after which the man was taken to Fazakerley Hospital. He was pronounced dead at 5.45 pm four days later having never regained consciousness.

Investigation Methodology

1. The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. In keeping with that agreement a Senior Investigating Officer (SIO) was appointed to carry out the bulk of the investigative work on my behalf. He was supported by one of my own investigators.

2. The investigation was opened at Liverpool shortly after the man's death. The Governor and her staff produced the man's core file and a number of other documents for examination. Notices were issued to staff and prisoners informing them of my investigation.

3. Representatives of the Prison Officers' Association (POA) and the Independent Monitoring Board were also informed about the investigation.

4. Documents relating to the man's time in custody were examined and a number of prison staff and prisoners were interviewed.

5. My investigator contacted the Coroner's Officer at Liverpool, to brief him on the nature and scope of my investigation and request a copy of the Post Mortem report.

6. A meeting was held with the family during which a number of concerns were raised.

The Deceased

7. The man was 46 years old at the time of his death. He had three siblings, a brother and two sisters. He was not married but had been in a relationship with his partner for 17 years. They had three children, two boys and a girl, and the man had a son from a previous relationship. He was unemployed at the time of his death.

8. Thirteen years ago his father died, and the man's family believe that it was his reaction to the death that started him drinking to excess. Upon reception at Liverpool he told staff that he drank up to 8 litres of cider a day. His drinking caused arguments and occasionally violence within his relationship, both of which were factors in his remand to Liverpool.

9. The man had written two letters whilst in Liverpool, probably on his first night, one to his mother and one to his partner. In the latter he refers to the latest argument which appears to have been on his mind.

HMP Liverpool

10. HMP Liverpool was opened in 1855 to replace a much older and more cramped establishment in the centre of Liverpool. It covers some 22 acres. There are eight wings, all of which are in use having been refurbished and equipped with integral sanitation. The prison is a category B establishment and serves the whole of the Merseyside area. The man was located on B wing, which primarily houses remand and trial prisoners. Prison records show that in July 2004 there were 172 prisoners on B wing.

Events prior to the man's death

11. The man was remanded into custody by Liverpool magistrates for an alleged assault on his partner. Prior to that hearing he had been living in an Approved Premises. It appears that he had been excluded from the premises after infringing the rules concerning alcohol.

12. The man went through the reception process at HMP Liverpool during which he denied any thoughts of, or intention to, self-harm. He saw a healthcare nurse and was recommended for detoxification from alcohol. A doctor prescribed Librium for 13 days and Thiamine 300mg for 28 days.

13. The man made a telephone call to his partner from reception. That call lasted a little over 30 seconds and after making it clear that she had had enough, his partner terminated the call. The man made no other calls during his time in custody.

14. In reception, he spoke with a Listener. A Listener is a prisoner who has volunteered to undergo training by the Samaritans and who is available to carry out a similar role as that organisation does in the community. Without breaking his promise of confidentiality, the Listener has said that the man was not contemplating self-harm.

15. After the reception process, the man was located in a cell on B wing, sharing with another prisoner. The following day the induction process continued, and an Officer made enquiries at Approved Premises on the man's behalf to find one willing to accept him, thereby allowing him to be released from prison. The officer had some initial positive results and had informed the man about them.

16. On the morning he was found, the man and his cellmate woke about 07:00 am and watched the news on TV until they were given hot water to make a drink about 08:00 am. About 08:30 am the man was unlocked to enable him to collect his medication from the dispensary on B wing. He returned a short while later.

17. About 10:15 am, an officer unlocked the cell to collect the cellmate for a court video link. He does not recall seeing the man who died. The evidence points to the cellmate being the last person to see the man before he was found hanging. The cell was locked again.

Discovery of the man's death

18. Sometime after 11:00 am the cellmate was returned to B wing and allowed to make his own way back to his cell. He looked into the cell through the observation window but did not see the man. The cellmate then walked to the level 5 landing to speak with a friend. About 11:40 am the cellmate returned to level 3 and looked through the toilet observation window. He saw the man apparently looking out of the window with his back to him. The cellmate banged on the door to attract his attention. When he had no response he alerted nearby staff.

19. An officer entered the cell and found the man hanging by a torn sheet ligature around his neck attached to the window. His feet were still on the floor. With the assistance of other officers, the man was cut down and laid on the floor. Healthcare and an ambulance were called. Healthcare staff arrived, assessed the situation and commenced CPR. A defibrillator was attached to the man and an airway inserted into his mouth. CPR continued until about 11:52 am when the paramedics arrived.

20. The paramedics attached their defibrillator, which showed no cardiac output. Prison staff continued CPR whilst the paramedics administered drugs intravenously on two occasions. After the second injection a cardiac output was detected. About 12:27 pm the man was taken by ambulance to the accident and emergency department of Fazakerley hospital. He was treated there for about an hour before being transferred to the Intensive Therapy Unit (ITU).

21. At 12.45 pm, the prison Chaplain, together with a Senior Officer, went to inform the man’s mother, and then the Chaplain accompanied her to the hospital.

22. The man's condition deteriorated over the next few days. On the day before the man died, a doctor spoke to the man's family having decided that the man should not be resuscitated should he arrest again. He noted that discussion on the medical notes. On the day the man died a doctor told the family that the prognosis was exceptionally poor and that he was quite likely to die soon. At 17:45 pm the man was dead. He was not on 'life support' on the day of his death. Although his partner was at the hospital, it was the man's mother who was notified by telephone of his death, as his nominated next of kin.

Clinical review

23. The North Liverpool Primary Care Trust were asked to prepare a clinical review of the medical care that the man received whilst at HMP Liverpool and Fazakerley hospital.

24. The reviewer found that the initial health screen of the man appeared appropriate and sufficiently comprehensive and the diagnosis and treatment for his potential alcoholic abuse was also appropriate.

25. The clinical response when the man was found hanging was appropriate and the quality of the resuscitation adequate. The review made comment on the initial radio call being made to the wrong person and not stating the urgency of the situation.

26. The man's care in the Intensive Therapy Unit at Fazakerley hospital was of a very high standard. The review found that there was adequate communication between the medical and nursing teams and the man's family.

27. Although it is a matter for the Coroner to determine the cause of death, the review postulates the causes to be hypoxic brain injury, cardio-pulmonary arrest and hanging.

Observations and conclusions

28. When the man arrived at Liverpool he did not give any indication of thoughts of or an intention to take his own life. He was appropriately medicated for alcohol detoxification and efforts were made to find him a suitable bail address. His cellmate said that even a short time before the man hanged himself he had not noticed any change in his behaviour.

29. I conclude that no act or omission by the Governor or staff at HMP Liverpool contributed to the death. I also believe that staff acted appropriately and with due care upon finding the man hanging.

30. Both the clinical review and the SIO (SIO report not published) draw attention to the fact that the initial call for help upon finding the man hanging went to the wrong person. This failure meant that the healthcare staff and the control room were not immediately aware of the urgency of the situation. In fact, upon hearing the call, the correct member of staff had contacted the control room to ascertain if he was required and was told no.

31. Conclusion - *Some staff were unclear regarding whom to contact in a medical emergency and that could have led to a response delay. However in this case there is no evidence to suggest that the man's medical care was adversely affected by the confusion.*

32. The SIO highlights in his report that the prison contingency plans for attempted suicide and death in custody were in place and adhered to. However, he also notes that the plans used were variously dated May 2000, September 2000 and September 2003.

33. Conclusion - *Having more than one version of contingency plans in circulation could lead to confusion but did not on this occasion.*

34. When the man arrived at Liverpool he was allowed to make a telephone call. The calls made in reception are recorded but no record of which prisoner made which call is logged. The investigation team was only able to trace the call the man made after speaking to his partner and obtaining the number he rang.

35. Conclusion - *Not having the ability to correlate the telephone number called, the name of the recipient, and the name of the prisoner making the call could have serious implications. The prison currently collects this information via the PIN telephone system once the prisoner is on a wing.*

Recommendations

36. Local radio procedure in respect of medical responses should be re-examined and a code system for identifying the nature of the emergency considered.

37. Operational staff should be trained to ensure that they are fully conversant with how to summon appropriate medical assistance.

38. The Governor should ensure that only current copies of contingency plans are in circulation.

39. A system should be introduced to allow details of the telephone numbers and the person contacted by prisoners in Reception to be logged in their records.

40. The Governor should issue commendations to the staff who responded to the medical emergency and those who administered CPR, and to a Senior Officer and the Chaplain for their liaison with the man's family.

Stephen Shaw CBE
Prisons and Probation Ombudsman