Investigation into the circumstances surrounding the death of a prisoner at HMP Liverpool on 8 June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the death of a man who died at HMP Liverpool on 8 June 2006. The prisoner was 68, was serving a life sentence and had been in prison since January 2004. Despite this, staff built up a reasonable rapport with him and managed him well. The man had entered prison with a heart condition that was treated appropriately and monitored regularly. The post mortem indicated that he died from a heart attack due to a coronary heart disease. The inquest into his death held in late June 2006, recorded that he died from natural causes.

I am grateful to the Governor and his staff for their co-operation during this investigation. North Liverpool Primary Care Trust, which is responsible for the provision of healthcare in the prison, were also told of the death and asked to conduct a clinical review of the care that the prisoner received during his time in custody in accordance with NHS procedures. The clinical review states that the man's health appears to have been appropriately monitored and supported.

I observe that the prisoner was one of a growing number of elderly people in prison who find it hard to adjust to what is still a predominantly young person's environment. Whilst I am mindful of the pressures created by a record prison population, I also feel that more careful consideration could be given to the placement of elderly prisoners. I make no recommendations in this report.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

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SUMMARY

At 9.58am on 8 June 2006, a life sentence prisoner who had served two years of a minimum term of 15 years sentence, was pronounced dead in a single cell at HMP Liverpool. He had been discovered lying on his bed, partially clothed and lifeless, at about 7.05am,by an officer who was doing the routine roll count of prisoners. Resuscitation efforts were not attempted as it was clear to staff that the man had been dead for some time. He was 68 years old. He had entered prison with a serious heart condition for which he was receiving appropriate medication and regular monitoring.

This was the man's first experience of prison. Whilst he complied with many aspects of the prison regime, he was described as a very confrontational man who had a dogmatic, rigid attitude and who did not suffer fools gladly. Staff noted that he associated with very few prisoners and that younger prisoners would be inclined to irritate him because of his short fuse. This manifested itself in various ways such as actively seeking confrontation with staff and prisoners alike. During the course of his sentence, staff had been concerned about the prisoner's mental health. He was assessed by the prison's Mental Health In-Reach team (MHIT) who had determined that he was of reasonable mind.

The post mortem on the man indicated that he died of Acute Myocardial Insufficiency (heart attack) due to Coronary Artery Atheroma (narrowing of the arteries to the heart) with Thrombosis (arteries blocked by a blood clot). The inquest into his death took place in late June 2006,and found that he had died from natural causes.

THE INVESTIGATION PROCESS

1. The investigation into the circumstances surrounding the prisoner's death was opened by one of my investigators when he visited HMP Liverpool on 18 July 2006. My investigator spoke to a number of staff who had managed the prisoner. Notices had been issued to staff and prisoners informing them about the investigation and giving them the opportunity to speak with my investigator. No prisoners or staff came forward in response to my notice.

2. The Governor and his staff produced the prisoner's core record and Medical Record for review.

3. North Liverpool Primary Care Trust were commissioned to conduct a clinical review into the care and treatment that the man received whilst at Liverpool. The review which is attached to this report as an annex.

4. One of my Family Liaison Officers contacted the prisoner's next of kin on 21 June 2006, offering the family the opportunity to meet with him and the investigator to discuss the purpose of the investigation, and to raise any concerns or questions that the family would like to be addressed. They declined this offer and I am not aware of any concerns that the man's family have in regard to his care or treatment.

5. My investigator contacted Her Majesty's Coroner by letter to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. As the inquest into the man's death has already taken place, my final report will be sent to the Coroner for his information.

THE PRISONER

6. The man was born in 1938. He left school at the age of 15 and trained as a builder at college. At the age of 19 he joined the army, where he attained the rank of Warrant Officer. On leaving the army in 1981, he became a lorry driver, but had to stop in 1991 because of ill health. At the time of his arrest, he was living an isolated existence on a rural small holding with his wife.

7. The prisoner married in the early 1960s and has two children, one of whom, (his son) was his nominated next of kin. His wife had been diagnosed with schizophrenia some years ago. The marriage was described as tempestuous and violent. The prisoner did not maintain contact with his children or grandchildren and did not receive any visits whilst in prison.

8. In January 2004, the man was arrested for a serious assault on his wife. He was then remanded into custody, at HMP Hull. The prisoner's wife subsequently died in hospital in early February, and he was charged with her murder.

9. Following news of her death, the prisoner was placed on the F2052SH (Self-Harm) regime at Hull. The system is designed to support those prisoners who are in crisis and who may attempt self-harm. The man was upset and distressed at his wife's death. In compliance with the F2052SH document, he was observed frequently and supported by staff. He was monitored until 18 April 2004 when the document was closed.

10. In July 2004, the prisoner was advised about vulnerable prisoner status. (Vulnerable prisoners are those whose offences or behaviour are such that they may need to be segregated from other prisoners for their own safety and protection). However, he declined the offer, but insisted on being allocated a single cell because of his age. Although there was no medical reason to support his request, the cell sharing risk assessments completed at Hull determined that his behaviour was unpredictable and aggressive. He was therefore allocated a single cell on security grounds.

11. On 23 July 2004, the man was sentenced to life imprisonment, with a minimum term of 15 years by the Crown Court. He showed some remorse for the offence but maintained that he should have been charged with manslaughter.

12. On 27 July 2004, the prisoner was described by his Lifer Manager at Hull as a strange man. The Lifer Manager at Liverpool also told my investigator that whilst staff managed to build up a reasonable rapport with the prisoner, he could be aggressive and loud in his conversation. As an ex-military man who had experience of command and demanded respect from his peers, he found it very difficult to accept younger prisoners who

did not necessarily accord him the respect that he thought he deserved. The post sentence report indicated that he often resorted to violence as a means of resolving conflict.

13. The man came into prison with health problems and had been diagnosed with heart problems caused by atrial fibrillation with a fast ventricular response. For this he was treated with warfarin, furosemide, digoxin, aspirin and ramipiril. It was also noted in his initial health screen interview that he was deaf in his left ear. He was often described in his prison record as a man who was prone to verbal and aggressive outbursts. The prisoner had no known contact with mental health services before entering prison. The post sentence report indicated that in 1998 he had suffered a stroke, although he was adamant that this did not happen.

HMP LIVERPOOL

14. Liverpool prison is currently the largest prison in England. It currently holds adult convicted, unconvicted and remand male prisoners, committed by courts in the Merseyside and Wirral area. Liverpool has a certified normal accommodation of 1,186 prisoners and an operating capacity (maximum crowded capacity) of 1,473. About ten per cent of this population are sentenced to life imprisonment.

15. In the recent past, Liverpool has struggled with a poor regime, low level of cleanliness and lack of hygiene for its prisoners. The most recent report by Ms Anne Owers, HM Chief Inspector of Prisons (HMCIP) in September 2004, found noticeable improvements in the regime and environment, but expressed concern about the apparently high levels of bullying and drugs.

16. 'A' wing is a first stage unit for life sentenced prisoners and holds a maximum of 114 prisoners. Some non life sentence prisoners are located on this wing because they require single cell accommodation. In her inspection report, Ms Owers noted that in respect of 'A' wing,"*There were good staff-prisoner relationships and the unit regime was relaxed, providing plenty of time out of cell. Most prisoners were in double cells and additional facilities were limited.*"

17. All staff working within healthcare in Liverpool are appropriately qualified. There are 38 in-patient beds including single, double and three bedded wards and two safer cell units. Two full time general practitioners are available each week day, one of whom provides cover, on a rota basis, during the evenings for late receptions. Primecare is contracted to provide out of hours medical cover. Appointments to see a doctor are triggered by a wing application. There are four surgeries in the main prison that are manned throughout the day by clinical staff. Healthcare at Liverpool is provided by the North Liverpool Primary Care Trust (PCT), having transferred to the local PCT on 1 April 2004.

EVENTS LEADING UP TO THE PRISONER'S DEATH

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18. On 18 January 2005, the man was transferred from Hull to Liverpool on the first stage of his life sentence programme. His medical record was transferred with him. On arrival at Liverpool, he insisted on being given a single cell. The cell sharing risk assessment initially completed on the prisoner concluded that he was considered to be a low risk. On his induction to Liverpool, the core record states that he did not believe that the Prison Rules applied to him because of his age. The prisoner sought a recommendation from healthcare to support his request for single cell occupancy. On 23 January, he was allocated a single cell on 'A' wing.

19. On 26 January, he was seen by a dual diagnosis nurse at the request of an officer on 'A' wing who was concerned about his memory retention. The assessment determined that his cognitive skills were intact

20. On 10 February, the core record noted that the prisoner was a quiet, polite man who could hold a conversation. However, he did not associate with other prisoners and spent a significant amount of time in his cell. The record notes that he was a compliant prisoner who turned up for his food and medication on time. He was also a diligent worker in the workshop and reported daily for employment. A note in his core record indicates that he was settling down well to the routine of the wing.

21. On 8 April, it was noted in his core record that he was very agitated in respect of the late arrival of his medications. A further note indicates that he was derogatory towards women and that he had a temper.

22. On 11 April, the prisoner became confrontational to staff at the servery on being served his dessert. On this occasion he was told by staff to move away from the servery. On 13 April, he apologised to an officer for his behaviour. However, the conversation with the officer became confrontational and the officer noted that the prisoner was invading his personal space, making the officer feel uncomfortable and threatened. My investigator was told by staff that the man was frequently challenged in regard of his anger.

23. The core record notes that, on 16 April, the prisoner was again very agitated and confrontational in his mood. A request was made for a psychological assessment with a view to placing him on the Enhanced Thinking Skills (ETS) course and the Healthy Relationship Programme (HRP). Staff told my investigator that he was made aware of these programmes, but that he was not willing to engage as he considered them to be a waste of time for someone in his position. Indeed, the prisoner believed that he would die in prison and at his Life Sentence Planning interview was derisive of the process.

24. On 21 April, staff spoke to the prisoner in an endeavour to establish if there were any underlying issues that caused him to be angry. The man said that he was tired of being used as a babysitter for remand prisoners, and admitted to staff that he was bad tempered. Staff told my investigator that the man seemed to thrive on confrontation and he had admitted to them that a good argument kept him going, as he had nothing else in his life.

25. On 28 April, the prisoner was spoken to by a Healthcare Officer. The prisoner reiterated that he wanted to retain his single cell status. Following this discussion, a cell sharing risk assessment was completed by a Senior Officer. This indicated that the prisoner continued to be a high risk in light of his unpredictable and aggressive behaviour.

26. On 30 April, the core record notes other verbal outbursts directed against staff. Because of his behaviour it was planned to speak with the prison doctor in order to support his request to retain a single cell in the belief that this might help to calm him down.

27. On 12 May, the prisoner was assessed by the Dual Diagnosis team because of a concern that his unpredictable behaviour could be a form of dementia. The assessment determined that he did not have mental health problems. It also established that one of the reasons why he was verbose in speech and was inclined to invade personal space could have been because of deafness in his left ear. Staff told my investigator that the prisoner would stand extremely closely to lip read, but in view of his aggressive nature this could be construed as threatening to some staff on the wing. Following this assessment he was referred for hearing tests. The man was due to be fitted with a hearing aid, but died before he received it.

28. On 25 June, the core record once again notes a confrontation with a member of staff in respect of food. My investigator established that on some occasions food advertised on the menu is not always available. This can cause irritation to prisoners, although alternative menus are provided. Staff told my investigator that the prisoner would complain boisterously if the menu advertised was not available. The record notes that he perceived himself as the 'Prisoners' Champion' in this matter.

29. The prisoner was also challenged by staff about his personal hygiene on several occasions. My investigator established from speaking to staff that he was very self-conscious of showering in front of other prisoners. In light of this, he was unlocked earlier than other prisoners so that he could attend to his hygiene needs.

30. The records indicate that the prisoner continued to be a diligent and conscientious worker, although he could be 'hot headed' and disruptive in the workshops - frequently remonstrating with other prisoners if he considered that they were not pulling their weight.

31. On 30 June, the prisoner was sacked from the workshop because of an altercation with the workshop manager. It was noted by staff in the wing conduct report that he was upset about the contents of his probation report as well as the fact that his hearing test had been cancelled.

32. On 9 July, efforts were being made to find the prisoner employment or some form of education to fill his day, as he had no hobbies or interests. On 25 July, he had his ears syringed. However, he was still experiencing hearing difficulties. A letter was sent from Liverpool to Walton Hospital requesting a hearing test on 29 July.

33. On 12 September, healthcare staff were called to the workshop because the prisoner had complained of dizziness. He was taken to hospital for tests and remained an in-patient at the University Hospital Aintree until 19 September. In compliance with Prison Service policy, he was handcuffed and subject to escort and observation by prison officers. Following his admission to hospital, he was prescribed bisoprolol, heparin and warfarin. He was discharged back to 'A' wing.

34. By 5 October, the core record notes that the prisoner was still very confrontational over the slightest issue. However, he continued to attend for work and was compliant in other respects of the prison regime. An SO told my investigator that, whilst the prisoner was a confrontational man, the structure of prison life in some respects resembled the man's experience in the army. The SO said that he could be very intolerant of other prisoners. Staff told my investigator that the prisoner was very much 'old school' and had few associates on the wing of his own age. Younger prisoners sensed that he had a short fuse, and would on occasion seek to light that fuse for entertainment as a means of breaking the monotony of prison life. An SO told my investigator that, even had the prisoner been transferred to another location with elderly prisoners, there was no guarantee that he would associate with his peers because of his dogmatic and inflexible attitude on a multitude of issues.

35. On 12 October, the man attended the Walton Hospital for hearing tests. The tests determined that he suffered from impacted wax in his left ear. It was advised that he should take softening drops and have his ears syringed once again.

36. On 21 October, whilst being interviewed by a member of the Resettlement team, the prisoner became very angry and aggressive. He assaulted a member of staff. He was restrained by staff using Control and Restraint techniques and was placed in handcuffs. He was escorted to his cell. He was placed on report and, following a disciplinary adjudication, suffered the loss of his privileges for seven days. The showed no remorse for his action. It was established that he was upset that he was not receiving his pension rights.

37. On 7 November, the core record noted that the prisoner was not too well and spent most of the day in his cell. However, despite his health, he wanted to work.

38. On 8 November, the man returned from work early, complaining of chest pain and shortness of breath. He was seen by the prison doctor who diagnosed a chest infection. This was treated with oral antibiotics. He was reviewed on 11 November, and stated that his chest felt a lot better.

39. On 25 November, the medical record notes that the prisoner was seen by a consultant at University Hospital Aintree. At this time his heart condition was considered to be stable. His bisoprolol medication was increased to 3.5mg. He was to be reviewed by the consultant in January 2006.

40. On 1 December, he was also seen as an outpatient at Aintree Hospital in respect of his atrial fibrillation (heart murmur) and left ventricular dysfunction. It was noted that he experienced shortness of breath on climbing stairs.

41. On 26 December, the man was challenged again about his personal hygiene, after complaints from other prisoners and staff. He became angry, shaking his fists at the officer who challenged him. On that day the prisoner wrote a letter to a governor complaining that he was not receiving his medication or weekly blood tests. In a letter dated 16 January 2006, the Healthcare Manager responded to the prisoner stating that medications and blood tests were done at specific times that were well known and understood by the man. The letter said that alterations to this regime could not be changed at the request of prisoners. It was also noted in the medical record that the prisoner was sometimes reluctant to comply with the regime and would demand his medication when he saw fit. Staff told my investigator that he was a punctilious man who would complain bitterly if his medications were not administered on time.

42. On 20 January 2006, the prisoner was as seen as an outpatient at Aintree Hospital. He was reviewed by the consultant and stated that he felt reasonably well. His bisoprolol was increased to 5mg daily and he was to be reviewed in two months time.

43. On 21 January, the core record noted that the man was still feeling inconvenienced and upset in respect of the issue of his medications and his weekly blood tests. However, he was compliant in taking them.

44. On 2 February, the prisoner returned from work after he had assaulted another prisoner in the workshop. He was subsequently sacked from his job and placed once again on report.

45. On 3 February, the prisoner was upset about a notice at the food servery stating that there was no custard or spaghetti because of a technical problem in the kitchen. He became loud and confrontational, saying that he had nothing to lose.

46. On 8 February, the prison received a letter from the man's solicitor enquiring about their client as they had not heard from him since July 2005. The Governor responded to the solicitors on 2 March, informing them that he would ask the prisoner to make contact. There is no indication that the prisoner made contact.

47. On 18 March, he was again involved in a dispute at the hotplate when a menu was offered. Although options were available to him, the prisoner refused what was on offer and refused instructions by officers to remove himself from the hotplate area. He was spoken to by an SO who told him that if did not comply with the officer's order he would be placed on report and taken to the Care and Separation Unit. The prisoner later apologised for his behaviour.

48. On 27 March, the medical record notes that the man was experiencing occasional dizzy spells. He was also re-tested on his cognitive skills at the request of wing staff who were still concerned about his short term memory. The tests established that his cognitive skills were reasonable for a man of his age.

49. On 7 April, the prisoner was again returned to the wing from work following an incident with younger prisoners. He complained of feeling dizzy, although he was not suffering from chest pain or any discomfort. He was reviewed by healthcare staff who found that his blood pressure was high. He was advised to calm down and was referred to the prison doctor for a medication review. The doctor subsequently asked that his blood pressure be monitored over the following weeks.

50. On 18 April, the core record noted that the prisoner was placed on report once again because he threatened a member of staff in a dispute over the delivery of his newspaper. Following the incident in the workshop on 7 April, it was noted in the core record that although he presented himself for work on a daily basis, workshop staff were reluctant to employ him because of his disruptive behaviour. Consequently, he remained on the wing and felt frustrated that he had nothing to do.

51. On 12 May, the prisoner attended Aintree Hospital for a review of his heart condition. His blood pressure was recorded at 140/75. He told medical staff that he felt quite well, although he was experiencing some shortness of breath on effort. His heart condition appears to have been stable and he was to be reviewed the following month. He also attended an out-patients appointment at Aintree Hospital on 1 June, where nothing untoward was found.

52. On 14 May, the core record noted that the prisoner was once more involved in an altercation with another prisoner. He was spoken to by an SO who noted that the man still found it difficult to accept his situation.

53. By 3 June, the core record notes that the prisoner's behaviour had improved, although there was an issue about the state of his cell and his personal hygiene. A note in his record on 6 June indicated that he was a man who could still be easily angered. Staff told my investigator that, in the days preceding his death, the man was slightly more subdued than usual.

54. At about 6.45am on 8 June, Officer A (who had been on night duty) began the roll check or count of prisoners on the wing in preparation for the day staff. She worked her way down the landings. She looked through the door flap of cell and noticed that the prisoner was on the top bunk half clothed. He appeared to be very grey in colour and had dark lips. At about 7.05am, Officer A was joined by Officer B who had reported for day duty. Officer B and Officer A conferred briefly outside the prisoner's cell and formed the opinion that he appeared to be dead and had been so for some time.

55. Officer A then went to 'B' wing to find a senior member of staff to assist in the unlocking of the prisoner's cell in compliance with the prison's standard security procedures. An SO unlocked the cell and entered it with Officers A and B. On entering the cell they asked if the prisoner was okay, but did not receive a response. The SO told my investigator that the man was cold to touch and it appeared that he had been dead for some time.

56. Officer A contacted the duty nurse, Nurse A, through the Control Room to asking her to attend the prisoner's cell. At about 7.10am, Nurse A entered the cell. In a statement to the Governor following the man's death, she noted that he had full skin discolouration and no vital signs. Rigor mortis had set in and, in view of this, resuscitation efforts were not made. Nurse A then requested other nursing colleagues to attend the prisoner's cell in order to confirm her opinion. Staff formed the opinion that he had passed away in his sleep.

57. Following the discovery of the prisoner, a Principal Officer (PO) was informed by radio of the man's death and attended the cell at about 7.15am. At 7.22am, the Control Room contacted the ambulance service. At 7.39am, the paramedics arrived and were escorted to the prisoner's cell. The prison chaplain also attended. The paramedics left the cell at 8.07am. Death was certified by a doctor at about 8.58am.

58. At about 8.22am, prisoners on 'A' wing were unlocked in order to continue with the day's regime.

EVENTS AFTER THE PRISONER'S DEATH

59. The man's cell was locked and sealed to await the arrival of the police and the Coroner's Officer. Liverpool then implemented its contingency plan following a death in custody. This included contacting the National Operations Unit and informing the Independent Monitoring Board of the death.

60. An SO told my investigator that he broke the news of the man's death to an elderly prisoner who was located across the landing who had developed a friendship with the deceased. Other prisoners were told of the man's death later on that day. A notice from the Governor was also posted on the wing.

61. At about 9.30am, a hot debrief, chaired by the acting deputy governor was held. With the exception of Officer B who was sent home, other key staff who were involved in the discovery of the prisoner were present. A representative from the prison's Care and Support team also attended in order to offer support should staff require it.

62. A governor who had known the prisoner was nominated by the prison to inform the prisoner's next of kin, his son of the death. The prison chaplain accompanied the governor to the son's home address in North Yorkshire and broke the news later that day. Although the family had no contact with the prisoner since he had been in prison, the news was upsetting. The family were informed that the circumstances of the man's death would be investigated by the Prisons and Probation Ombudsman. The Governor wrote a letter of condolence on 9 June.

63. My investigator contacted Merseyside Police. The police investigation has determined that there were no issues in respect of a third party involvement or any criminal investigation surrounding the prisoner's death.

64. On 20 June, the man's funeral took place. It was paid for by the Prison Service. The prison chaplian took the service which was also attended by a governor. The prisoner's son also attended the funeral.

65. The inquest into the man's death took place on 27 June. It determined that he had died of natural causes.

CLINICAL REVIEW AND POST MORTEM

66. The North Liverpool Primary Care Trust was asked to undertake a clinical review into the care that the man received whilst at HMP Liverpool. The review concluded that he was diagnosed with a heart condition that was appropriately treated and medicated. Medication was prescribed and administered in accordance with heart failure guidelines. The prisoner was monitored appropriately in hospital and in prison.

67. A post mortem carried out on 9 June indicated that the man died of Acute Myocardial Insufficiency (heart attack) due to Coronary Artery Atheroma (narrowing of the arteries to the heart) with Thrombosis (arteries blocked by a blood clot).

ISSUES CONSIDERED DURING THE INVESTIGATION

Life Sentence Planning and Offending Programmes.

68. It is clear that the prisoner was a confrontational man by nature, and that he would become aggressive and argumentative over the slightest issue. However, whilst efforts were made to address this behaviour, he was not willing to engage, perceiving specialist programmes to be a waste of time for a man of his age who was two years into a life sentence. Indeed, he was extremely sceptical about the purpose of the Life Sentence Planning process. By his own admission, the prisoner was a cantankerous man who actively sought and relished confrontation with staff and fellow prisoners. With this in mind, I judge that staff managed him reasonably well and tried hard to support him through the first stage of his life sentence.

Relocation to an establishment for elderly offenders

69. This was the man's first experience of prison. He was intolerant of many other people, especially the young, and this would manifest itself in an aggressive and confrontational way with prisoners and staff. He was an elderly man with health problems, who felt that he should be accorded some privacy, dignity and respect. I note the efforts made by staff to ensure that he was given this privacy when showering, although I feel that some wider consideration could perhaps have been given to transferring him to another establishment with a greater proportion of elderly prisoners. However, I am also mindful that there was no guarantee that the prisoner's behaviour would have changed had he been relocated.

    In response to my draft report the Prison Service have said that the allocation of prisoners from local prisons to the training estate will be done primarily on the basis of the security category, offender management requirements and nearness to home. Other individual factors such as age, will also be taken into account and managed appropriately, within existing facilities in the prison estate, as there are only a small number of establishments that provide dedicated facilities for elderly prisoners which are more usually geared to issues of mobility.

ANNEXES

Documents considered during the investigation

1. The prisoner's medical record
2. The prisoner's core record.
3. Clinical review from North Liverpool Primary Care Trust.