

**Investigation into the circumstances surrounding the death  
of a man  
at HMP Liverpool in April 2008**

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

**February 2009**

This is the report of an investigation into the circumstances of the death of a man at HMP Liverpool. The man was a Latvian national who had come to Britain eleven years earlier and who was serving a short sentence for theft. He was found hanging in his cell on 22 April 2008. The man was 28 years of age and had two young children. I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried by one of my colleagues. A clinical review was carried out by Liverpool Primary Care Trust.

I would like to thank the Governor of Liverpool, and his staff for their help and assistance during the course of this investigation.

The man had been at HMP Liverpool for less than a month at the time of his death. At that point he had served 41 days of a sentence of just 120 days duration. During that time, the man had seemed reluctant to engage in education and staff had spoken to him about this. His continued refusal to attend classes had led to him being put onto basic regime a few days before his death. Apart from that there is nothing to indicate that the man was having any particular difficulties, despite the fact that his family ties were in Kent and he had been transferred far from home. At the time of his death he had only 19 days imprisonment remaining before his release from custody at the half-way point in his sentence.

The man left no note to explain his actions, and this investigation has revealed little that might indicate a motivation. The post mortem suggests he had engaged in sexual activity shortly before his death, but there is no evidence that this was other than consensual. My report makes one recommendation. This is a national recommendation about contact with families following a death in custody.

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

**February 2009**

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## SUMMARY

The man was born in Latvia in 1980. He came to England with his mother when a teenager and they settled in Kent. At college, the man met his partner with whom he had two young children.

On 13 March 2008, the man attended Canterbury Magistrates' Court where he was found to have breached the conditions of a 120 days suspended sentence imposed for theft. The effect of the breach was for the suspended sentence to become activated. The automatic release date for the sentence was 11 May 2008. This was the man's first time in custody.

Due to overcrowding of prisons in London and the South East, the man was sent to HMP Blakenhurst in Worcestershire. He remained in Blakenhurst until 26 March when he was transferred to HMP Liverpool.

As a convicted prisoner, the man would normally be required to engage in some purposeful activity such as work or education. When he reached Liverpool the man was given a place in education. The man's records show that he was a well-behaved prisoner with all staff describing him as quiet and polite. He spent his association time playing chess and cards with two other East European prisoners (one also from Latvia and the other from Georgia).

There was an area where the man's behaviour fell below acceptable standards, however. This was his engagement with education; his records show that he regularly missed classes. On one occasion he was warned that if he continued to miss classes he was liable to lose privileges. Despite the warning, the man again missed a class and on 19 April his entitlement to privileges was reduced to basic level for seven days. To help manage this change in regime the man was moved to a new landing of the prison wing.

At about 2.00am on 22 April, staff responded to calls for help from the man's cell-mate. He had woken to find the man hanging from a ligature tied to a pipe on the cell wall. Officers went into the cell and were quickly joined by healthcare staff followed by ambulance paramedics. Examinations indicated that the man had died some time earlier. It was around 19 hours later that the man's family were informed of his death.

By the time of his death the man had just 19 days remaining to serve before his release from custody at the half-way point.

My investigation found that there were no indications to staff or other prisoners that the man was contemplating taking his life or that he felt depressed. The decision to place the man onto a lower level of privileges was reasonable given that he kept refusing to attend education classes. I have asked the Prison Service to consider amending its instruction to prisons concerning the breaking of news to the bereaved relatives. There was too long a delay in informing the man's partner and mother of his death.

## THE INVESTIGATION PROCESS

1. My investigator first visited Liverpool on 25 April 2008 when he met the governing Governor, the Head of Residence, the Head of Safer Custody and a representative from the Prison Officers' Association. My investigator also met the Chair of the Independent Monitoring Board as well as the Coroner's Officer. My investigator was given contact details for the police investigators (the police always carry out their own investigation following a death in prison custody which precedes my investigation).
2. My investigator interviewed seven members of staff from Liverpool and two staff from other prisons who were involved in contacting the man's family after his death. My investigator spoke to four prisoners. No other prisoners came forward in response to the posting of notices about the man's death.
3. Liverpool Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Liverpool prison.
4. One of my Family Liaison Officers contacted the man's mother and his partner. My Family Liaison Officer and investigator later visited the man's partner at her parents' home in Gravesend in Kent. Her parents were at the meeting as was her community support worker. The man and his partner have two young daughters but they were not at the meeting.
5. The man's partner explained that they met at a basic skills course they were both doing at a college in Kent. She said the man had grown up in Latvia and came to the UK with his mother when he was 17. She described him as a very shy and timid person. She said that he would not go out of his way to speak to someone he did not know and nor would he usually ask others for help. She said the man was embarrassed about his command of English, which often led to him making the excuse that he was not bothered or interested in doing his course work. The support worker said that the man spoke reasonably good English but she agreed that he was an unassuming person.
6. The man's partner's mother said that he had sounded very upset when he last called from Blakenhurst. He told her he was happy at Blakenhurst and did not want to be moved to a different prison. The family therefore wanted to know why the man had been transferred to Liverpool given that he seemed settled at Blakenhurst.
7. The man's mother also lives in Kent. She has two other sons. The man's mother also asked about the reason for her son's transfer to Liverpool.
8. The man's partner and mother were also visited by the police investigators and my investigator spoke to the police about the meetings. Something mentioned to them by the man's partner was that he had told her that he was raped when he was 13 years old.

## HMP LIVERPOOL

9. HMP Liverpool was built in 1855 to replace a much older and more cramped establishment in the centre of Liverpool. There are eight wings, all of which are in use having been refurbished and provided with an integral sanitation system.
10. Liverpool is one of the largest prisons in England, accommodating around 1,400 prisoners. It holds category B and C convicted male adults as well as remand and unconvicted male adults. I wing, where the man was located, holds category C prisoners. (Categorisation and allocation of prisoners is central to sentence planning. The man's categorisation was considered while he was in Blakenhurst when he was classified as a category C prisoner. This indicates that he was judged as presenting a reasonably low risk of escape and a reasonably low level of risk to the public were he to escape. Category C prisoners are usually allocated to 'training prisons' where they are ordinarily expected to engage in some purposeful activity such as taking a prison job or going to education.)
11. The most recent inspection of Liverpool by Her Majesty's Chief Inspector of Prisons was an unannounced follow-up inspection in February 2007. The Chief Inspector's findings included:

“The incentives and earned privileges scheme was almost entirely related to behaviour rather than compliance with sentence plan targets or other goals. A single clearer system now operated throughout the prison ...

“In our survey, 73 per cent of prisoners ... said they were treated with respect by most staff. At 67 percent, the figure was lower among black and minority ethnic prisoners but this was a significant improvement [from the time of our last inspection] ...”
12. In common with all prisons, Liverpool runs an Incentives and Earned Privileges (IEP) scheme. The IEP scheme aims to encourage and reward responsible behaviour on the part of prisoners as well as effort and achievement in work and other constructive activities. Privileges above the minimum entitlement, such as more time out of cell for association, are earned by prisoners through good behaviour and performance. Privileges are removed if the prisoner fails to maintain acceptable standards. The IEP scheme at Liverpool has three levels: basic, standard and enhanced. On entering custody, prisoners are placed initially on the standard privilege level with a review undertaken within the first month. When a prisoner has consistently achieved the type of behaviour and performance specified in the local scheme, he or she may advance to the level above. If the prisoner's behaviour or lack of progress demonstrates that he or she cannot sustain his current privilege level, he may be downgraded to the level below.
13. Prior to the man's death, there had been 12 apparently self-inflicted deaths at Liverpool prison since April 2004. No matters arising in those cases were of direct significance to the circumstances surrounding the man's death.
14. The Independent Monitoring Board's report for the year 2007/2008 again contains no matters significant to the man.

## KEY FINDINGS

15. In October 2007, the man was arrested and charged with attempted theft. He was later convicted of this offence at Canterbury Magistrates' Court and sentenced to 120 days imprisonment, suspended for 12 months. The man returned to Canterbury Magistrates' Court on 13 March 2008, charged with breaching the conditions of his suspended sentence. As a result, the original 120 day sentence was imposed and he was ordered into prison custody. The man's release date for the sentence was 11 May 2008.
16. After spending the night of 13 March in police custody, the man was taken to HMP Blakenhurst, a category B local prison in Worcestershire. This was his first time in prison custody. The reason he was sent to a prison in the Midlands was due to overcrowding of prisons in London and the South East. On arrival at Blakenhurst, the man received a standard First Reception Health Screen interview with a nurse. The man reported that he was asthmatic for which he was taking prescribed medication. He declared no other medical problems. He said that he had never been treated for mental health problems, that he had never tried to harm himself and that he had no present thoughts of self-harm.
17. My investigator obtained recordings of the telephone calls made by the man while he was in Blakenhurst. All four of his conversations were with his partner's mother as his partner was not at home when he telephoned. My investigator considered the man's English to be of a good standard. He also thought that the man sounded untroubled about being in prison and about his sentence – he said that he had been given 120 days but would only have to serve half of that time. His partner's mother asked the man what he was doing with his days and he replied that he was doing nothing. He compared being in prison to being on holiday. He also mentioned that he was enjoying the prison food. Towards the end of the man's time in Blakenhurst an officer there noted him to be a quiet individual about whom the officer had no concerns.
18. The man was transferred to HMP Liverpool on 26 March. The reason for the transfer was probably due to overcrowding in Blakenhurst. However, the consequence was that he was now held in a prison about as far as his home in Kent as it was possible to be. The man received a reception health screening assessment on arrival at Liverpool which indicated no health concerns. He was then located into a cell on the fourth landing of I wing.
19. Entries made in the man's records at Liverpool show that in the week commencing Monday 7 April he missed going to education on Monday, Wednesday and Thursday. On Thursday 10 April, a Senior Officer (SO) warned the man that if he continued to miss education classes his Incentives and Earned Privileges (IEP) status would be reviewed. The man signed to acknowledge receipt of the written warning which explained:

"It has been brought to the attention of the ... Wing Manager that your behaviour is unacceptable ...

"You have been seen and advised by ... officers on a number of occasions and given the opportunity to improve. You have failed to do so ...

“You are now being given a final written warning ... This means that if your unacceptable behaviour continues, you will be placed on Basic Regime ...”

20. The following day, an officer made an entry in the man’s records: “Although quiet and polite I have had a chat with the man about wing rules and attending work ...” At interview the officer described the man as very quiet, polite and amenable. He spent a lot of time playing chess with two other East European prisoners on the landing and would continue playing right up until lock-up time. Other than telling the man when it was time to return to his cell for lock-up, the officer’s only substantial interaction with him was about attending education. The officer said that when asked why he was missing classes, the man just shrugged his shoulders. The officer reminded the man that he was on a final warning for missing education. His impression was that the man saw no point in going to the classes. The officer said that he was shocked when he subsequently heard of the man’s death.
21. A second officer told my investigator that he had quite a few interactions with the man while he was on the fourth landing. He said that he was the ‘movements officer’ on quite a few occasions around this time. As movements officer his role was to find out who was and who was not going to work. The man’s name arose quite frequently as a person who was missing education. The officer would ask him why he had not gone to education, to which the man would reply that he did not want to go without elaborating any further about his reasons. The officer said that apart from that aspect of the man’s conduct, he was a very well behaved prisoner. He was quiet, and always polite and respectful to both staff and other prisoners.
22. The man again missed education on 18 April resulting in an IEP review the following morning. The review was carried out by a senior officer and a third officer. At interview, the senior officer said that when he asked the man why he missed education the previous day he replied that he had overslept. The senior officer told the man that his excuse was unacceptable and that his IEP status would be reduced from standard to basic for one week. The senior officer said that the review lasted just a few minutes. He added that while some prisoners can react aggressively to having their IEP status reduced, the man seemed unconcerned at the decision.
23. A third officer told my investigator that he worked on the first landing on I wing. As the man was located on the fourth landing, the IEP review on 19 April was their first meeting. The officer gave similar evidence to the senior officer about the man’s explanation for missing education and his apparent lack of concern on being told that his IEP level would be reduced for seven days.
24. One of the outcomes of being lowered to basic status was a reduction in the time the man was allowed out of his cell. In order to help manage this aspect of the man’s new regime, he was moved to a new cell on the first landing on I wing (cell 1-28).
25. When the man moved down to the first landing another officer became his new personal officer. On 20 April, the personal officer recorded that: “the man is letting himself down by failing to attend education. This is an area he needs to focus on.” The personal officer told my investigator that he went to see the man that day to introduce himself and to explain his expectations about standards of

behaviour. The personal officer asked the man why he had been put on basic regime. The man replied that he had not been going to education but that he was now planning to do so. The conversation only lasted a minute or two. That was the only interaction that the personal officer had with the man.

26. A fourth officer told my investigator that he normally works on the fifth landing on I wing and therefore had little direct contact with the man. However, at around 5.00pm on the afternoon of 20 April he was helping unlock cells for prisoners to collect their evening meals. When he unlocked cell 1-28 the man said that he was not hungry. The officer tried to tempt the man by saying that there were some nice things on the menu, but the man repeated that he was not hungry. The officer looked at the man's records and saw that he was on basic regime. This surprised the officer as his understanding was that the man was a well-behaved prisoner. The officer asked the man why he was on basic regime. The man said that it was because he was not going to education. The officer asked him if he would now start attending classes and the man said that he would. The officer told my investigator that the man seemed fine; there was nothing about his demeanour to give any cause for concern. The officer added that it is not particularly unusual for prisoners to refuse meals. They might instead eat canteen items that they have purchased<sup>1</sup>. They might also eat their breakfast packs which are distributed in the evening.
27. Nothing of note appears to have occurred for the following 24 hours. The man's cell-mate had been put on basic regime the same day as the man. One of the consequences was that they would have spent most of their time locked in their cell. At 6.45pm on 21 April, the second officer noted that the man's cellmate called him to the cell to say that the man had not had his canteen sheet for the week ahead. The officer told the man's cellmate that it would not be possible for him to obtain a canteen sheet at that time in the evening, but he would collect one first thing in the morning. The man was sitting on his bed and he nodded his head indicating to the officer that he was satisfied with the explanation.
28. A fifth officer told my investigator that a little after 8.00pm on 21 April a cell bell call was made from cell 1-28. When the officer went to the cell the man's cellmate asked for some hot water. The officer refused his request and told him that the cell bell should not be used for trivial reasons. The officer said that the man was at the back of the cell laughing at the conversation.
29. My investigator spoke to several prisoners who had had contact with the man. One of the prisoners is from Georgia and was on the fourth landing at the same time as the man and another prisoner also from Latvia. He said that the three of them played chess and cards together. The man did not speak about his plans for the future, although he spoke a little about his family and was upset about being separated from them. The prisoner from Georgia said that he was very surprised at the man's death as he had never said or done anything to make him fear for his safety. He said that people would have helped the man if he had asked, but the only thing he ever asked for was cigarettes. The prisoner added that the staff at Liverpool treated them well. He also said that the man was not frightened of the other prisoners.

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<sup>1</sup> The word canteen refers to the prison shop. Prisoners are able to spend their own money on items such as cigarettes and sweets. They submit their orders by completing canteen sheets.

30. The other prisoner from Latvia had been discharged from prison by the time this investigation was underway. My investigator sent a letter, translated into Russian<sup>1</sup>, to the discharge address to ask for his observations. Unfortunately, he has not responded.
31. My investigator spoke to two prisoners who shared a cell with the man while he was on the fourth landing. Both of these prisoners are of British origin. Both reported having no problems sharing with the man, but they also said that he hardly spoke.
32. The prisoner, who shared cell 1-28 with the man from 19 April, told my investigator that he and the man had little conversation in the time they shared. His cell-mate tried to speak with the man but he would usually reply with very brief answers before continuing to read his book. He said that the man had a lot of books. One of the books was about executions at Liverpool prison in the days of capital punishment (this book was still in cell 1-28 when my investigator first visited Liverpool). The cell-mate said that the man could speak English, but he was not fluent which was why he (the cell-mate) intervened in alerting the second officer that the man had not been given a canteen sheet. The cell-mate added that on the Saturday (19 April) the man declined lunch saying that he was not hungry. When the cell-mate spoke to him further about this, the man admitted that his reason for declining lunch was that he did not have a plate. It seemed to the cell-mate that the man was embarrassed about approaching staff about this. The cell-mate collected a plate for him so he could obtain his tea-time meal. The cell-mate added that the man's death was a complete shock as there was never anything about his demeanour to suggest he might be thinking of doing such a thing.
33. My investigator asked about the man's telephone usage while at Liverpool prison. He was told that the records show that the man made no calls while he was there.

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<sup>1</sup> Russian remains the common language across the former Soviet states.

## The discovery of the man's death

34. At 2.00am on 22 April, a second senior officer and the fifth officer heard a prisoner (the cell-mate) shouting for assistance. When they reached cell 1-28 and opened the cell observation flap they saw the man hanging from a ligature that had been made from a bed sheet and tied to a pipe high up on one of the cell walls (2.47 metres, or 8' 1", from the ground). The senior officer unlocked the cell door. An OSG<sup>1</sup> arrived and, between the three staff, they radioed for further assistance as well as cutting the ligature and lowering the man to the floor. At this point a nurse arrived. Her subsequent notes included:

“Called at [approximately 2.00am ... Checked for vital signs; none present – fixed dilated pupils, no respiration, no pulses. Stiffness around neck, extremities cold to touch. Connected [defibrillator<sup>2</sup>] no shockable rhythm present. Went to commence [cardio pulmonary resuscitation] and paramedics arrived and took over. Pronounced life extinct at [2.10am] ...”

## After the man's death

35. The duty governor was contacted at home and arrived in the prison within around 30 minutes of the man's death. The duty governor spoke individually to all members of staff to check whether they needed any immediate care. The duty governor also held a debriefing meeting before staff went off duty. She told them about the help available from the prison's care team.
36. The cell-mate was extremely upset about what had happened. He was initially taken to the staff rest room, after which he was taken to a care suite and two prisoner Listeners<sup>3</sup> were brought to sit with him. (I note the contradiction in the clinical review reporting the Head of Healthcare's surprise at the cell-mate's apparent lack of distress when she saw him.)
37. The man's nominated next-of-kin was his partner. She lives in Kent, as does his mother. Due to the distance between the prison and the homes of the two families, Liverpool's head of residence contacted HMP Rochester. The head of residence spoke to the duty governor at Rochester, to ask for staff from that prison to break the news. The head of residence asked the duty governor at Rochester to give the families his telephone number so he could deal with all the questions they were likely to ask.
38. The visits were not made until very much later that day and my investigator spoke to Rochester's duty governor to ask about the reasons for the delay. The duty governor agreed that it was in the early morning that she was first contacted by Liverpool. It was after midday, however, before the local police force confirmed that there was nothing on record about the two family addresses to indicate any potential security problems for staff. By that time Rochester's family liaison officer (FLO), who had been due to make the visits, was no longer

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<sup>1</sup> Operational Support Grade (OSG) staff do not receive the same level of training as Prison Officers. They carry out tasks that do not involve a great deal of prisoner contact.

<sup>2</sup> A defibrillator measures electrical activity in the heart and issues audible instructions about treatment, for instance whether or not an electrical shock should be given.

<sup>3</sup> Listeners are prisoners trained by the Samaritans to provide emotional support to other prisoners.

available. This was because he was travelling that afternoon to join a residential training course. The duty governor and the FLO telephoned several other local prisons to see if they had any trained FLOs who could make the visits. Rochester met with no success either with those enquiries or with enquiries to the local area office.

39. The duty governor at Rochester next contacted HMP Belmarsh. They initially agreed to make the visits before later withdrawing their offer to help. The reason for the change of mind was that the duty governor there thought that a lot of time had already passed since the man's death and it would be unfair for Belmarsh's FLO to have to take any blame from the families for the delayed notification.
40. Rochester's duty governor then agreed with Liverpool's duty governor that the police should be asked to visit the families. Shortly after agreeing on this, Liverpool's Head of Safer Custody rang back to say that the visits should not be made by the police but rather by prison staff. The duty governor at Rochester agreed that she would make the visits with one of their chaplains. They arrived at the man's partner's home around 8.45pm and reached the man's mother's home at about 9.30pm.
41. Liverpool subsequently liaised directly with the funeral directors about the man's funeral arrangements.

#### **Other matters**

42. The findings at the man's post mortem included indications that he had engaged in sexual intercourse in the last several hours before his death. No injuries or bruising were found to suggest that the man had struggled or been forced to engage in sexual activity against his will. When the police interviewed the man's cell-mate about the findings he told them that he and the man had commenced a consensual sexual relationship.
43. The police interviewed some of the prisoners who had previously shared with the cell-mate. They found no evidence to cause them to doubt the cell-mate's evidence about the consensual aspect of his sexual relationship with the man and no charges are to be brought against him.
44. While wishing to avoid a direct inference, I consider it appropriate to repeat here the report from the man's partner that he told her that he had been raped as a 13 year old.
45. When cell 1-28 was examined after the man's death the name Borat was found to have been written on the toilet ceiling. ('Borat' was the name used for a parochial and unsophisticated television character from Eastern Europe in a film of the same name.) I understand that the prison believes the writing to have been present for some time.
46. A matter of which my investigator was made aware after the man's funeral was that his mother was having difficulty in coming to terms with his death because she had not had the opportunity to view his body. The man's coffin had been sealed for the funeral service and I understand that the practice within the Russian Orthodox faith – as with many other faiths – is for the coffin to be open.

For different reasons, the man's partner also regretted not having had the opportunity to view his body.

## **ISSUES**

### **The man's allocation to HMP Liverpool**

47. The man's family ties were in Kent. Despite that, he was held first at Blakenhurst in the Midlands and then in HMP Liverpool. I do not know if this was relevant to his death, but it is self-evidently destructive of family ties if prisoners are held so far from home. I understand the man received no visits at Liverpool and I know that he made no telephone calls.

### **The reconsideration of the man's IEP level**

48. Prison Rules require every prison to provide a system of privileges that can be granted to prisoners in addition to their minimum entitlement. The system used for this is the Incentives and Earned Privileges (IEP) scheme. Privileges above the minimum are earned by prisoners through good behaviour and performance and are removed if they fail to maintain acceptable standards.
49. All of the evidence indicates that the man was a well behaved and polite man. However, he frequently missed going to education and a number of entries were made in his records about this. The senior officer gave the man a final written warning on 10 April explaining that if his behaviour continued that way he would be placed on basic regime. The man was spoken to the following day and reminded that he was now on a final warning.
50. The man was again noted to have missed education on 18 April. The matter was considered at an IEP hearing on 19 April. When asked by the senior officer why he missed education the previous day, the man replied that he overslept. The senior officer decided that the man's status should be reduced from standard down to basic for seven days. As a matter of good practice, the Governor will wish to satisfy himself that there are no indications of bias in Liverpool's operation of the IEP scheme on grounds of ethnicity or nationality. He may also wish to benchmark his prisons use of the IEP scheme against that in similar prisons. However, on the facts as I know them I am satisfied that it was a reasonable decision to reduce the man's IEP level. It is worth remarking that there is nothing to indicate that this decision caused the man any particular concern.

### **Did staff miss any signals that the man might have been at risk?**

51. The man made no telephone calls while in Liverpool but he made several calls while at Blakenhurst. My investigator obtained and listened to a recording of these calls. The man gave no indications in any of these calls that he was distressed about being in prison. When asked what he was doing all day he said that he was doing nothing and was enjoying the 'holiday'. My investigator thought that the man spoke clear English and had a reasonable vocabulary. There should therefore have been no language barriers to prevent him from discussing any concerns with staff.
52. If the man did have any concerns it might have been his temperament that proved the barrier to seeking help. His partner described him as very shy. She said that he would not go out of his way to speak to someone he did not know; nor would he usually ask others for help. This personality trait might well have

been the explanation for two incidents that occurred after the man moved down to the first landing at Liverpool. His new cell-mate intervened twice to help him. The first time was to obtain a plate for the man. He apparently declined lunch on 19 April claiming not to be hungry, but subsequently confessed to his cell-mate that he declined lunch as he had no plate. The cell-mate thought that the man was too embarrassed to ask the officers to supply one. The second incident was when the cell-mate intervened to tell an officer that the man had not been supplied with a canteen sheet for the week ahead.

53. The Georgian national prisoner, who associated with the man when he was on the fourth landing, said that his friend never gave any signals that he might have been at risk. Nor did he ever ask for help.
54. The evidence given by staff indicates that the man's behaviour remained consistent throughout his brief time in Liverpool. All spoke of him as a very quiet and polite individual. I have found no evidence that the man gave any signal or warning to alert either staff or fellow prisoners that he might be at risk.

### **The time taken to inform the man's family of his death**

55. Prison Service Order (PSO) 2710 deals with contact with families following a death in custody. The guidance includes that:

“The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated Family Liaison Officer working alongside a chaplain, or Governor or most senior individual available together with the chaplain ...

“If distance from the prison presents a problem, a dedicated Family Liaison Officer or chaplain based in the [prison] nearest the family home could inform the family face to face ... This individual must give the family contact details at the establishment where the death occurred and the visit should be followed up by that establishment as soon as possible.”

56. The two people who needed to be notified of the man's death were his partner and his mother, both of whom live in Kent. Because of the distance involved Liverpool made contact with the prison closest to the family homes, HMP Rochester. The duty governor there agreed that Rochester would make the visit. Before visiting family homes prisons always make security checks, usually through the prison based police liaison officer, to ensure that staff are not at jeopardy. It took some time for the security checks to confirm that it would be safe for staff to visit. By then, Rochester's FLO was no longer available and the duty governor spent much time in pursuing various other options, as described earlier in my report. Eventually it was she and one of Rochester's chaplains who made the visits: at 8.45pm to the man's partner, and 45 minutes after that to his mother.
57. It should not have taken so long for these visits to be made. I appreciate that Rochester is a small establishment which does not have the staffing levels found at larger prisons. Nevertheless, once Rochester agreed to Liverpool's request, it became their responsibility to carry out the duty with the same speed and efficiency as would be expected in the case of a death of one of its own prisoners. And one of the consequences of the present overcrowding within the

prison estate is that many prisoners find themselves located in a prison at a great distance from their family home.

**I recommend that the Prison Service consider amending PSO 2710 to stress that a prison taking on from another the responsibility of breaking the news of a death in custody has a responsibility to do so efficiently and expediently.**

## RECOMMENDATIONS

The following recommendation, and two best practice recommendations made by the clinical reviewer, appeared in the draft version of this report. The Prison Service's responses are included in italics:

1. I recommend that the Prison Service consider amending PSO 2710 to stress that a prison taking on from another the responsibility of breaking the news of a death in custody has a responsibility to do so efficiently and expediently.

*Prison Service response: Recommendation accepted. Safer Custody and Offender Policy Group are planning to issue a protocol, endorsed at a Director level, to Area Managers, Governors and Family Liaison Officers which will make clear the procedures to follow when one establishment asks another to inform a family of a death in custody. Date for implementation is January 2009.*

The two best practice recommendations from the clinical reviewer were for consideration by the PCT and the healthcare team at Liverpool. These were:

2. That consideration be given to conducting a brief mental health assessment on prisoners located into a basic cell.

*Prison Service response: Best practice recommendation accepted locally. This may involve issues around medical confidentiality. However, the establishment will discuss the idea with the PCT for managers to contact the on duty healthcare officer and make an assessment based on medical records if basic conditions will present a problem for a prisoner being moved to a basic cell after an IEP board decision. Target date for completion is 1 December 2008.*

3. All healthcare team members' designations need to be illustrated in the electronic IMR.

*Prison Service response: Best practice recommendation has been accepted and implemented. This will be reviewed on 1 December 2008 to ensure process is being adhered to.*

In addition to the above, the Prison Service also responded to the comments made in paragraph 50 of this report. The Service's response on this was that the IEP scheme at Liverpool was subject to quality checking by managers and the scheme includes an appeal process. Liverpool has agreed to consider benchmarking its scheme against schemes in similar prisons.

## COMMENTS FROM THE MAN'S FAMILY IN RESPONSE TO THE DRAFT REPORT

In accordance with set procedures, copies of this report were sent in draft form to the man's family as well as to the Prison Service and HM Coroner.

Through her community support worker, the man's partner questioned how it was that the cell-mate failed to hear anything when her partner hanged himself. She also questioned why he waited so long before raising the alarm.

The man's partner questioned whether the word Borat was written in the cell before her partner was transferred to that cell. She also said that he was looking forward to returning to the family and their new home so she was certain that he would have left her a note to explain his actions.

Finally, she was adamant that her partner was not homosexual and would not have willingly had sexual intercourse with a male.

The man's mother did not respond directly to this office following issue of the draft report to her. However, she was visited by one of HM Coroner's officers who took a statement from her. The statement included that:

- When my boys were young, back in Latvia, we lived together as a family unit, with my mother, my son's grandmother. She moved in to my home when my father died. I looked after her as she suffered from heart disease.
- Prior to my son's death, I had not seen him for three years.
- My son never told me of being raped by anyone.
- My son was not homosexual, he had had children with his partner.
- I have concerns regarding my son's imprisonment. I do not understand why he was sent to HMP Liverpool, a Category B Prison, when he was a non violent offender. HMP Liverpool is so far away from where the family live it made things very difficult.
- I am concerned that it took so long for the Prison Service to tell me and my family of my son's death. It took 19 hours. We were later told that more information would be made available to us but that information never materialised.
- I am also saddened that I was unable to hold an open coffin funeral as is normal in my culture. I feel that I have not been able to say goodbye properly.