

**Report of the investigation into the death of
a male prisoner at HMP Liverpool in June 2005**

Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at HMP Liverpool in June 2005. The man was found hanging in his cell in healthcare at approximately 4.15pm that day.

I offer my sincere sympathy and condolences to the family of the man who have suffered the tragic loss of a loved one. Prisoners and staff at Liverpool who had met the man also expressed their sympathies. The man was a very vulnerable man who had been considered as at risk of suicide or self harm in each of the prisons in which he served his sentence.

The man died six days after Liverpool adopted the ACCT (Assessment, Care in Custody and Teamwork) approach to the care of those at risk of suicide and self harm. The investigation reveals failures in that system at the time of the man's death. This report also focuses on the decision to locate the man alone in his cell. At the time I issued my draft report a clinical review had yet to be received. This has now been received and notes that the mental health services were not involved in or informed about the key decision to move the man into a single cell. They have made a number of recommendations that I urge the prison to consider.

The investigation was carried out on my behalf by Mr T Wright. I am grateful to the Governor and all Liverpool staff for their willing cooperation.

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Prisons and Probation Ombudsman

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SUMMARY

This is the report of an investigation into the death on 11 June 2005 of a male prisoner. The man died in the Healthcare Centre at HMP Liverpool where he was serving a prison sentence.

The investigators reviewed the man's records and spoke to a number of staff and prisoners. The man had a long criminal history and had been to prison before. He had been in prison custody on this occasion since 31 July 2002. The man had abused a variety of substances and had mental health problems. He had a history of mental instability and had self harmed in the past. He was considered to be a suicide risk, and a suicide prevention document was opened for him at each of the prisons where he had served his current sentence.

The man was received into Liverpool prison on 3 June 2004, and was being treated for his medical problems, which included a pain in his head that would not go away. He continued to experience mental health problems and received treatment for these.

On 13 May 2005, the man seriously self harmed and was sent to outside hospital for treatment. While there, he told his visitors that he intended to kill himself in the not too distant future.

On 10 June, the man became extremely agitated while in his shared accommodation. He was given some medication to calm him, moved to a single cell, and was put on a constant watch until his condition improved. Later that day, a doctor decided that the man could be kept in a single cell if necessary. It is possible that this decision – which may have been made without full knowledge of the circumstances and without interviewing the man – was flawed. Healthcare staff decided that the man should indeed remain in the single cell. No risk assessment was carried out, and the suicide prevention arrangements under the ACCT process, including the previous ACCT observation schedule, were not reviewed to see what additional support the man might need in a single cell.

At approximately 4.15pm on 11 June 2005, the man was found hanging from the door to the toilet area of his cell in the Healthcare Centre by an agency nurse. Other staff were alerted and cardio pulmonary resuscitation (CPR) was started. Healthcare staff and a paramedic team attended the man, but efforts to revive him were unsuccessful and he was pronounced dead at 4.35 pm. I find that staff arrived as soon as possible and did all they could to save the man's life.

The prison subsequently provided support to prisoners and staff. The Governor and the prison chaplain personally broke the sad news to the man's family.

The report makes four recommendations. The clinical review identifies a number of learning points and I urge the Primary Care Trust in partnership with the Prison to consider these fully.

THE INVESTIGATION PROCESS

1. The investigation was opened on 15 June 2005. My investigators met with the deputy governor and other senior staff. They were later given a helpful and comprehensive briefing on the events leading up to and after the man's death. Ombudsman's notices were issued to staff and prisoners, identifying the scope of the investigation and inviting anyone who wished to see the investigators to make themselves known. My investigators visited Liverpool on 22 and 23 June, and again on 28, 29 and 30 June.
2. Staff and prisoners in key positions or locations were identified and were invited to speak to the investigating team. All responded willingly. The local branch of the Prison Officers' Association was briefed on 15 June. The representatives were helpful and offered constructive comment and advice. My investigators spoke with the chair of the Independent Monitoring Board on several occasions and found his advice and assistance to be very valuable.
3. The Coroner's office was contacted and additional information was provided.
4. A Family Liaison Officer from my office in the company of one of the investigators visited the man's sisters. They were later joined by his brother-in-law. The family raised a number of issues of concern which I hope are covered in this report.

HMP LIVERPOOL

5. Liverpool prison, also called Walton, was built in 1855. The site covers 22 acres and has a single capped security wall. It is a local establishment serving the Merseyside and Wirral area. It accommodates category B convicted male adults and unconvicted men held on remand. On 16 June 2005, HMP Liverpool held 1,371 men in custody. It has a certified normal accommodation figure of 1,186 and an operational capacity (maximum crowded capacity) of 1,473.
6. Liverpool was last inspected by HM Chief Inspector of Prisons in September 2004. The Chief Inspector found that, while there had been improvement since the previous inspection, the prison was not thought to offer a safe environment for prisoners. The Chief Inspector said that bullying and drugs were rife and that staff needed to develop skills, and assume responsibilities, for managing prisoners who were not locked in their cells for most of the time. Her report said that the establishment's suicide and self harm policy was clear and widely understood. However, it was felt that the level of staff training in this area was low.
7. The F2052SH system for supporting suicidal and self harming prisoners was replaced by ACCT (Assessment, Care in Custody and Teamwork) on 5 June 2005. This was later than the planned date of 1 April. It is understood that one of the reasons for this was to allow staff training to be brought to the required level. By the start date, there were 431 staff trained to foundation level including 33 staff in the Healthcare Centre. There were 68 case managers trained including nine in Healthcare, and 42 assessors trained (six in Healthcare). The requirement was that all staff and prisoners were to be aware that the change was to take place, be familiar with ACCT and be aware of their role in the process. This first phase of training prioritised first line staff, giving good cover to the residential areas of the prison. Not all staff had been formally trained on 5 June, but subsequent training added another 118 by 18 October, including clerical staff.
8. There had been two earlier deaths in Liverpool prison during 2005: that of a prisoner who died of natural causes and a prisoner who was found hanging. In December 2004, there were two deaths, one from natural causes and one of a prisoner who was found hanging. In the investigation of the apparently self inflicted death, it was found that individual members of staff provided a high standard of care, support and monitoring for the prisoner while he was in the residential wing.
9. It is understood that a number of changes have been made to ACCT arrangements at Liverpool in the light of these deaths. They include the appointment of a second full time suicide prevention co coordinator. A second family liaison officer has been nominated. A suicide prevention action plan is being worked up for inclusion in the prison's Performance Improvement Plan.
10. The healthcare facilities at Liverpool prison are provided by North Liverpool Primary Care Trust.

KEY EVENTS

11. The man was received into Liverpool on 3 June 2004, having been in prison custody since 31 July 2002. He began his sentence at HMP Altcourse, spending time at HMP Wymott and HMP Acklington. The man was underweight and appeared to be in poor physical health. It would seem that his transfer to Liverpool was prompted by the need for him to be in an establishment with a full time healthcare facility.
12. Throughout his time in prison, the man had experienced depressive symptoms, and had self harmed a number of times by cutting his arms. He had periods when he heard disembodied voices, and at times exhibited symptoms of paranoia. He seemed to crave the attention of others, and it appeared that cutting himself was a way to enable him to achieve this goal. F2052SH documents were opened for him at all the establishments at which he served his sentence.
13. The man complained of pains or a “blockage” in his head and neck that, despite medical investigation, could not be attributed to any physical cause. He presented with these pains nearly all the time, not only when he saw the doctor. The man told prisoners and staff that he was suffering pain on a regular basis. He often reported sick, and the main medication given to him was analgesia. The man told staff that this was having no effect on his pain, and he complained that he needed something stronger.
14. The man had visits from, and correspondence with, his sister who was guardian to one of his children.
15. He arrived at Liverpool on an open F2052SH, and was located in a general residential area of the prison. Despite what seemed to be a positive beginning, the man began to appear fearful of other prisoners. He believed that he was in danger of harm from them because of the nature of his offence, and after a short time he became withdrawn in his dealings with others. He spent a lot of time in his cell and was unwilling to communicate with prisoners or staff.
16. The man was seen by a psychiatrist and was considered to be in need of a place in the healthcare centre. He was transferred there on 7 September 2004. Initially he was put in shared cell accommodation, and while there he became more communicative and sociable with other patients and staff. However, he continued to complain about his head and neck pains and was treated with paracetamol.
17. On 9 November, the man made superficial cuts to his arms that he showed to staff. He told them that he did not feel safe and felt that other prisoners were going to hurt him. The man seems to have had a morbid fear of transfer to a residential area where he thought he might be harmed by other prisoners. This is a recurring theme in the contact records made by staff in their dealings with him.

18. On 22 November, the man was informed that his brother had died in suspicious circumstances. The man became very upset and was seen by a psychiatrist and the prison chaplain. While he was distressed about events, he did not express any thoughts of suicide or self harm to the chaplain.
19. Because of his reports of continued head pain, it was decided that the matter should be investigated further. On 7 January 2005, the man was taken to a specialist neurological centre where tests were conducted, none of which identified any physical cause for his symptoms.
20. It is noted in the man's F2052SH, that on 26 January he became argumentative and threatened that he would "... string myself up ..." if put on ordinary location. According to the accounts of staff, this is but one example of frequent comments of this nature that were made by the man (as he said things like this so often, they were not all recorded). It is not clear what triggered them, but any suggestion that he might go to a wing made him anxious. Another occasion was on 10 February when he told staff that he felt suicidal. As at other times, it appears that he was offered reassurance by staff that he could stay in healthcare and would be safe.
21. On 23 February, the man attended his brother's funeral and consequently received extra support from staff. Although the man spoke of hearing voices and having thoughts of self harm, the month of March seems to have been a relatively settled time for him. However, a little later his paranoid behaviour resumed. He was seen by a psychiatrist on 6 May, who suggested that the man's head and neck pains might be psychosomatic.
22. The man sent a letter to his sister on 4 April, in which he described the pain he was experiencing. On 13 May, the man cut his arms again, but this time so seriously that his life was threatened through loss of blood. A prison form, F213SH, was raised (this is a form on which injuries to prisoners are recorded). As he usually did after these acts, the man went to a member of staff and showed them what he had done. He received immediate attention to stem the bleeding, and treatment at outside hospital was arranged. While he was there he expressed suicidal thoughts to members of his family who came to visit him. It is understood that he said that he intended to kill himself in the not too distant future and before he was released from prison.
23. On his return to the prison, the man was seen by a clinical psychologist to whom he expressed the wish to commit suicide by hanging at an unknown point in the future. He was still very preoccupied by the pain he described as a "blockage" that he was experiencing in his head, ears and neck.
24. The man had not seen his daughter for some time. The reason for this was that the prison had erroneously attributed child protection concerns and prevented any visits. Attempts had been made earlier in the year by the community mental health team and his daughter's family support worker to arrange a visit to the prison and the

error emerged. It was said that the man's reaction to the prospect of seeing her again appeared mixed. While apparently happy and excited at first, it seemed subsequently to worry him and affect his mood in a negative way. It was suggested that the man was concerned about his daughter seeing him in the poor physical condition that he was in. It was proposed that the visit take place in early June. In the event, the arrangements for the visit did not go smoothly and, unfortunately, an attempt to arrange a special visit failed due to the non availability of a member of social services staff to accompany the child to the prison.

25. On 6 June, a nurse was given a noose by another patient who said that it belonged to the man. This was not thought to be significant, as the discovery of nooses was not an unusual occurrence. The man seemed to the nurse to be in reasonable spirits.
26. At approximately 6.00am on 10 June, the man was in his three bed room in the healthcare centre with two other prisoners. He was seen to be in a highly agitated state. He was repeatedly running and then banging his head against his locker. Staff restrained him and he was placed in the association room with members of staff. He had to be physically held in a chair to prevent him from banging his head. When the doctor arrived, the man was given medication which seemed to calm him.
27. Later he was moved to cell M2-4, where he remained with members of staff. At approximately 12.00pm, he was moved to a single cell, M1-3, with a member of staff who stayed with him on constant watch until it was thought that the man had improved. The available documentation does not indicate how long the constant watch remained in place or who undertook the observation.
28. That afternoon, the deputy in-patient manager telephoned the doctor to ask him to come and review the man to see if it was possible for him to be placed in a single cell if required. The deputy in-patient manager told my investigator that staff had concerns about the effect on other patients of seeing, or having to deal with, the man in an agitated state. In effect, they wanted to know whether keeping the man in a single cell was an option. At around 3.30pm, the doctor arrived and authorised single cell accommodation "... if needed". Subsequently the healthcare staff made a team decision that the man should remain in a single cell.
29. The doctor says that the deputy in-patient manager asked him to assess the man with a view to moving him out of the emergency cell. He saw the man in the cell, but recalls that the man was sleeping so he did not speak to him. In coming to the decision that the man could be placed in single cell accommodation if needed, the doctor says he relied primarily on the advice of the deputy in-patient manager, as he was not the man's regular doctor. He was aware that the man had been on an open ACCT and that the ACCT might still be open. He was also aware that the man had cut his arms badly on 13 May, and of his threats to kill himself on 16 May and 19 May. He had seen the man only three times in all. The doctor says the man presented a varying risk from hour to hour and day to day, and he had to trust the

staff's judgement, because he was not part of the man's day to day care. In effect, by saying that the man could be placed in a single cell, he was saying that healthcare staff needed to make a judgement of the risks to the man and other patients.

30. There was no review that day of the man's ACCT document, including a review of the care map. Accordingly, there appears to have been no formal review of the overall care that the man needed in the light of his behaviour that day and his new location. There is no evidence that any consideration was given to whether the level of ACCT observations should be increased, and these remained at six times in 24 hours.
31. The man stayed in the cell for the rest of the day and that night. It was an apparently uneventful period. According to the ACCT document, he was observed twice by night staff.
32. He was seen by the chaplain the next morning, 11 June, at 9.25am. The chaplain recorded that the man said his head hurt but that he would get over it.
33. The agency nurse coaxed the man to the morning exercise period, and it was reported in the ACCT that he was quiet and lying on his bed over the lunch period. As he did not feel up to going to collect it, his lunch had been taken to him. Thinking the man could do with some fresh air, the agency nurse tried to persuade him to attend exercise that afternoon, but he would not go. At approximately 3.30pm, the in-patient manager, spoke to the man. She found him to be anxious and complaining about his head pains. As these were the usual things that he spoke about, she found nothing to alert her to any additional problems.
34. At approximately 3.50pm, the agency nurse locked the door to the man's cell while he went to prepare for the serving of the tea meal. At approximately 4.15pm, he returned and looked through the man's door observation hatch. He saw the man hanging by his neck from the open door to the cell toilet area. After shouting for assistance, he entered the cell and took the man's body weight. Three staff attended with resuscitation equipment. A further member of staff joined them after informing the control centre of the emergency by using his radio. Cardio pulmonary resuscitation was begun immediately.
35. A defibrillator was attached to the man and it registered a flat line. At 4.18pm, an ambulance was called and paramedics were at the prison by 4.25pm and attending the man very soon afterwards. Sadly, despite the attempts to revive him, the man's death was pronounced at 4.35pm.
36. My investigators spoke to prisoners who knew the man and were told that healthcare staff offered emotional support to them following the tragedy. Staff who were interviewed said that they knew of the staff care team and the help that they were able to offer. It is not known what the rate of uptake was.

37. The news of the man's death was broken in person by the Governor and the prison chaplain, who called on one of the man's sister and his named next of kin. They then went with her to another sister's house. They afterwards visited her father. One sister said that, as a result, she had felt rushed by events and had not had the opportunity to take the news in herself.

ISSUES

Clinical review

38. A clinical review, to be completed by 15 August 2005, was requested from North Liverpool Primary Care Trust on 14 June 2005.
39. Mersey Care NHS Trust completed a clinical review of their service involvement with the man. They summarised their findings as follow:

‘The man was a very distressed individual detained in the Prison Service. The risk of him completing suicide was very high based on historical, dynamic and future risk factors. The request for Psychological Services was to determine whether he would benefit from a psychological approach and whether his symptoms were functional. The Mersey Forensic Psychology Service saw the man within an appropriate timescale and was in the process of completing a report at the time of his death. Brief notes were made in the man’s inmate medical record as is custom and practice and the bulk of information and recommendations were to be communicated in a report following the final session. Psychological Services and the CMHT were not involved in or informed about a key decision (moving cell) which increased the man’s risk of suicide. There are a number of recommendations which may improve the clarity of Psychological Service’s involvement in the future’.

40. The clinical review has identified a number of learning opportunities, which I urge the Primary Care Trust and Prison to consider and action accordingly.

The Primary Care Trust and Governor should consider the findings of the clinical review and draw up an action plan to address the identified learning points.

Decision to place the man in single cell accommodation

41. The man had mental health problems and self harmed by cutting. In the period prior to his death, the man had seriously self harmed and had spoken on a number of occasions about killing himself and using a ligature. According to his latest cell sharing risk assessment, he was not thought to be a danger to other prisoners. However, he had become very agitated early on 10 June in his three person cell which would have been distressing to those around him.
42. During the afternoon of 10 June, the doctor had a request from the deputy in-patient manager, for his opinion whether the man could be placed in single cell accommodation. The doctor authorised a single cell if it was thought necessary by staff. The doctor has said that he was not the man’s regular in-patient doctor and, in coming to the view that he did, he had to trust the judgement of healthcare staff. He did not speak to the man at the time he decided he could be placed in a single cell.

43. The decision to put the man into cell M1-3 alone - once the doctor had said this could be done if required - was described by the deputy in-patient's manager to have been a team decision taken to reduce distress to other patients on the grounds that the man's behaviour might upset them. The man was not known to be violent to others, but it is not hard to see how conduct such as he demonstrated on 10 June could cause distress to someone who was locked in the same cell. However, there is no documentary evidence that any risk assessment process was undertaken to weigh up the risk the man actually posed to himself as well as to others.
44. The clinical review has identified that the community mental health team had no involvement in or were informed about this key decision to move the man into a single cell, despite their involvement in his care whilst at Liverpool.
45. By the afternoon of 10 June, the man's circumstances had changed considerably. He had said on a number of occasions during the preceding weeks that he would kill himself, he had seriously self harmed, and a noose that was said to belong to him was handed to staff on 6 June. Most importantly, he had become dangerously agitated on the morning of 10 June, and had been moved to a single cell and put on constant watch. Yet there is no evidence of any formal review of the suicide prevention arrangements. There was no documented alteration to the man's ACCT observation schedule of six times daily. Given the background, this might reasonably have been expected to have been changed to more frequent intervals, or even a constant watch, with additional support provided to him by staff. In the event, the man was observed only twice during the night of 10 June.

The Governor should review the placing of prisoners on an open ACCT in single cell accommodation, and publish clear instructions on the limited circumstances when this is appropriate.

Management of the suicide prevention procedures

46. The man was the subject of F2052SH and ACCT procedures. His last review was dated 28 May 2005, when it was noted that he was experiencing fleeting thoughts of self harm, but there was no mention of the very serious episode of cutting of 13 May. This is not to say that the matter was ignored. An F213SH had been raised and filed, and there was a care plan review on 18 May, where there were a number of quality entries describing the man's condition and care. As he was resident in healthcare, the core document for his care was the medical record, and it is often the case that staff turn to this when wanting to update themselves or to contribute to the record.
47. The ACCT that was opened for the man on 5 June was a continuation of the suicide prevention care given to him on the F2052SH. An initial assessment interview was conducted and recorded on 5 June, with an ACCT care map produced. The man was put on weekly review and was to be encouraged to participate more in the life of the wing. The case manager identified the need for the man to find alternatives to

his self harming behaviour with the help of staff. The man often cut himself and then showed the resulting wounds to staff, and it was this aspect of his behaviour that seems to have been the main concern when his care was considered. Despite the man having said on a number of occasions that he would kill himself (even mentioning hanging), staff who looked after him were shocked when he was found on 11 June. It would seem that they did not consider him to be someone who would genuinely wish to kill himself, but rather a prolific self harmer who craved attention.

48. On 6 June, a noose was handed to a member of staff and she was told that it belonged to the man. The nurse in question assessed the situation as giving no cause for concern as the man himself appeared to be in a reasonable mood, and the making and finding of nooses were regular events in Healthcare. During the course of the investigation, it transpired that this indeed appeared to be a regular occurrence involving some patients. It would appear that some patients would exhibit evidence to staff of threatened self harm behaviour to gain their attention. Nonetheless, all finds of ligatures must be taken seriously.

The Governor should issue clear guidelines on what to do when a ligature is found.

49. The ACCT manual requires that a case review takes place within 24 hours of opening a new document. This was not done in the man's case. The concerns about the man's self harming behaviour had in fact been raised long before. Perhaps the ACCT transition guidelines could have been clearer on this, but given that the man had had a review within the previous fortnight, this was a reasonable interpretation of the requirements. In any event, it would not have been possible for every newly opened ACCT in the prison to have been reviewed in one day.
50. Not all staff in healthcare had ACCT training at the time of the investigation and this should be addressed. For example, the agency nurse was not aware that the ACCT is to be used by all staff to note their concerns. If he had comments or concerns with a prisoner on an ACCT, he said he would speak to a more senior member of staff. This is clearly less than ideal as important information may not be recorded. The best person to report on these matters is the member of staff who has the face to face contact, and who writes up the record as soon as possible after the event.

The Governor and PCT should ensure that all staff, permanent and agency, and particularly those in Healthcare, are trained in suicide and self-harm awareness and the use of the ACCT documentation. This training should make sure that staff are aware that potential self harming behaviour is dangerous, whatever the motivation behind it.

The man's daughter

51. It is much to be regretted that the man's daughter, was unable to visit him. I understand that the man's visits were stopped on child protection grounds, because his records had become confused with another prisoner. The family believe that this mix up created anxiety for the man and may have affected his mental health. I support their views that denial of access to families can be distressing and may well have played a part in the deterioration in the man's mental health.

CONCLUSIONS

52. The man was someone who clearly needed a lot of staff attention. I note that he often cut himself and showed staff his wounds. This was seen as his pattern of self harming behaviour, and may have caused staff to underestimate the level of risk that the man presented.
53. He was located in a single cell at the time of his death. The process that led to his being alone is a cause of concern. The authorisation was given by the doctor without interviewing the man. It then appears that the actual decision to place the man in a single cell was made by the healthcare team in the light of the doctor's authorisation. I note this was done without any risk assessment process, and without any formal review of the care that the man required in the light of his new circumstances. The support the man needed was not reassessed, and his ACCT care plan and level of observations remained unchanged.
54. The clinical review has identified that the risk of the man contemplating suicide whilst in prison was high, based on the historical, dynamic and future risk indicators. The man was seen by the Community Mental Health Team and yet when it came to the decision to move him into a single cell they were not consulted with.
55. Staff in healthcare do not seem to take the existence of ligatures as seriously as they should. The Governor and the Primary Care Trust should review these matters and produce clear guidelines on what to do when a ligature is found. The discovery of a ligature should be recorded so that management and staff are aware of the extent of the problem.
56. When the man was discovered in his cell, staff responded promptly, and I believe that all reasonable steps were taken to save his life.

RECOMMENDATIONS

The Governor should review the placing of prisoners on an open ACCT in single cell accommodation, and publish clear instructions on the limited circumstances when this is appropriate.

The Governor should issue clear guidelines on what to do when a ligature is found.

The Governor and PCT should ensure that all staff, permanent and agency, and particularly those in Healthcare, are trained in suicide and self-harm awareness and the use of the ACCT documentation. This training should make sure that staff are aware that potential self harming behaviour is dangerous, whatever the motivation behind it.

The Primary Care Trust and Governor should consider the findings of the clinical review and draw up an action plan to address the identified learning points.