

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Byrnes, a prisoner at HMP Liverpool, on 21 July 2023

A report by the Prisons and Probation Ombudsman

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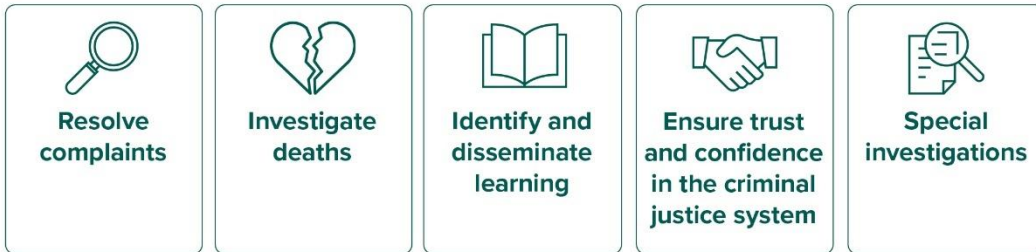
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OUR VISION

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.

If my office is to best assist HM Prison and Probation Service in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Nathan Byrnes was found hanged in his cell at HMP Liverpool on 21 July 2023. He was 38 years old. I offer my condolences to his family and friends.

Mr Byrnes died a week after he was transferred to Liverpool. He had several risk factors for suicide and self-harm and prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT). I am concerned that his ACCT assessment lacked detail, his care plan was incomplete and there was no consistency in the prison staff chairing his case reviews.

Staff misjudged Mr Byrnes' risk of suicide and self-harm when they reduced his ACCT observation levels the day before he died. Prison and healthcare staff placed too much emphasis on their perceptions of his state of mind, based primarily on comments he made, and not enough emphasis on his known risk factors.

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

Adrian Usher
Prisons and Probation Ombudsman

September 2024

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Summary

Events

1. On 9 February 2023, Mr Nathan Byrnes was convicted of driving offences and sentenced to 12 months in prison. He was sent to HMP Forest Bank. He had attempted suicide in the past after the breakdown of a relationship and was monitored under suicide and self-harm prevention procedures (known as ACCT) several times in prison.
2. On 14 July, Mr Byrnes was transferred from HMP Lancaster Farms to HMP Liverpool after a court hearing. Prison and healthcare staff at Liverpool reviewed him and started ACCT procedures.
3. Over the next five days, prison staff chaired two ACCT reviews and a mental health nurse completed an initial mental health screen. Mr Byrnes mostly presented as “low in mood” and was concerned about not being closer to his family and sharing a cell.
4. At 1.45pm on 20 July, a Supervising Officer (SO) chaired an ACCT case review and noted that Mr Byrnes had had an argument with his ex-partner (his main source of support) and wanted to move to a prison closer to his family. Attendees reduced his ACCT observation levels from every half hour to six observations during the day and six overnight.
5. At 9.15pm, an operational support grade (OSG) conducted an ACCT check and found Mr Byrnes crying. She asked if he was okay and offered him a Listener (a prisoner trained by the Samaritans to support prisoners in crisis) but he declined.
6. At around 12.05am on 21 July, an OSG looked through Mr Byrnes’ cell door observation panel and saw him hanging from a ligature attached to the toilet door. She radioed a medical emergency code and additional staff arrived, went into the cell, cut the ligature and started cardiopulmonary resuscitation (CPR). Minutes later, a nurse arrived at the cell and helped with CPR. At 12.19am, ambulance paramedics arrived and pronounced that Mr Byrnes had died.

Findings

Identifying the risk of suicide and self-harm

7. Mr Byrnes had several risk factors for suicide, including a previous suicide attempt following a relationship breakdown. When assessing his risk, prison staff placed too much emphasis on what Mr Byrnes said about his risk of suicide rather than objectively considering his known risk factors and prematurely reduced his ACCT observations.
8. The ACCT assessment lacked detail, failed to expand on areas of increased risk for Mr Byrnes and to take account of the fact that he arrived at Liverpool not long after he had been monitored under ACCT procedures at his previous prison. Mr Byrnes’ former ACCT was in its post-closure period. This meant that prison staff at Liverpool could have restarted it which would have enabled them to identify and address any

similarities in risk, see what interventions staff had undertaken and ensure continuity.

9. Prison staff did not complete all aspects of the ACCT care plan. They failed to act on those actions which were included in a timely manner and omitted two further support actions that had been recorded in the medical record.
10. For case reviews to be fully effective, there should be a consistent case co-ordinator chairing all ACCT case reviews. Instead, a different member of staff chaired all three of Mr Byrnes' ACCT reviews.

Recommendations

- The Governor should ensure that temporarily promoted staff have sufficient knowledge to complete the duties they will be mandated to undertake.
- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that staff:
 - conduct detailed ACCT assessments that take account of all background information, including ACCTs within the post-closure period;
 - add all support actions to the care plan ensuring that they are specific and meaningful, aimed at reducing risk, and update them at each review;
 - ensure a consistent case management approach to ACCT by allocating a sole case co-ordinator; and
 - consider all relevant factors when assessing a prisoner's risk factors and not rely solely on their behaviour and comments when deciding to stop ACCT procedures.

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 visited Liverpool on 4 August 2023. He interviewed two prisoners and obtained copies of relevant extracts from Mr Byrnes' prison records.
13. The investigator interviewed 13 members of staff at Liverpool and by video link between 4 September and 6 October.
14. NHS England commissioned a clinical reviewer to review Mr Byrnes' clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
15. We informed HM Coroner for Liverpool and the Wirral of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.
16. The Ombudsman's office contacted Mr Byrnes' mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Byrnes' mother said that although Mr Byrnes was unhappy about moving to HMP Liverpool, he seemed fine when she had spoken to him in days before his death.
17. Mr Byrnes' family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.
18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Liverpool

19. HMP Liverpool is a category B local prison. Spectrum Healthcare UK Trust provides physical healthcare services and Merseyside NHS Trust provides mental healthcare services.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Liverpool was in July 2022. Inspectors reported that reception staff were welcoming, supportive and effectively identified risk and vulnerability through safety interviews. They found that leaders had developed a positive culture characterised by good relationships and a sense of community that motivated prisoners to behave well. However, inspectors also found that the supply of illicit items, including drugs and mobile phones, remained a substantial threat to the prison. They noted that despite good work in response to the supply and demand for drugs, staff did not coordinate it as well as they could have done and that the drug strategy was out of date.

Independent Monitoring Board

21. 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 latest annual report for the year to 31 December 2021, the IMB found that early days procedures were largely effective and that initial screenings were completed before staff moved prisoners to their first night location. They also reported that Partners of Prisoners (an organisation which supports families through their contact with the criminal justice system) and the chaplaincy provided individual support to prisoners going through difficult periods. However, they reported concern about the lack of mandatory drug testing and the increase in drone activity over the prison.

Previous deaths at HMP Liverpool

22. Mr Byrnes was the nineteenth prisoner to die at HMP Liverpool since July 2020. Of the previous deaths, thirteen were from natural causes, two were drug-related and three were self-inflicted. Two of the previous self-inflicted deaths occurred within the eight days before Mr Byrnes' death. Up until the end of March 2024, a further three prisoners had died at Liverpool, two from natural causes and one self-inflicted.

Assessment, Care in Custody and Teamwork

23. 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 the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be

irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

24. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the support actions have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

25. On 9 February 2023, Mr Nathan Byrnes was convicted of driving offences and sentenced to 12 months in prison. He was sent to HMP Forest Bank. It was not his first time in prison.
26. Mr Byrnes had a history of depression, anxiety, self-harm and substance misuse. He had attempted suicide in the past after the breakdown of a relationship. Staff at Forest Bank reviewed him frequently and monitored him using suicide and self-harm prevention procedures (known as ACCT) on three occasions.
27. On 30 May, Mr Byrnes was transferred to HMP Lancaster Farms. He was monitored under ACCT procedures when he arrived, and staff reviewed him frequently.
28. On 28 June, prison staff stopped ACCT procedures after Mr Byrnes reported that his personal circumstances had improved. They noted that he kept himself busy with a wing cleaning job and had not reported any thoughts of suicide or self-harm. Mr Byrnes' ACCT went into the post-closure phase.
29. On 6 July, an officer conducted an ACCT post-closure review and recorded that Mr Byrnes did not report any thoughts of suicide or self-harm. She concluded that the ACCT should remain closed.
30. On 13 July, an officer saw Mr Byrnes for a keywork session and noted that Mr Byrnes had reported feeling settled on the wing and was in regular contact with his family.

HMP Liverpool

14 July

31. On 14 July, Mr Byrnes was transferred to HMP Liverpool after attending a court hearing. He arrived at 4.44pm. (Prison staff told the investigator that Liverpool often received prisoners from Manchester if more local prisons were operating at capacity.)
32. At 6.03pm, a nurse conducted an initial reception screen and recorded that Mr Byrnes replied "yes" when asked if he had harmed himself or attempted suicide within the last twelve months. He added that Mr Byrnes reported a history of anxiety and depression but said that he no longer took medication as he felt well. He also recorded that while Mr Byrnes had a history of substance misuse, he did not report any problems and said that he had not used drugs in the last three months.
33. At 7.20pm, an officer conducted a first night screening questionnaire. He noted that Mr Byrnes had previously attempted suicide in 2021 and been subject to ACCT procedures while in prison but did not report current thoughts of suicide or self-harm. The officer completed a cell-sharing risk assessment (CSRA) and assessed Mr Byrnes as a standard risk and suitable to share a cell.
34. At 8.10pm, a prison manager started ACCT procedures because Mr Byrnes presented as anxious and stressed about sharing a cell. (Because Mr Byrnes's

previous ACCT plan was in the post-closure phase, the manager could have re-opened it rather than beginning a new ACCT plan.) She noted that he said he had seizures that often resulted in incontinence but healthcare staff could not find any evidence of this. Staff completed an immediate plan and set his ACCT observation levels at six observations during the day and six at night.

35. At 8.43pm, prison staff moved Mr Byrnes to a shared cell on B wing, which, at the time, was the prison's induction unit.

15 July

36. At 1.45pm on 15 July, an officer conducted an ACCT assessment and recorded that Mr Byrnes felt stressed about moving away from Manchester. He noted Mr Byrnes had a history of self-harm but did not record anything to indicate that he had tried to understand the context of his self-harming history. There was also no reference in the note of the assessment that he had been monitored under ACCT procedures at Forest Bank and Lancaster Farms.
37. At 3.45pm, a Custodial Manager (CM) chaired Mr Byrnes' first ACCT case review, which a mental health nurse attended. (The officer was unable to attend but briefed the CM beforehand.) The CM noted that Mr Byrnes was tearful and said that he had not expected to transfer to Liverpool. He said that he wanted a single cell and to be closer to his family as he had an autistic son who found using public transport difficult. Attendees reduced his ACCT observation levels to three observations a day and three at night, with three meaningful conversations. The CM added three support actions to the careplan: to ask the Observation, Classification and Allocation Unit if there was space at Forest Bank; make a referral to the Safety Intervention Meeting (SIM, a meeting of senior managers to discuss those who require multidisciplinary case management) and attend a GP appointment about his reported seizures.
38. After the ACCT review, the mental health nurse completed a primary mental health screen and standardised depression and anxiety tests. She scored Mr Byrnes 11 and 10 respectively, indicating moderate depression and mild/moderate anxiety. She recorded that she attended his ACCT review and referenced two support actions that were not on the care plan: a referral to Partners of Prisoners to promote access to his family and to Clinical Psychology for therapeutic work.

16 to 18 July

39. At 2.43pm on 16 July, a mental health nurse reviewed Mr Byrnes following a request from prison staff. She recorded that he appeared "low in mood" and said he would have been in tears if she had seen him earlier. He repeated his concern about experiencing seizures and she advised him that he had a GP appointment scheduled for 20 July.
40. At 2.19pm on 17 July, an officer saw Mr Byrnes for an initial keywork session and explained that he would be allocated a keyworker once he left the induction wing.
41. At 4.35pm, Mr Byrnes phoned his ex-partner from his in-cell phone. She was angry with him for lying about remaining in contact with his current partner. (He tried to call her back several times but she did not answer.)

42. At 6.05pm on 18 July, an Acting Supervising Officer (SO) noted that Mr Byrnes had approached him and said that he was struggling with his mental health. He noted that Mr Byrnes appeared anxious and upset and increased his ACCT observation levels to half hourly, with two daily conversations. The Acting SO did not consider arranging an urgent case review. In interview, he said that he was not aware that he had to, as he had not received ACCT case co-ordinator training. He said he had been temporarily promoted in July and was not due to complete the training until October.
43. In the night conversation section of the ACCT record, an Operational Support Grade (OSG) noted that Mr Byrnes appeared stressed and said that he had had an argument with his ex-partner on the phone.

19 July

44. At 1.30am on 19 July, the OSG recorded in the ACCT record that Mr Byrnes was tearful throughout the night and had said that he "just needed to talk to his family".
45. At around 10.30am, a mental health nurse recorded that she saw Mr Byrnes for a welfare check following a request from prison staff. She noted that he was emotional but did not appear distracted. Mr Byrnes told her that he was struggling with sharing a cell and had not been sleeping. He said that he had an issue with his ex-partner which had resulted in a loss of contact with her for the time being. He said that he had previously attempted suicide 12 months ago following a relationship breakdown.
46. At around 11.00am, a SO chaired an ACCT case review, which a nurse attended. He recorded that Mr Byrnes became visibly upset and said that he had ongoing suicidal thoughts because he had to share a cell. He said that he got on with his cellmate but he was due for release that day. He said that his thoughts of suicide and self-harm the previous night were "8/10". The SO added that Mr Byrnes said that he had had issues with his ex-partner, but they had maintained contact. Attendees agreed that his ACCT observation levels should stay the same.
47. After the ACCT review, the nurse spoke to a chaplain about Mr Byrnes, who said he would review him. At 11.39am, the chaplain recorded that he had spoken to Mr Byrnes, who had asked him to contact his ex-partner. He tried to contact her by telephone but was unable to get through and left a voicemail message.
48. Between 7.29am and 11.02pm, Mr Byrnes phoned his ex-partner 15 times and left several voicemail messages. In the recordings, he sounded tearful and said things like, "I need you, you're the only one that's there for me." He also said, "I'll ask my mum to text you."
49. At 9.00pm, Mr Byrnes phoned his mother. He told her that he would rather be in a Manchester prison and asked her to text his ex-partner.
50. In the night conversation section of the ACCT record, the OSG recorded that Mr Byrnes presented as very tearful and said that he was struggling with his mental health. However, he also said that he had spoken to his mother and it had helped.

51. Later that night, the OSG recorded that Mr Byrnes continued to be tearful and talked about wanting to move to another prison. (Mr Byrnes' cellmate had been released and he remained the sole occupant of his cell until his death.)

Events on 20 and 21 July

52. At 11.25 am on 20 July, a substance misuse recovery worker recorded that he went to see Mr Byrnes for an initial appointment, but he refused to engage. He noted that Mr Byrnes said he had "done all that before" and did not need support.
53. In the morning conversation section of the ACCT record, an officer noted that Mr Byrnes presented as tearful. She asked if he would like to see a Listener but he declined.
54. At 1.45pm, a SO chaired an ACCT case review which a nurse and a student nurse attended. He recorded that Mr Byrnes said he had had an argument with his ex-partner and wanted to move to a prison closer to his family. The SO recorded that Mr Byrnes said he had not harmed himself in a long-time and did not plan to do so. He also noted that Mr Byrnes said he was due for release in October and that he wanted a job as a baker. The nurse recorded that Mr Byrnes felt low and said his "head was spinning". Attendees reduced his ACCT observation levels to six during the day and six overnight.
55. Between 3.53pm and 9.14pm, prison phone records show that Mr Byrnes tried to contact his ex-partner six times and his partner twice. They did not answer.
56. At 9.15pm, the OSG conducted an ACCT observation and found Mr Byrnes crying. He told her that he was fed up seeing different members of staff at ACCT reviews and having to repeat himself. She told the investigator that he declined to see a Listener.
57. Between 10.05pm and 11.16pm, Mr Byrnes tried to phone his ex-partner nine times and his partner twice. Again, they did not answer.
58. At 12.05am on 21 July, the OSG looked through Mr Byrnes' cell door observation panel while conducting ACCT checks. She saw Mr Byrnes hanging from a ligature attached to his toilet door. She shouted, "Code blue" to an officer who was on the landing below (to indicate that a prisoner is unconscious or has breathing problems). The officer made his way to the cell, and the OSG radioed a code blue.
59. Two officers arrived at the cell quickly and found the first officer trying to remove a cell key from his secure pouch. An officer opened the door. Staff went into the cell, cut the ligature and laid Mr Byrnes on the floor. An officer started cardiopulmonary resuscitation (CPR).
60. A short while later, a nurse arrived and noted that Mr Byrnes was not breathing and had blue lips. She helped prison staff with CPR but did not use a defibrillator, that was available to her. They continued CPR until paramedics arrived at 12.19am and pronounced that Mr Byrnes had died.

Events after Mr Byrnes' death

61. On 24 July, Mr Byrnes' ex-partner received an undated letter from him. In the letter, Mr Byrnes wrote that he felt low, needed help and wanted to give up. He said that he was not coping and wanted to end his life. An OSG told the investigator that staffing levels affected the speed with which prisoner mail was processed. He said that there had been OSG shortages around the time of Mr Byrnes' death which might account for why Mr Byrnes' ex-partner received the letter after his death. (Prison staff in the mail department would not have known that Mr Byrnes had died when they posted the letter.)

Contact with Mr Byrnes' family

62. At around 6.20am on 21 July, the prison appointed a family liaison officer (FLO). At 8.20am, the FLO and a Governor visited Mr Byrnes' mother, his next of kin. There was no answer, so they rang and left her a voicemail message and visited Mr Byrnes' partner, whom he had also named as a next of kin. At around 9.00am, they broke the news of his death and offered support.
63. At 12.00pm, Mr Byrnes' mother, who was aware of Mr Byrnes' death, called the FLO. He explained that he had tried to visit her earlier that morning, offered support and explained the next steps.
64. The FLO supported Mr Byrnes' family until his funeral which took place on 22 September 2023. The prison contributed to its cost in line with national policy.

Support for prisoners and staff

65. After Mr Byrnes' death, a Governor and a prison manager 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.
66. The prison posted notices informing other prisoners of Mr Byrnes' death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Byrnes' death.

Post-mortem report

67. A post-mortem examination confirmed that Mr Byrnes died from hanging.
68. Routine post-mortem toxicology tests found the presence of MDMB-4en-PINACA, a type of psychoactive substance. The post-mortem report states that the toxicologist was unable to offer an opinion on when Mr Byrnes last used the drug or whether he was experiencing the effects of the drug during the fatal incident.

Findings

Managing Mr Byrnes' risk of suicide and self-harm

69. PSI 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.
70. Mr Byrnes' had only been at Liverpool for a week and was upset about having to share a cell, being away from his family, and not being able to have visits from his son. While prison staff at Liverpool appropriately started ACCT procedures and healthcare staff were frequently involved in the ACCT process, we identified several deficiencies in the management of the ACCT process.

Initial assessment

71. The ACCT assessment lacked detail and failed to expand on areas of increased risk. PSI 64/2011 states that the ACCT assessor must document the findings and outcome of the assessment by completing all the relevant sections of the form and recording all background information checked in the 'key information' section.
72. Mr Byrnes' ACCT documentation did not refer to his previous ACCTs since his imprisonment in February 2023 or that he arrived at Liverpool during the post-closure period of his previous ACCT at Lancaster Farms. This meant that staff at Liverpool could have re-started the ACCT. Re-starting the ACCT would have helped maintain continuity, helped staff get a contextual understanding of risk, identify any similarities and build on interventions that had already taken place.
73. While a keywork officer identified that Mr Byrnes had harmed himself in the past and that family contact was important to him, he did not fully explore his previous suicide attempt or self-harm or the circumstances under which they occurred. He identified that a relationship breakdown or the continued lack of contact with his family was a trigger but a more detailed exploration might have led to a greater understanding of the associated risk, particularly when Mr Byrnes talked openly and frequently about having argued with his ex-partner, evidently a source of support, on 17 July.

Care plans

74. PSI 64/2011 states that completing a care plan is an integral part of the ACCT process and that it must reflect a prisoner's needs, level of risk and the triggers of his distress. The policy guidance annex to PSI 64/2011 states that care plan support actions should be set to mitigate and lower risks.
75. Mr Byrnes' ACCT care plan did not fully meet his needs, with a section to record his contribution left blank and the two actions that a nurse recorded in Mr Byrnes' medical record (a referral to Partners of Prisoners and psychology) omitted. While we recognise that the nurse completed the actions, adding them to the ACCT care plan would have highlighted them to attendees at future ACCT case reviews and enabled them to follow up the referrals and action them.

76. Prison staff did not refer Mr Byrnes to the SIM until 20 July despite attendees at his first ACCT case review agreeing it as a care support action. As SIMs are weekly, this meant that staff missed an opportunity to discuss Mr Byrnes a week earlier. A prison manager told us that she knew that she should have made the referral, but it was a busy day and she forgot. While we appreciate the pressures of working in a prison environment, particularly at weekends when staffing levels are reduced, it is vital that sufficient time is given to ACCT case reviews and follow up actions.

Case reviews

77. A different member of staff acted as the case coordinator in all three of Mr Byrnes' ACCT reviews at Liverpool. For case reviews to be fully effective, staff should use a sole case co-ordinator approach. A SO told the investigator that the number of prisoners coming into prison subject to ACCT procedures made it difficult for induction wing staff to act as a case co-ordinator and they would normally transfer prisoners to the SO of their allocated wing.
78. While we appreciate that it is not always possible for the same person to chair case reviews, particularly during the early days in custody, having a sole case co-ordinator while a prisoner is on the induction wing provides consistent case management, accountability and improved communication. Indeed, Mr Byrnes reported frustration about the number of different people involved in his ACCT reviews and having to repeat himself.

Change of observation level on 19 July

79. While the Acting SO appropriately increased the frequency of Mr Byrnes' ACCT observations, this should have taken place following an urgent case review that day. PSI 64/2011 states that an urgent case review needs to take place as soon as possible if risk is likely to have increased between planned reviews. The Acting SO told us that he did not know this had to happen as he had not received ACCT case co-ordinator training since his temporary promotion. He said he was due to complete the training in October 2023, some three months after he was temporarily promoted.
80. It is poor, and potentially dangerous, practice to temporarily promote staff without providing them with sufficient knowledge to fulfil the responsibilities of the role. We make the following recommendation:

The Governor should ensure that temporarily promoted staff have sufficient knowledge to complete the duties they will be mandated to undertake.

Assessment of risk

81. PSI 64/2011 requires all staff who have contact with prisoners to be aware of the triggers and factors that might increase the risk of suicide or self-harm. Staff judgement is fundamental to the ACCT system which relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. While a prisoner's presentation is important and reveals something of their level of risk, it is only one piece of the evidence in assessing risk. Staff should make a considered, objective evaluation of all known risk information when assessing the risk of suicide and self-harm.

82. Prison and healthcare staff failed to consider fully the impact of the breakdown of Mr Byrnes' relationship with his ex-partner on his risk of self-harm and suicide. A nurse recorded on 19 July that Mr Byrnes had previously attempted suicide following a relationship breakdown, but staff did not discuss this at his ACCT case review. The ACCT assessment identified relationship breakdowns as a trigger and staff should therefore have explored this in more detail to mitigate the risk.
83. Staff also failed to assess Mr Byrnes' risk accurately at his ACCT case review on 20 July, despite evidence that his risk of suicide and self-harm had increased. Mr Byrnes' relationship with his ex-partner had not improved and night staff had recorded that he had spent much of the night crying. A SO told us that he could not recall reading anything of concern in the ACCT record before the review and although Mr Byrnes mentioned having an argument with his ex-partner, he thought his main concern was to move to another prison.
84. The SO told us that attendees decided to reduce Mr Byrnes' observations as he was nearing his release date (due in October), presented as forward-planning and he had not reported thoughts of suicide and self-harm. We consider that the ACCT case review panel prematurely reduced Mr Byrnes' observations and relied too heavily on what he said, and too little on the other information available to them.
85. At interview, the Head of Safer Custody told us that while the prison tried to use single case managers, a shortage of supervising officers at the time meant that it was not possible. He said that, with support from the national safety team, staff had had training around the recording of observations and that the prison's safety team conducted weekly quality assurance checks. However, despite this process being in place when Mr Byrnes died, there remained deficiencies in his ACCT, which suggests it requires improvement.
86. While we cannot know whether more frequent observations would have changed the outcome for Mr Byrnes, it would have given staff the chance to monitor his emotional response more closely. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide and self-harm in line with national instructions, including that staff:

- **conduct detailed ACCT assessments that take account of all background information, including ACCTs within the post-closure period.**
- **add all support actions to the care plan ensuring that are specific and meaningful, aimed at reducing risk, and update them at each review;**
- **ensure a consistent case management approach to ACCT by allocating a sole case co-ordinator; and**
- **consider all relevant factors when assessing a prisoner's risk factors and not rely solely on their behaviour and comments when deciding to reduce observation requirements.**

Psychoactive substances

87. Post-mortem toxicology results found the presence of psychoactive substances in Mr Byrnes' system. However, the post-mortem report was unable to determine when or in what quantity Mr Byrnes took psychoactive substances or whether he had experienced any adverse effects from them when he died. The pathologist did not find that substance misuse contributed to Mr Byrnes' death.
88. Healthcare staff asked Mr Byrnes about his substance misuse when he arrived at Liverpool. He did not disclose any information to indicate the need for an urgent substance misuse referral. There was also no evidence in Mr Byrnes' prison records to indicate that staff had seen him under the influence of illicit substances or that he was involved in the prison's illicit drug trade.

Governor to note

CCTV evidence

89. PSI 58/2010 states that the PPO must have unfettered access to evidence for their investigations.
90. Prison staff were unable to provide the investigator with CCTV footage of the emergency response on 21 July. A CM told the investigator that although staff downloaded the footage within the 12-day window in which it was available before being automatically deleted, it later became apparent that it did not play. She said that by the time staff realised and tried to download the footage again, they could only go back to 11.30pm on 20 July. We have therefore not been able to check the timing of events and details of the staff statements and transcripts against the CCTV footage.

Head of Healthcare to note

Cardiopulmonary resuscitation

91. European Resuscitation Council Guidelines 2015 (updated in 2021) state that resuscitation should not be attempted when there is clear evidence that it will be futile. A nurse identified that Mr Byrnes had stopped breathing, did not have a pulse and that his lips and tongue were blue/purple. However, she told us that she did not consider stopping resuscitation as she considered that she had to continue CPR until paramedics arrived and that it was not her decision to stop. She also said that she was not aware of the guidelines about when not to perform CPR.
92. The clinical reviewer considered that the emergency response was not equivalent to that Mr Byrnes would have expected to have received in the community as available equipment, namely a defibrillator, was not used and the nurse was not aware of guidance to support the decision-making process when deciding to perform CPR.

Inquest

93. At the inquest, which took place on 30 April 2026, the Coroner concluded that Mr Byrnes died by suicide.

**Prisons &
Probation**

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