

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Johnston, a prisoner at HMP Liverpool, on 27 November 2019

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Alan Johnston, a prisoner at HMP Liverpool, died of blood loss on 27 November 2019 after he made a significant cut to his arm. He was 32 years old. I offer my condolences to his family and friends.

This is a worrying case which was also investigated by Merseyside Police, although we understand that they took no further action.

Mr Johnston had a history of mental ill health and significant and prolific self-harm. He had last harmed himself a month before his death and had regularly been monitored under suicide and self-harm monitoring procedures, known as ACCT.

There was a clear and well-documented pattern to Mr Johnston's self-harm which regularly occurred after confrontations with staff and prisoners. We are extremely concerned that staff underestimated his risk and did not start ACCT procedures after he had an altercation with another prisoner.

I am also concerned about the delay to prison staff going into Mr Johnston's cell when they found his cell observation panel blocked on the day he died. Although the delay was unlikely to have had an impact on the outcome for Mr Johnston, it may be critical in another emergency.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Kimberley Bingham
Acting Prisons and Probation Ombudsman

July 2023

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Summary

Events

1. On 28 January 2019, Mr Alan Johnston was remanded to HMP Liverpool, charged with the possession of indecent images. It was not his first time in prison. He frequently harmed himself and had a clear pattern of behaviour, often harming himself after confrontations with prisoners or staff. He was often monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT).
2. Mr Johnston had a history of abusive behaviour towards staff and prisoners and had been monitored under violence reduction procedures. We were told that prisoners routinely picked on Mr Johnston because of the way he looked and behaved towards them. On several occasions he told staff that he was being bullied. However, in more settled periods, he had a prison job and got on better with other prisoners.
3. Mr Johnston had significant contact with prison mental health services.
4. Mr Johnston was due for release on 13 December. In the weeks before his death, he expressed concerns to probation and housing agencies about his safety and about being asked to live in St Helens, where he was known to the community.
5. At around 4.11pm on 27 November, Mr Johnston was involved in an altercation with another prisoner and staff used force to return him to his cell. Over the following hours, he presented as agitated to prisoners and staff and, around three hours later, staff noticed that he had blocked his cell door observation panel.
6. At 7.51pm, officers opened the cell door and found Mr Johnston had made significant cuts to his arm. Healthcare staff initially tried to resuscitate him and paramedics later assisted them. However, their efforts were unsuccessful. At 8.28pm, paramedics confirmed Mr Johnston's death.

Findings

7. We are very concerned that following the altercation with another prisoner on 27 November, staff did not start ACCT monitoring procedures, despite Mr Johnston's clearly repeated pattern of self-harm after altercations with others.
8. It is apparent that Mr Johnston was bullied during his time at Liverpool. Although staff investigated specific instances of bullying that he raised, we have asked the Governor to remind staff of the need to address name-calling and other inappropriate 'banter' in the prison.
9. We are concerned about the delay to staff going into Mr Johnston's cell when it became known that he had blocked his cell door observation panel.
10. The clinical reviewer concluded that the care Mr Johnston received at Liverpool was of a good standard and equivalent to that which he could have expected to receive in the community.

Recommendations

- The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

- The Governor should ensure that prison staff:
 - fully and promptly identify and investigate information about bullying, in all its forms;
 - appropriately challenge alleged perpetrators; and
 - effectively support victims and properly consider and address the possible impact on their risk of suicide and self-harm.

- The Governor should ensure that all staff are aware that, subject to a risk assessment, they should enter a cell as quickly as possible if there is reason to believe that a prisoner may be at risk, in line with PSI 24/2011.

- The Governor should ensure that staff are aware of and understand what is expected of them when they find a cell observation panel obscured.

- The Governor should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
12. The investigator obtained copies of relevant extracts from Mr Johnston's prison and medical records.
13. NHS England commissioned a clinical reviewer review Mr Johnston's clinical care at the prison.
14. The investigator interviewed eight members staff and four prisoners at Liverpool, some jointly with the clinical reviewer. Some of the interviews were conducted remotely because of restrictions during the COVID-19 pandemic.
15. We informed HM Coroner for Liverpool and the Wirral of the investigation. He provided us with a copy of the post-mortem and toxicology reports. We have sent him a copy of this report.
16. We suspended our investigation into the death of Mr Johnston due to an investigation by Merseyside Police. The investigator obtained transcripts of interviews, and other evidence, from Merseyside Police. The police investigation led to a delay in publishing our own report into Mr Johnston's death.
17. We contacted Mr Johnston's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Johnston's mother asked why her son was not identified as at risk of suicide and self-harm.
18. Mr Johnston's mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Liverpool

19. HMP Liverpool is a local prison holding up to 750 adult men. Spectrum Healthcare UK Trust provide physical healthcare services and Mersey Care NHS Foundation Trust provide mental healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Liverpool was in July 2022. Inspectors reported that Liverpool was a well-led, safe and respectful prison which had made a commendable and sustained improvement in outcomes since their previous inspection in 2019.
21. Inspectors reported that violence and incidents of self-harm had fallen markedly since their last inspection, and relationships were good between staff and prisoners. It was particularly notable that records of self-harm had fallen by 60% since the 2019 inspection. Inspectors reported that most prisoners who had been subject to ACCT monitoring had been positive about the care they received, and records showed a good understanding of individuals' risks and triggers.
22. Inspectors reported that the CSIP referrals and investigations they reviewed were of a reasonable quality but that weaknesses included poor recording of progress and updates to plans which meant that some challenging behaviour was not addressed as effectively as it could be. They found that the safety team and other leaders were aware of these issues and continued to promote better use of the process.
23. Inspectors found that health services at Liverpool were progressive and well-led, and mental health services were well resourced and staff were skilled and competent.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report for the year ending December 2021, the IMB reported that overall, Liverpool was a safe environment for prisoners and prisoners were treated as fairly as possible considering the severe COVID-19 restrictions which continued into 2021.

Previous deaths at HMP Liverpool

25. Mr Johnston was the fifth prisoner to take his life at Liverpool since February 2018. In our investigation into the death of a prisoner in February 2018, we identified the failure of staff to respond to escalating risk and to take appropriate action to address known risk factors.
26. Between February 2018 and Mr Johnston's death, there were six deaths from natural causes and two drug-related deaths. Since Mr Johnston's death, there has

been a further self-inflicted death, two drug-related deaths and nine further deaths from natural causes. There are no similarities between our findings in our investigations into these deaths and that of Mr Johnston's death.

Assessment, Care in Custody and Teamwork

27. ACCT is the Prison Service care planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise prisoners. As part of the process, a care plan which includes support and intervention, should be in place. The ACCT plan should not be closed until all the actions of the care plan have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

28. Mr Alan Johnston had served previous custodial sentences. In June 2008, he was diagnosed with a depressive disorder and treated with antidepressants. Mr Johnston also had a significant history of self-harm from an early age and had previously been supported under suicide and self-harm monitoring procedures, known as ACCT.

HMP Liverpool

29. On 28 January 2019, Mr Johnston was remanded to HMP Liverpool, charged with the possession of indecent images of children. When he arrived, he was assessed as medically unfit so was taken to hospital to treat a leg wound. When he returned, Mr Johnston was hostile and refused to engage with the reception nurse. Staff started ACCT procedures.
30. On 29 January, Mr Johnston removed the dressing from his wound and smeared faeces into it, which he used to assault staff. At an ACCT case review, Mr Johnston said he did this because staff had “wound him up” and he was frustrated. Prison staff stopped ACCT monitoring on 12 February.
31. Later on 29 January, a prison GP reviewed Mr Johnston and re-prescribed his medications for pain relief, depression, anxiety, psychosis, asthma, stomach acid and his wound.
32. During Mr Johnston’s first days at Liverpool, prison staff noted that he was aggressive and threatening, used his emergency cell bell inappropriately and, because of his poor behaviour, had received threats from other prisoners.
33. From the end of January to November, healthcare staff treated Mr Johnston on numerous occasions after he had harmed himself by cutting or opening previous wounds. His wounds were cleaned and dressed in line with health care plans in place. When Mr Johnston’s injuries were too severe for healthcare staff to treat, he was treated in hospital. He frequently threatened and verbally abused healthcare staff at Liverpool and often accused them of not treating him properly.
34. During this period, Mr Johnston also had numerous interventions from the mental health nurses and other mental health professionals operating at the prison, including from psychiatric and psychological services. (The mental health team also regularly attended Mr Johnston’s ACCT reviews.)
35. On 14 March, an officer challenged Mr Johnston about his continued abusive and threatening behaviour and misuse of his cell bell. Later that day, Mr Johnston blocked his cell door observation panel, told staff he wanted to die and made significant cuts to his arms and legs which required hospital treatment. Staff started ACCT procedures and began constant supervision.
36. On 15 March, at an ACCT assessment, Mr Johnston said he had harmed himself because he was being bullied and had not got his medication. Mr Johnston said he got a sense of release from harming himself. He said that he was disappointed at his “failure” and hoped to die but wanted to engage with the mental health team. Mr

Johnston was moved to the prison's vulnerable prisoners (VP) wing for his own safety.

37. At an ACCT case review on 16 March, Mr Johnston said that he had settled and felt safe on the VP wing. He said he had harmed himself because he was frustrated and that he was pleased he had not killed himself. Prison staff stopped the constant supervision and now monitored Mr Johnston at irregular intervals.
38. At an ACCT case review on 22 March, Mr Johnston said that throughout his life, he had had thoughts of self-harm and sometimes heard voices in his head. He agreed to speak to a GP and psychiatrist operating at the prison for a medication review. (He saw a psychiatrist on four occasions at Liverpool to review his medication.)
39. On 11 April, Mr Johnston was involved in a fight with another prisoner. Both men were charged under prison disciplinary procedures. Two days later, Mr Johnston removed a dressing from his arm. He said he felt frustrated about issues with his medication and that his physical ailments were not being addressed. Staff recorded that Mr Johnston's inappropriate behaviour, which included verbal abuse, continued over the following days.
40. On 29 April, at an ACCT case review, Mr Johnston reported feelings of anxiety and thoughts of self-harm. He said that other prisoners had threatened him because of his behaviour. The following day, prison staff recorded that Mr Johnston was unable to go to work because of threats from other prisoners as a result of his inappropriate behaviour.
41. On 14 May, at an ACCT case review, Mr Johnston told a Custodial Manager (CM) that he had harmed himself the previous day but had not told anyone about it. (The method of Mr Johnston's self-harm was not recorded.) The CM told Mr Johnston that he should always tell staff if he harmed himself, as not doing so might result in his death. Arrangements were made for Mr Johnston to start work again as his behaviour had improved and it was noted that he now mixed with other prisoners, collected his medication and meals and was no longer under threat.
42. On 15 May, Mr Johnston assaulted a prisoner. The other prisoner had accused Mr Johnston of intimidating others and of being a bully. Mr Johnston later made significant cuts to both his legs. He refused to go to hospital for treatment. Because of Mr Johnston's challenging behaviour, staff monitored him under a Challenge, Support and Intervention Plan (CSIP, a multidisciplinary approach which focuses on those who pose a raised risk of violence to others and works to change their behaviour).
43. The following day, Mr Johnston was involved in a verbal altercation with several prisoners. He told staff that he would kill anyone that wound him up and blamed others for his behaviour. Mr Johnston later apologised for his actions.
44. On 27 May, at an ACCT case review, Mr Johnston told staff that he was being bullied again. Later that day, he spoke aggressively to another prisoner. That evening, Mr Johnston opened the wounds on his legs. The next day, he said he had harmed himself because he was "wound up" and that he felt calmer afterwards. The other prisoner was moved to another landing on the wing.

45. At an ACCT case review on 5 June, Mr Johnston complained to a CM that nobody helped him, that he was not allowed to work and that he got no support from the mental health team. Mr Johnston said that he would continue to “break rules about cutting”, although he had no access to razor blades when he was being monitored under ACCT procedures. At a case review on 7 June, prison staff noted that Mr Johnston was settled, wanted to engage with the mental health team and understood that his behaviour needed to improve before he could work again.
46. On 10 June, Mr Johnston misused his cell bell and when challenged, he was abusive towards staff. He later told them that he had deliberately opened a wound, for which he received treatment in hospital.
47. Over the following week, Mr Johnston’s abusive behaviour towards staff and prisoners continued. On 17 June, staff noted that he continued to think of ways to end his life and to complain about the way healthcare staff treated him.
48. On 20 June, Mr Johnston was convicted and sentenced to 21 months in prison. (This meant that he was due to be released from prison on 13 December to serve the rest of his sentence in the community.) At an ACCT case review, he said that his thoughts of self-harm remained “very high”.
49. On 10 July, prison staff ended ACCT monitoring. They noted that Mr Johnston had not harmed himself for six weeks and was working with the mental health team.
50. On 25 July, Mr Johnston abused staff, misused his cell bell and later cut a wound on his leg. Staff re-started ACCT procedures. The following day, Mr Johnston said that he had cut himself due to a build-up of events, including issues about his wound dressings, being locked in his cell and being tormented by other prisoners.
51. On 29 July, Mr Johnston was involved in a further altercation with a prisoner. The following day, he became aggressive after he told staff that he had not been treated for a self-harm injury earlier that day. (He was later treated in hospital.) Two days later, Mr Johnston cut his knee. He told staff that he had been bullied by another prisoner and would continue to harm himself until the bullying stopped. The allegation was addressed as part of Mr Johnston’s continuing CSIP review and the other prisoner was reported to the violence reduction team.
52. Over the following days, Mr Johnston’s behaviour improved. At an ACCT case review on 6 August, he discussed with staff his concerns and anxiety about his release.
53. On 9 August, Mr Johnston threatened and abused another prisoner and prison staff returned him to his cell. He blocked his cell door observation panel and smashed the furniture and television in his cell. Mr Johnston then opened a wound on his arm, for which he had to be treated in hospital.
54. The following day, Mr Johnston opened the wound on his arm again. He was not able to attend an ACCT review due to the severity of his self-harm and it was noted that he had been shocked at his injuries. Mr Johnston was also unable to attend an ACCT review the following day when he cut himself again.

55. On 12 August, Mr Johnston said that he had harmed himself because he had been frustrated following his dispute with the other prisoner and he was anxious about where he would live on his release from prison.
56. On 15 August, Mr Johnston had a further altercation with a prisoner. He was restrained and taken back to his cell, where he then harmed himself.
57. On 25 August, Mr Johnston reopened the wound on his arm and was treated in hospital, where he remained for several days. At an ACCT case review on 31 August, he said that he harmed himself because he felt that he was not being listened to and was not treated properly by healthcare staff.
58. On 1 September, Mr Johnston's CSIP monitoring ended as staff thought he was more settled and had made some progress. At an ACCT case review, staff recorded that Mr Johnston had not harmed himself for a week and was feeling "more grounded". They ended ACCT procedures. Over the following weeks, no significant concerns were raised about Mr Johnston's behaviour and he did not harm himself.
59. On 13 September, Mr Johnston discussed concerns about his accommodation on release with his prison offender supervisor. It was noted that he continued to work with the housing charity, Shelter, about these concerns.
60. On 11 October, Mr Johnston told his prison offender supervisor that he did not want to live in St Helens on release. She told him that he would likely be released to a probation-run Approved Premises.
61. On 26 October, Mr Johnston was involved in an altercation with a prisoner. He later cut an old wound on his arm and had to be treated in hospital. Prison staff noted that Mr Johnston had dealt with the altercation by harming himself, as he had done in the past. They started ACCT procedures.
62. Mr Johnston told an ACCT assessor that his actions had not been an attempt to take his life, but a coping mechanism. The assessor noted that he remained very concerned about having to live in St Helens, as he felt his safety would be at risk if he did. The assessor noted that Mr Johnston would continue to work with the mental health team and with his prison offender supervisor.
63. Mr Johnston said at the first ACCT case review that he felt the world was against him. He left the review in an "irate manner" after he had complained about his property. He later told an officer that probation was "setting him up to fail". After leaving the review, Mr Johnston had an altercation with an officer. He was locked back in his cell, where he opened a wound. Mr Johnston was taken to hospital for treatment due to significant blood loss.
64. On 28 October, Mr Johnston told an officer that he had harmed himself because he had been told that he would have to live in St Helens on his release, where he said he would be threatened with death due to his offence. Mr Johnston was told to continue working with probation and Shelter and it was arranged for his offender manager to visit him.
65. On 31 October, a CM noted at an ACCT case review that Mr Johnston had got back into a routine, but that his release and accommodation arrangements on release

continued to concern him. Prison staff recorded that Mr Johnston settled over the following days.

66. On 7 November, at an ACCT case review, the CM noted that the review had gone well, that Mr Johnston worked hard, that there had been no further incidents that had concerned staff and that he had mixed with other prisoners. The CM noted that the only outstanding and ongoing issue related to where Mr Johnston would live on release. The staff present agreed that the ACCT procedures could stop.
67. The next day, his prison offender supervisor asked for an update from Shelter about Mr Johnston's housing situation. The following day, an officer noted that Mr Johnston appeared relaxed and cheerful and hoped that a meeting with his community offender manager, where he could put forward his objection to moving to St Helens, would be beneficial.
68. On 11 November, his prison offender supervisor and Mr Johnston's community offender manager, discussed his housing needs with him. They noted that he had agreed to move to St Helens, but would then move to another area, including to emergency accommodation, if necessary. It was noted that Mr Johnston remained anxious but felt better knowing he would be assisted.
69. On 14 November, at an ACCT post-closure review, staff noted that Mr Johnston's housing issues had still not been fully resolved, but that he was not as worried as he had been. (Mr Johnston's occupational therapist had noted on 14 November, that a number of risk issues had been identified relating to threats from the public against Mr Johnston, of which the police were aware. The probation service was trying to organise for a panic button to be installed in his home.)
70. On 15 November, Mr Johnston met, a psychologist operating at the prison, for one of his regular sessions. Mr Johnston said he had recently experienced an increase in stress but had not harmed himself. He reminded him to focus on protective factors such as not having access to blades and to use coping strategies that he had developed in previous sessions with the psychologist.
71. On 19 November, Mr Johnston, told an officer that he was upset and did not want to return to St Helens. He said that he understood that he would only be considered for emergency housing if something untoward happened when he was released. Mr Johnston told the officer that his housing issues continued to make him anxious but acknowledged that his offender manager continued to speak to the police and local housing agencies to ensure that protective measures were in place when he was released.
72. The officer told the investigator that Mr Johnston often goaded other prisoners when he lost his temper and that other prisoners would respond in a "tit for tat" manner. The officer said that whenever he saw Mr Johnston being bullied, he would address the perpetrator. He recalled speaking to a prisoner who was subsequently monitored under CSIP procedures because of his behaviour towards Mr Johnston.
73. On 22 November, the psychologist noted Mr Johnston's "generally positive progress". He noted that Mr Johnston remained focussed on his release, but remained concerned about his return to St Helens, and was due to meet housing agencies again. Mr Johnston said he had used coping strategies to good effect and

The psychologist noted that their two remaining sessions would focus further on those strategies.

Events of 27 November

74. At around 4.11pm on 27 November, Mr Johnston was involved in an altercation with a prisoner. The prisoner told us that he had challenged Mr Johnston because he was using his mouth to eat his food directly from his meal tray. The men became involved in a verbal and then physical confrontation which ended with the prisoner falling downstairs. Officers intervened and they and a Supervising Officer (SO) returned Mr Johnston to his cell.
75. At around 4.12pm, an officer checked on Mr Johnston. He told Merseyside Police that Mr Johnston was kicking something in his cell and shouted to a prisoner (who was still near his cell). The officer said that he could not recall what Mr Johnston said.
76. At 4.14pm, a SO answered Mr Johnston's cell bell. She told police that Mr Johnston was standing in his cell, shouting. The SO asked him if he had any injuries and Mr Johnston told her to "fuck off". An officer told police that while he looked after the prisoner, Mr Johnston shouted out and asked to speak to him.
77. At 4.15pm and 4.16pm, Mr Johnston rang his cell bell. An officer answered the bell both times. He told police that he could not recall anything about his contact with Mr Johnston but that Mr Johnston had not said anything about self-harm.
78. At around 4.17pm, a prisoner, spoke to Mr Johnston. He told police that he was worried that Mr Johnston would cut himself and advised him not to do so. An officer then led the prisoner away from the cell. He said that he told the officer that he was trying to help Mr Johnston by trying to calm him down and that he asked the officer to watch Mr Johnston. He told police that the officer did not listen to him. The officer told police that he could not recall what the prisoner told him but said that he did not speak about any increased risk to Mr Johnston or say that he would cut himself. An officer told police that he could not hear Mr Johnston from the cell door and could not recall if his cell bell was on.
79. At 4.19pm, an officer reset Mr Johnston's cell bell and spoke to him for around 30 seconds. The officer said that Mr Johnston was walking up and down his cell, screaming at him and was extremely agitated. The officer said that he asked Mr Johnston what he wanted, and that Mr Johnston replied, "Oh it's too late now". He said that Mr Johnston told him that other prisoners had abused him and continued to shout at him. The officer said that Mr Johnston would not calm down. He told Mr Johnston that he would not talk to him while he shouted and would speak to him the following day. The officer said that he could not recall speaking to any prisoners about Mr Johnston or that colleagues had raised concerns about him.
80. A prisoner told police that, when he had been returned to his cell, which was next to Mr Johnston's, he heard him "moaning" and heard an officer answer his cell bell. The prisoner said that the officer also answered a cell bell and that Mr Johnston shouted and swore at the officer. The prisoner said that the officer told Mr Johnston not to speak to him in the way that he was. The prisoner's cellmate said that Mr Johnston was "shouting and swearing his head off" and wanted food.

81. At around 4.20pm, an officer checked on Mr Johnston. He told police that Mr Johnston was sitting on his bed and did not show any signs of anxiety. The officer said that he could not recall speaking to colleagues about Mr Johnston and that no prisoners had raised concerns about him. The officer told police that Mr Johnston did not present as being at risk.
82. A prisoner and Listener said he spoke to Mr Johnston three times; firstly, at around 4.17pm, again at around 4.22pm and then at 4.38pm. He said that the officer, whom he thought knew how to manage Mr Johnston, tried to calm him down. He said he went to talk to Mr Johnston as he was worried he might cut himself. He said Mr Johnston was crying and really upset, he told him to calm down and to promise not to cut himself. Mr Johnston agreed not to, and he told him that he would try and get some more food. He said that he was unable to do this as he had to return to his own cell.
83. At 4.24pm, Mr Johnston rang his cell bell.
84. At around 4.27pm, a prisoner, went to Mr Johnston's cell door. He told police that he told Mr Johnston not to cut himself or do anything stupid. He said Mr Johnston was really upset and asked him to get a member of staff as he wanted to speak to them. He said he told an officer that Mr Johnston was going to cut himself. The prisoner alleged that the officer said, "I don't give a fuck". The officer said that he could not recall the conversation with him, and it was not one that he would have had. The prisoner said that he then told the officer who said that he "did not give a fuck as he was going home". The officer said that he did not remember speaking to him.
85. At around 4.32pm, a prisoner, went to see if Mr Johnston was okay as he had rung his cell bell. He said he asked an officer to speak to Mr Johnston which he said the officer did. (CCTV footage shows that the officer did not return to speak to Mr Johnston at that time.)
86. At 4.48pm, a prisoner went to Mr Johnston's cell door as his cell bell was ringing. He told police that Mr Johnston had blocked the cell's observation panel with paper. He said that Mr Johnston was shouting that he was going to kill himself and that he wanted an officer but did not say why. He said he told the officer that Mr Johnston wanted to speak to him, and the officer told him he would go and see Mr Johnston.
87. At around 4.52pm, an officer went to Mr Johnston's cell and reset the cell bell. This was now 29 minutes after Mr Johnston had first rung it. (The officer told police that he knew someone had pressed their cell bell, but as he was working on another landing, he was unable to see who it was and said that there were other staff on the wing. The officer said that when he had finished serving the evening meal, he noticed that the cell bell was still active, and went to answer it.) CCTV footage shows that the officer appeared to engage with Mr Johnston for around 30 seconds.
88. The officer told police that Mr Johnston was trying to explain to him what had happened and told the officer, "I don't want to speak to a dickhead". The officer said that he asked Mr Johnston what he wanted, and that Mr Johnston told him to "fuck off". The officer told police that when he checked on Mr Johnston, his observation panel was not blocked as he could clearly see and speak to him. He

said that during the evening, he never spoke to any prisoners or officers who thought that Mr Johnston might be at risk of self-harm.

89. Between 4.52pm and 7.12pm, no checks were carried out on Mr Johnston. At around 5.29pm, the officer walked past Mr Johnston's cell and looked towards it.
90. An officer started disciplinary proceedings paperwork for Mr Johnston, following his altercation with a prisoner. He was left alone on the wing from around 5.30pm because his colleagues were redeployed elsewhere.
91. At around 7.10pm, the night patrol officer, arrived for work and the officer gave him a verbal handover. The officer said that he told him that Mr Johnston had been involved in a fight with another prisoner. The night patrol officer said that the officer did not give him any information which would have caused him to have had concerns about either of the prisoners.
92. At 7.13pm, the night patrol officer, carried out his first check of the wing. He checked Mr Johnston's cell and noted that the cell observation panel was blocked. Not knowing if the cell was occupied, the officer returned to the wing office to check. The night patrol officer, said that he told the officer, who was still on the wing, about the blocked observation panel. The night patrol officer told police that the officer acknowledged what he had said but did not seem concerned about it and gave him no advice about what to do. (The night patrol officer, said that he was not aware that Mr Johnston had previously harmed himself or had ever been monitored under ACCT procedures.) The officer told the investigator that he could not recall the night patrol officer, telling him about the blocked observation panel. He said that if he had been told, he would have taken appropriate action.
93. At 7.20pm, the night patrol officer, carried out a further check and found that the observation panel was still blocked. Now knowing that the cell was occupied, he tried to get a response from Mr Johnston by kicking the cell door, told him that he must unblock the observation panel and said that if he did not do so, staff would have to unlock the cell door and go in. He said that Mr Johnston did not respond.
94. The officer left the wing at around 7.25pm.
95. At 7.34pm, the night patrol officer, returned to Mr Johnston's cell for around 12 seconds. At 7.43pm, he returned and spent around 30 seconds at the cell door. He said that he could not get a response from Mr Johnston. He told one of the support night managers who was nearby, that Mr Johnston had blocked his observation panel. He said the support night managers told him that he would come to the wing to open Mr Johnston's cell door. On his way back to the wing, the night patrol officer also told an officer another of the night support managers, that Mr Johnston had blocked his cell observation panel with tissue which appeared to have blood on it. The officer said she told another office that Mr Johnston had blocked his observation panel.
96. At around 7.48pm, the officer and the night patrol officer, checked Mr Johnston's cell. The officer said that she kicked the cell door and tried to get a response by shouting Mr Johnston's name but he did not respond. The officer said that she was aware that Mr Johnston was a prolific self-harmer as she had had dealings with him in the past. An officer had not arrived so the officer said that she called for further

assistance from him, as it was prison policy for staff not to go into a cell on their own. The night patrol officer, then returned to the wing office.

97. At around 7.51pm, an officer arrived at the cell, where the officer was waiting. The officer said that the officer unlocked the cell door and that it was then that they saw Mr Johnston lying on the cell floor, and that the cell was "covered in blood". An officer radioed an emergency code red, indicating a medical emergency involving serious blood loss. The officers did not enter the cell. The control room immediately called an ambulance. Around a minute later, the night patrol officer, returned to the cell.
98. At around 7.52pm, the emergency response nurse, arrived and went into the cell. The officers remained standing outside. She said that Mr Johnston was lying on his front, was cold to touch, unresponsive and unconscious and that there was a large quantity of blood in the cell. More healthcare staff arrived and helped she try to resuscitate Mr Johnston. They attached a defibrillator, which advised no shock. Attempts to resuscitate Mr Johnston continued until paramedics arrived at around 8.06pm. Paramedics continued the resuscitation efforts but at 8.28pm, they confirmed that he had died.
99. Merseyside Police attended after Mr Johnston's death. They noted that the cell door observation panel was covered with blood-stained tissue. The police removed two plastic knives, a razor blade and a broken plastic container from the cell.
100. A blood-stained note was also recovered in which Mr Johnston wrote:

"I tried not to cut. I did get the bell it took over 45 minutes for someone to answer. Then an officer answered and refused to get me someone to talk to. I then said I was going to cut myself, he laughed and said, "go on" so I have."

We do not know when Mr Johnston wrote this note. The officer told police that he did not have such a conversation with Mr Johnston.

Interviews with prisoners carried out by the police

101. Merseyside Police interviewed several prisoners after Mr Johnston's death. One prisoner said Mr Johnston would normally use his cell bell after harming himself or tell someone and that he was not surprised that Mr Johnston had self-harmed, as he had done it so often before. A prisoner said that Mr Johnston would react by harming himself after being involved in a dispute. A prisoner said that after arguments Mr Johnston would tell him that he would self-harm as it made him feel better. A prisoner said Mr Johnston would cut himself to release pressure and that staff knew this. A prisoner said that when Mr Johnston was involved in arguments, he would cut himself to get attention. A prisoner told police that Mr Johnston would ring his cell bell when he cut, as he did not want to die. The prisoner and Listener said Mr Johnston was well known to cut himself after an argument. A prisoner said that he had heard an officer tell Mr Johnston to harm himself.

Contact with Mr Johnston's family

102. Mr Johnston named his mother as his next of kin. Due to the time of night and to assist Liverpool, Merseyside Police broke the news of Mr Johnston's death to his mother at 11.30pm. Liverpool contributed to funeral expenses in line with national instructions.

Support for prisoners and staff

103. The Head of Safer Custody debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.
104. The prison posted notices informing other prisoners of Mr Johnston's death and offered support. Staff reviewed all prisoners assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Johnston's death.

Post-mortem report

105. A post-mortem examination found that Mr Johnston died as a result of blood loss due to an incised wound to his left forearm. Post-mortem toxicology results found therapeutic levels of fluoxetine, gabapentin, olanzapine (which were all prescribed to him) and dihydrocodeine.

Findings

Assessment of risk

106. Prison Service Instruction (PSI) 64/2011 on safer custody requires that all staff who have contact with prisoners are aware of the risk factors and triggers that might increase the risk of suicide and self-harm and manage prisoners identified as at risk under ACCT procedures. It states that potential triggers should be continually assessed.
107. During his time at Liverpool, Mr Johnston harmed himself, often significantly, on numerous occasions. This usually involved cutting or reopening wounds on his arms or legs. Mr Johnston's self-harm usually followed altercations or other incidents with staff or prisoners. He had other risk factors for suicide and self-harm, including evidence that he was anxious about his upcoming release and fearful for his safety on release. Mr Johnston was not being monitored under ACCT procedures at the time of his death and had last been subject to them a month earlier.
108. Mr Johnston's reaction to altercations and similar incidents was a significant trigger which was well documented. Other prisoners, concerned about Mr Johnston's welfare and the increased risk that he posed to himself by cutting, said that they asked staff to check on Mr Johnston on 27 November, as they were aware of his pattern of behaviour after such incidents. The staff involved told police that they could not recall these conversations with prisoners. Without independent corroboration, it is not possible to know exactly what happened and therefore we cannot say with certainty that the officers were aware of the prisoner's concerns.
109. Staff who worked on K Wing on the afternoon of 27 November told us and Merseyside Police that they did not consider that Mr Johnston was at risk of suicide and self-harm. An officer said he had not considered starting ACCT procedures as Mr Johnston had not expressed thoughts of self-harm and had not told staff he intended to harm himself. An officer said that Mr Johnston did not present as if he would harm himself and that he would normally alert staff that he was going to do so by ringing his cell bell. An officer said that Mr Johnston would usually tell staff if he was going to harm himself and that it did not cross his mind to consider starting ACCT procedures. An officer said that he did not consider starting ACCT procedures as Mr Johnston did not display any behaviours that made him think that he was at increased risk.
110. We are concerned that, given Mr Johnston's history and patterns of behaviour, prison staff did not recognise that he might have been at increased risk. There is no evidence that staff considered the impact that the altercation with another prisoner might have had on Mr Johnston, despite well documented evidence that he would harm himself after such incidents. We consider that staff who worked on the wing should have been aware of his previous consistent and repeated patterns of behaviour and considered starting ACCT procedures.
111. ACCT procedures can be started because of a prisoner's history and triggers, and it is concerning that several staff said that they did not consider starting ACCT procedures because Mr Johnston did not harm himself or express thoughts of doing

so. By not starting ACCT procedures, staff missed an opportunity to monitor and manage Mr Johnston's risk, which might have included frequent observations, removing sharp objects from his cell, or offering access to Listeners. We are also concerned that staff did not consider that the blocked cell observation panel was an indication of increased risk, despite his history of blocking his observation panel before he harmed himself.

112. In our reports into the death of prisoners at Liverpool in February and October 2018, we reported how staff did not review their level of increased risk after their presentation had changed. It is concerning that staff at Liverpool again failed to respond appropriately to Mr Johnston's escalation of risk in the hours before his death. We make the following recommendation:

The Governor should ensure that all staff have a clear understanding of their responsibilities to identify prisoners at risk of suicide and self-harm in line with national guidelines and, in particular, the need to record, share and consider all relevant information about risk, and start ACCT procedures when indicated.

Razors

113. After Mr Johnston died, police removed two plastic knives, a razor blade and a broken plastic container from his cell. Prisoners at Liverpool can have two safety razors in their possession. Prisoners subject to ACCT procedures are not allowed razors, although there are some exceptions to this. Because Mr Johnson was not subject to ACCT procedures at the time, there was no reason for him not to have razors.

Accusations of bullying

114. Staff and prisoners told us that Mr Johnston was not well liked by some other prisoners at Liverpool, and his behaviour towards them, his general appearance, poor hygiene, and self-inflicted injuries might all have contributed to the way he was treated. As a result, he was the subject of some name-calling and "banter". However, there were also more settled periods when Mr Johnston appeared to get on better with his peers.
115. On several occasions, Mr Johnston told staff that he was bullied by other prisoners. We were told that when bullying allegations arose, individuals were challenged and that staff followed this up by staff actions, including reporting the perpetrators to the violence reduction unit, monitoring them under CSIP and or moving them. However, prisoners' accounts indicate that there are also likely to have been unrecorded or unevidenced times that Mr Johnston was the subject of name-calling or bullying by other prisoners which staff might not have known about.
116. We appreciate that the prison environment can be challenging and unpleasant for many prisoners and that name-calling and bullying exists, irrespective of the fact that many who perpetrate it might consider such behaviour as "banter". This type of bullying can be difficult for staff to manage effectively, especially if several prisoners are involved in it and it happens when staff are busy with other tasks.

117. Despite this and the challenges for staff in managing such bullying, it is not acceptable for any prisoner to feel unsafe and the Governor must ensure that staff are reminded to “call out” any inappropriate behaviour by prisoners on one another. Even though it might be considered that such actions are just “banter”, staff must have confidence to challenge such behaviour and escalate, where necessary, in line with Liverpool’s safer prisons policy. We recognise the difficulty identifying and investigating name-calling and other inappropriate behaviour and the difficulty staff face in investigating unevidenced or unspecified fears that a prisoner is under threat. However, unwanted “banter” is a form of bullying.
118. Although we consider that staff acted appropriately when Mr Johnston made specific claims that he was being bullied, they must also be aware of and consider other forms of bullying and how, over time, it might affect a prisoner’s mental health and risk of suicide and self-harm. It is possible that Mr Johnston’s experiences might have contributed to his feelings of anger which in turn led to the inappropriate behaviour he then exhibited to others. We make the following recommendation:

The Governor should ensure that prison staff:

- **fully and promptly identify and investigate information about bullying, in all its forms;**
- **appropriately challenge alleged perpetrators; and**
- **effectively support victims and properly consider and address the possible impact on their risk of suicide and self-harm.**

Blocked cell observation panel and emergency response

119. Liverpool has a local policy which sets out what staff should do if they find a cell observation panel blocked. It states that if prisoners do not comply with an instruction to unblock their observation panel, staff must take immediate action to check on the prisoner’s welfare. In such circumstances, we would usually expect staff who cannot see or speak to a prisoner to radio for help from other staff and remain at the cell door. If they believe the prisoner may be at risk, they should assess the risk of opening the cell door themselves before help arrives.
120. PSI 24/2011 on management and security at nights gives national guidance about entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell must be opened, with a minimum of two or three staff present. However, the PSI says that preservation of life must take precedence over this. Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. However, night staff should not take action that they consider would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid and dynamic risk assessment.
121. It is unclear when Mr Johnston first blocked his observation panel. A prisoner said that it was blocked at 4.48pm. Prison staff said that this was not the case and the first member of staff to confirm that the observation panel was blocked was the night patrol officer, at 7.13pm. Despite Mr Johnston not responding to any of the

night patrol officer's attempts to communicate with him, and several staff having been informed of the blocked panel, it was nearly 40 minutes until the cell was opened. This is too long, particularly given the events of the afternoon. Our view is that he should have contacted colleagues for support immediately, remained at the cell, and opened it at the first opportunity.

122. When supporting officers arrived at the cell, Mr Johnston's observation panel was still blocked, and they were unable to get a response from him. An officer said she did not go into the cell because the prison was in patrol state and, for security reasons, she wanted an extra member of staff present and that it was not policy for officers to open cell doors at night alone. However, we note that the cell was opened with two staff present (and the night patrol officer in the wing office), despite there having already been two staff on the wing (an officer and the night patrol officer) for around three minutes.
123. We consider that staff should have acted with more urgency. We recognise that it can be difficult for staff to make instant decisions in difficult and unknown circumstances. However, when there is a potentially life-threatening situation, it is essential that staff act quickly and exercise good judgement. While we understand the need for staff not to put themselves in danger or risk the security of the prison, we would normally expect staff to go into a cell, or raise concerns with colleagues, as soon as possible when there is the possibility that someone's life is at risk. Although we recognise that the officers were not able to see Mr Johnston, they were aware that he had blocked his observation panel and was not responding.
124. Although the officers did not immediately go into the cell when they opened it, we appreciate that there was a significant amount of blood in the cell and they did not have access to personal protective equipment. The delay in opening the cell is unlikely to have affected the outcome for Mr Johnston. However, a delay of even a few minutes could make the difference between life and death in other medical emergencies. We identified a similar concern in our report into the death of another man at Liverpool in October 2018. We therefore make the following recommendation:

The Governor should ensure that all staff are aware that, subject to a risk assessment, they should enter a cell as quickly as possible if there is reason to believe that a prisoner may be at risk, in line with PSI 24/2011.

The Governor should ensure that staff are aware of and understand what is expected of them when they find a cell observation panel obscured.

Clinical care

Mental health wellbeing

Mr Johnston was assessed and reviewed by a range of mental health professionals throughout his time at Liverpool. The clinical reviewer considered that Mr Johnston had excellent support from the mental health team, including from psychiatrists, psychologist and mental health nurses. The clinical reviewer had no concerns about the mental health care that Mr Johnston received.

125. The clinical reviewer concluded that the physical, mental health and substance misuse care received by Mr Johnston at Liverpool was of a good standard and was equivalent to that which he could have expected to receive in the community.

Learning lessons

126. We consider it is important that staff learn from our findings. We make the following recommendation:

The Governor should ensure that a copy of this report is shared with all staff named in this report so that they are aware of the Ombudsman's findings.

Inquest Verdict

127. The inquest hearing into the death of Mr Johnston was held on 5 September 2024. It confirmed that the medical cause of Mr Johnston's death an incised wound to his left forearm. The inquest concluded that Mr Johnston died by misadventure.

**Prisons &
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