Investigation into the circumstances surrounding the death of a man in August 2006 whilst in the custody of HMP Liverpool

Report by the Prisons and Probation Ombudsman for England and Wales

January 2008

This is the report of an investigation into the death of a man at HMP Liverpool. He was found by his cellmate in the bathroom of their shared cell with a ligature around his neck. Despite efforts to resuscitate him, he was pronounced dead shortly after his arrival at the hospital. He was 22 years old.

I would like to extend my sincere condolences to his family and to all those touched by his untimely death. The man's family is understandably shattered by his loss. He was a troubled young man who, five weeks earlier, had found himself in an adult prison for the first time. He had been remanded in custody after being charged with demanding car keys from drivers with the intention of crashing one of their cars so that he could die.

The investigation has been undertaken on my behalf by two of my investigators. A clinical review of the healthcare the man received whilst at Liverpool was also carried out by the Head of Mental Health Integrated Commissioning at Liverpool Primary Care Trust, with clinical advice from a Medical Director and General Practitioner. I must apologise for the delay in producing this report.

From the time the man came into custody, he was identified as being at risk of self harm. He was monitored under the Prison Service's arrangements for caring for prisoners at risk of self harm and suicide. However, it is arguable that the level of risk that the man posed to himself was not recognised sufficiently.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2008**

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SUMMARY

The man was arrested on 14 July 2006. He had been threatening drivers with violence in an attempt to get their car keys so he could crash a car and kill himself. He was remanded in custody to HMP Liverpool. Although he had spent short periods in custody in the past, it was his first time in an adult prison.

On reception, the man was asked questions by a staff nurse as part of the standard procedure. He responded that he had not tried to harm himself before and did not feel suicidal. When the staff nurse spoke to him, he did not have details of documentation that had arrived at the prison flagging up his risk of suicide. Nevertheless, although he declined to see a doctor, the staff nurse insisted that he do so after feeling that his presentation was not quite right. Having read the man's suicide/self harm warning form, and assessing him the doctor concluded that the man did not warrant observation in the healthcare centre.

The day after the man's arrival, his cellmate on B wing alerted his landing officer to his concerns about the man's state of mind after finding blood on his bed sheet. The man told the officer that he was depressed but, paradoxically, was feeling better. The officer decided to initiate an Assessment, Care in Custody and Teamwork (ACCT) document for assessing, monitoring and supporting prisoners at risk of self harm or suicide. The man was assessed by a trained assessor and attended a case review. He told the staff there that his attempt to kill himself had been real but he had changed his mind and now wanted to stay alive.

The man's risk of self harm was raised to high and he was taken to the healthcare centre. He was assigned a named nurse to go to for advice and support. He told her of his poor body image and that he was conscious of his limp. On 20 July, he was found in a bathroom stabbing himself in the chest with a ball point pen. He was prescribed an anti-depressant but refused to take it. Later that day, he was the victim of an unprovoked assault by another prisoner who threw boiling water on his face and neck, resulting in hospital treatment. His named nurse commented that this was the worst thing that could have happened to the man at that time as it reinforced his low self esteem. Liverpool did not tell the man's family of the assault.

After a week, the man left the healthcare centre at his request after his risk of self harm was re-assessed as low. He was seen by a Prison Community Mental Health Team Nurse-Practitioner and a Consultant Psychiatrist who concluded that the man was suffering from mild depression and was not suicidal.

Although the man had started to attend education classes, he soon decided that he did not want to go and wanted to be left alone. Staff described his demeanour as withdrawn and quiet.

Whilst on a visit, the man told his mother that he had attempted suicide with a noose but it had not worked. Following this, the man's aunt telephoned Liverpool to alert them to her fears about his safety. The mother had previously tried to contact the prison with concerns for her son, and on one occasion had resorted to asking a worker in the visits canteen to pass a message on.

A case review was held on 18 August at which the man denied that the conversation with his mother had taken place. He admitted that he had not been taking his medication. His risk of self harm or suicide was assessed as low.

In the last week of August, staff were alerted to a crisis in the man's cell by his cellmate kicking the door repeatedly. They entered the cell and found the man suspended from the window bars in the cell bathroom. Despite efforts to resuscitate him, the man did not regain consciousness and died shortly after his arrival at the local hospital.

I make several recommendations concerning the care of prisoners at risk of self harm. I attach particular weight to the recommendations relating to the ACCT process and the importance of balancing what a prisoner says about how he feels against his actual behaviour.

THE INVESTIGATION PROCESS

1. My investigators visited HMP Liverpool on several occasions and were given access to all prison records relating to the man. These included his main prison record, his medical records and statements from staff. However, initial progress was delayed because my investigators were unable to obtain timely responses from Liverpool's liaison officer with regard to arrangements for staff interviews. Unfortunately, this was not an isolated example and I am disappointed that more than one of my investigators has encountered difficulties in making effective contact with Liverpool.

2. My investigators interviewed staff and one prisoner, and met representatives of the Independent Monitoring Board and Prison Officers' Association to offer them the opportunity to raise relevant issues. Contact was made with a Sergeant of Merseyside police who confirmed that there was no third party involvement in the man's death.

3. The man's family was offered, and accepted, the opportunity to contribute towards the investigation process. One of my investigators and my Family Liaison Officer visited the man's mother to learn of concerns raised by his family about his care whilst in Liverpool and how news of his death had been handled.

4. The mother wondered whether the man could have been placed on a different wing where he could have been observed more closely. She said she was unclear as to what medication he had been prescribed, whether he had actually been observed taking his medication and whether it had taken effect.

5. She expressed concern that a prisoner had been able to throw boiling water over him and that she had not been notified when this assault happened. She spoke of her difficulties in identifying appropriate staff to speak to about her worries for her son's well-being. She said she had resorted to asking a staff member in the Visits Canteen if they would pass a message on to the main prison on her behalf.

6. Referring to the day the man died, the mother wanted to know when his cell had been checked by the officer unlocking for exercise, and why his cell toilet had not been checked at that time given that the man was known to be at risk of self harm. She questioned the frequency of checks made on prisoners at risk and the reliability of the ACCT plan document. She said there was no proof that entries were made when staff said they were.

7. Concerning the immediate aftermath of the man's death, his mother wanted to know why there was a two hour delay in the family being notified, and why there was confusion over the hospital to which the man had been taken. She had noted that her son had a number of scratches and marks on his body, particularly on the top of his head and she wanted to know what had caused them. She added that she had been given her son's belongings but had not received some photographs of his girlfriend.

8. A clinical review was requested from Liverpool Primary Care Trust. I am grateful to the clinical reviewers for undertaking this review in a timely manner. As a result of the Community Mental Health notes being made available after the clinical review had been completed, an addendum was produced.

9. My investigators informed Her Majesty's Coroner of the nature and scope of the investigation. He has been provided with a copy of my report.

10. After seeing a draft version of this report, the man's family mentioned the name of a friend who had been at Liverpool at the same time as the man but has since been released. He was contacted by one of my investigators and was able to provide further helpful information.

HMP LIVERPOOL

11. HMP Liverpool is a refurbished Victorian prison which serves the courts of the Merseyside and Wirral areas. It holds up to 1,480 prisoners. The man's death was the third of four apparently self-inflicted deaths that occurred there in 2006.

12. B wing has capacity for 161 prisoners. As well as prisoners new to Liverpool, it holds unconvicted prisoners and is staffed during the day by a minimum of 12 officers and two senior officers.

13. All staff should receive basic training in suicide awareness and how to implement the Prison Service's procedures for caring for prisoners at risk of suicide and self harm, Assessment, Care in Custody and Teamwork (ACCT). At the time of the man's death, the last published inspection report by Her Majesty's Chief Inspector of Prisons on Liverpool was in September 2004. It noted that, although more staff needed to be trained in suicide awareness, all staff the inspectors spoke to knew what action to take if they found a prisoner in distress or who had self harmed. An unannounced inspection took place in February 2007 and was published in June 2007. Liverpool's comprehensive and informative Suicide and Self Harm Prevention Policy includes a section on the role of staff in remaining alert to signs and signals of distress in prisoners.

14. Mersey Care NHS Trust is responsible for providing a Prison Community Mental Health Team to provide continuity of care for prisoners in the community and in prison. Liverpool operates a system using a weekly single point of referral meeting to assess and review a prisoner's mental health with a view to selecting the most appropriate healthcare professional to meet their needs.

KEY EVENTS

15. The man had a history of car theft. When he was 17, he was badly injured in a car accident after a stolen car he was driving crashed. As a result, he was in a coma for three weeks. Although he regained consciousness, he was in hospital for three months and suffered a stroke which partially disabled the right side of his body so that he walked with a slight limp.

16. On 14 July 2006, the man had an argument with his girlfriend. According to his mother's statement to the police, he had drunk a quantity of alcohol and appeared upset. He asked his mother for her car keys and said he wanted to kill himself. When she refused to give them to him, he stormed out of the house and was later arrested for threatening drivers with violence in an attempt to get their car keys. He was charged with three counts of blackmail and possession of an offensive weapon. His Prisoner Escort Record (PER) which accompanied him from police custody to court indicated that there were warnings from 2005 concerning drugs, concealing weapons and long standing short term memory loss as a result of a head injury.

17. The man appeared at the Magistrates' Court on 17July and was remanded in custody. On the warrant committing him to stand trial at the Crown Court was written, "suicide wish identified. Bench request prison to assess whether appropriate to hold on a Hospital Wing." The accompanying bail form gave three reasons for refusing bail: that he was in custody for his own protection or welfare due to suicide threats, previous offences and "evidence of self-injury: attempted suicide". The last of these was underlined.

18. The duty probation officer at the magistrates' court (who was familiar with the man having met him when she worked for a training and employment organisation) faxed a suicide risk form concerning him to HMP Liverpool probation office. This read, "Recent offence part of endeavour to take his own life. Magistrates committed and remanded in custody on the understanding that he would be in the Hospital Wing." In the Inmate Concern Book, the duty probation officer at Liverpool noted the concerns expressed by the court about the man and sent copies of the fax to the doctor in Reception.

19. The man saw a Registered Mental Health Staff Nurse (RMN) on reception. In response to the standard questions in the First Reception Health Screen form, the man answered that he had been in custody before as a young prisoner, had not tried to harm himself previously and did not feel suicidal. He declined to see a doctor.

20. At interview with my investigators, the RMN said that he had interviewed him without any prior knowledge of his history. This meant that he could only go by what he was being told at the time. The RMN said he did not have any documents about him at the time, and was certain that he had not seen the suicide risk form that came from the court probation officer.

21. The RMN recalled meeting the man because "…he looked so young … he was telling me that there was no problems, he was feeling okay but there was

22. The RMN noted in the man's medical record that he had seen a suicide/self-harm warning from the police concerning him but, although he advised the man to see the doctor, he declined saying that he felt better. My investigators asked the RMN whether he had seen the suicide/self-harm warning form before or after he had spoken to the man. He was not sure, as he had written his notes some time after first meeting him, but thought he had seen the form after conducting the initial health screen.

23. He said that something about the man had prompted him do two things he would not do normally. He had noticed that the man was sitting in the reception waiting room with other prisoners who were eating a meal but he was not. The RMN gave him some food and, despite his having declined to see the doctor, he grabbed hold of him just as he was about to leave Reception for the main part of the prison and insisted that he see the doctor. Asked why he did so, he could only describe it as intuition.

24. Despite the suicide/self-harm warning form, the man denied feeling suicidal or distressed when he was seen by the prison doctor in Reception. The doctor wrote in the man's medical record that his demeanour and eye contact were good and that he did not seem to be experiencing discomfort. He decided that it was not necessary for him to be in the healthcare centre for observation but, as a precaution, he told the man about the availability of Listeners (prisoners trained by the Samaritans to listen to and support prisoners experiencing distress). The doctor told one of my investigators that the man kept saying he wanted to go to the gym and, despite the suicide warning forms, his mood was good and he appeared to have some insight into his problems. The doctor decided that the man did not need to be placed in the healthcare centre at that time and that it appropriate for him to be placed on an ordinary wing. However, he made a note in the medical record that the wing should follow up with Listeners if necessary.

25. The man was taken to B wing, the designated wing for unconvicted prisoners, and seen by the First Night Centre officer who is responsible for newly received prisoners. He told the officer that he was expecting to be remanded in custody and that he had no problems. The officer was not aware that the man's offence was linked to an attempt to end his life. The next day the man attended induction for new prisoners. This included learning the routines of the wing, suicide prevention and discovering more about Listeners and Insiders (prisoners who are trained to answer queries about day-to-day life in prison).

26. That evening, the man's cellmate told the landing officer of his concerns about the man's well-being, saying that there was blood on his bed sheets. The officer went to their shared cell and spoke to the man who told him that he wanted to self-harm and was depressed. Paradoxically, the man also said that he felt better. It was not established how he had harmed himself. The landing officer told my investigators that, not only did his conversation with the

27. After talking to the man, the landing officer decided to open an ACCT (Assessment, Care in Custody and Teamwork) Plan, a document which can be initiated by any member of staff to monitor and assess the care of prisoners at risk of suicide or self-harm. In the ACCT Plan, the officer described the man's mood as low due to being in Liverpool for the first time.

28. The opening of the ACCT Plan triggers a process for staff to provide a prisoner in distress with individual care. The landing officer discussed the purpose of the ACCT plan with the man who said that wanted to stay in the same cell with his current cellmate. An Immediate Action Plan was drawn up by the wing senior officer (SO) at 7:10pm with the involvement of the man and the landing officer. They agreed that the man would remain in a shared cell. He would be seen for a full assessment within 24 hours, and he would be seen by a doctor to explore his feelings of depression. The Listeners scheme was explained to the man. It was written in the ACCT plan that he would move to the crisis suite if his low mood worsened. The level of observation on the man was set at one observation per staff shift period and three observations during the night. There are three day shift periods.

29. On 19 July, the man was assessed in more depth by a wing officer, a trained ACCT assessor. The man told the wing officer that he had suffered a stroke when he was 17 and was feeling depressed because of the after-effects of that. He said he had tried to hang himself with a torn bed sheet but could not go through with it and now wanted to stay alive. A case review followed the assessment. The man said that his attempt to kill himself had been real but he had changed his mind and now wanted help. He said that, although he had contact with both his family and his girlfriend, he hid his feelings and problems from them. He wanted to be occupied and again talked about attending the gym and perhaps education classes.

30. After assessing what the man had said, the duty SO, the wing officer and the man discussed a plan of action known as the CAREMAP. The man's depression was identified as an issue so an urgent referral to the mental health team was made. It was also decided that he should attend remedial gym (gym sessions with exercises tailored to address specific physical problems).

31. The man's risk of self harm was raised to "high" with a plan to review his situation on 26 July, in a week's time. The duty SO written summary noted that the man was very vague and she told my investigators that he was not very forthcoming, did not really want to co-operate with the process, and that he did not know what he wanted and found it hard to concentrate. When asked why she had raised his risk, she said that the man "was not overly defensive but just did not engage". Her work experience and knowledge told

32. Also on 19 July, another RMN working in the prison's healthcare centre, went to see the man on B wing as a result of the ACCT plan being opened on him. A member of B wing staff had telephoned her to register their concern about him. She told my investigators that she was very concerned when she saw the risk alert form from the Magistrates' Court in the man's medical record which stated that magistrates had an expectation that the man would be admitted to the healthcare centre. She showed it to her manager who told her to go and take the man immediately from B wing to the healthcare centre. She spoke briefly to him and asked him to go with her, which he did, albeit reluctantly.

33. The second RMN talked to the man for some time and he began to speak about his offence. He said that he was not a "drinker" but had had a few drinks to get up some courage before threatening someone for their car keys. It had been his intention to take the car and crash it, thereby killing himself. He mentioned the car accident he had been involved in when he was 17 and his stroke. The second RMN said his body image was distorted and he saw himself as very slight so he wanted to go to the gym to "be bigger". She said he was conscious of his limp. She had tried to assure him that he was not as small as he feared nor were his disabilities as obvious as he felt they were. The interview ended with the nurse reassuring the man that she was available for him to talk to at any time. She explained that she would be his named nurse and the person he should go to if he had any worries. Equally, she would check regularly on him. The man remained in the healthcare centre. It was noted in his ACCT Plan at 7:30pm that evening that he had attended evening association (a period for recreation where prisoners can socialise) but that he had "isolated himself from others".

34. On 20 July, the healthcare officer (HCO) who is also a registered mental health nurse was working in the healthcare centre. She told my investigators that she saw the man go to the bathroom and a few minutes later (about 9:35am) she called through the door to check that he was okay as she knew that he had problems with self harm. The man did not reply so the HCO went into the bathroom but could not see him in the bathing area. She found him in a toilet recess sitting on a chair stabbing himself in the chest with a ball point pen. He continued to do this when she approached him, but eventually stopped and handed her the pen after she asked him to several times. The HCO called out to the senior nurse but, although they tried to get the man to open up about his feelings, he remained unwilling. The HCO spoke to the second RMN about the man's actions and updated his clinical record and ACCT Plan accordingly. The man then got ready for a visit he was due to have with his mother. Whilst he was having his visit, the second RMN spoke to the duty doctor about him and he agreed to write a prescription for the anti depressant Zispin, also known under its generic name as Mirtazapine. However, throughout his stay in the healthcare centre, the man refused to take his medication as he felt he did not need it.

35. When describing how the man had behaved during the incident, the HCO said that he did not seem agitated or distressed. On the contrary, "he seemed quite self possessed really." He was not frenzied, there were no marks on his body and he did not need medical treatment. She said it was clear to her that he did not want their involvement in any way.

36. When the second RMN talked to the man about what had happened in the bathroom, he said he had done it out of frustration rather than any real attempt to harm himself. He said he was frustrated with being in the healthcare centre. He did not want to be there as he felt there was a certain stigma associated with it. The man told the nurse that he did not have a suicide plan to cut himself, take an overdose or hang himself. He admitted that the way he would have wanted to die was by stealing a car and crashing it.

37. Later that day, the man collected his lunch from the servery and passed another prisoner on the way. Without provocation, the second prisoner shouted abuse at the man and threw hot water over him, scalding the man's face and neck. The man fell to the floor and was kicked by the prisoner, who was then restrained by staff. The man's burns were treated. He was said by the second RMN to have been very angry and she spent some time calming him down. The assailant was charged under the Prison Rules with assault.

38. The second RMN and two officers accompanied the man to a local hospital to have his injuries assessed. He was prescribed painkillers and cream and returned to Liverpool. The nurse felt that the assault was the worst thing that could have happened to the man as it compounded his low self esteem associated with his poor body image. She did not tell the man's family that he had been taken to hospital after an assault but believed that someone else would have done so.

39. The next day the man's mood was described in the ACCT plan as "sullen". The day after that (22 July), the man again refused his medication and appeared generally unhappy. However, an entry in his clinical record by the HCO said that he could be "distracted to laughter". She explained to my investigators that at times the man appeared very low in mood but, with some engagement, one could strike up a conversation with him and have a shared joke.

40. On 23 July, the second RMN referred the man to the Single Point Referral (SPR) meeting to take place the next day, having previously done so on 19 July. This is a weekly meeting held by mental health agencies who visit and work in the prison. It is composed of several mental health professionals with different specialisms. During this meeting, all prisoners who are referred are discussed, and a decision is made about the most appropriate professional to see them. The man told the second RMN that he felt better and wanted to go back to a prison wing.

41. On 24 July, the man again refused his anti-depressant and, after seeing the GP, the prescription was stopped as he was not compliant. The SPR meeting

42. On 25 July, the HCO recorded that the man was still asking to return to an ordinary location and “was a little flat but interacted well”.

43. The staff nurse described the man as quite friendly and pleasant whilst in the healthcare centre. She told my investigators that he chatted to her about sport as she was involved in marathon running and he was interested in getting fit. In her opinion, the man was a poor coper and appeared vulnerable. She described him as quietly spoken, not loud or a user of coarse language. She knew that he was not happy in the healthcare centre. The man thought he might settle in better if he was on a wing where he wanted to be.

44. On 26 July, the man and the second RMN discussed returning to an ordinary wing. A review of the man’s progress was held, attended by three members of staff (including RMN2) and the man. It was noted that the man had not recently self harmed and had not expressed suicidal ideation. It was agreed that he could return to B wing, but the second RMN reiterated that he should ask a member of staff to call her if he wanted to see her at any time. The man’s self harm risk was reviewed and assessed as low.

45. The RMN2 prepared and signed a healthcare centre discharge report on 26 July, a copy of which was placed in the man’s ACCT plan and his medical record. It said that the man had not expressed self harm intent whilst in the healthcare centre and that his return to B wing was at his request. The man returned to B wing but remained on the ACCT plan. However, second RMN’s name was not specifically mentioned in the man’s CAREMAP as the person to contact.

46. On 27 July, it was noted in his ACCT plan that at education induction the man was “extremely quiet and withdrawn but stating is feeling ok.” No written observations were made in the man’s ACCT plan between 28-30 July.

47. On 1 August, the CPN contacted the man’s aunt, a mental health support worker, to obtain some background information about the man before her scheduled assessment with him. The CPN visits Liverpool weekly but is not based at the prison. She agreed to keep the aunt abreast of the man’s progress provided he was happy with this.

48. On 2 August, the man was seen by the CPN to conduct an initial mental health assessment. At first the man seemed reluctant to talk, but he told her that he was hearing voices and this was causing him some distress. The CPN told my investigators that the “voices” the man spoke of were probably thoughts in his head as he was quite low in mood. The man was unsure how

49. A teacher wrote in the man's ACCT plan on 3 August, "Very quiet. Has not engaged at all with other members of the class. Has produced some limited work. Very limited communication skills. Seems distant and withdrawn." An officer also wrote that day that the man did not answer when he was asked how he was, and seemed distant as if his mind was on other things.

50. At his ACCT case review on 4 August, the man said he did not know how he felt about anything and was not very talkative. It was noted that he seemed to keep his thoughts and feelings to himself, which made it difficult to communicate with him. It was decided to keep him on the ACCT plan for a further two weeks. His level of self harm risk was reviewed and was kept as "low".

51. On 7 August, the man was seen by a Consultant Psychiatrist, for a more in-depth consultation. His medical record note shows that he expected a sentence of between three and five years. The man told the doctor that he felt unhappy, had problems sleeping and was losing weight (half a stone since he had been in prison). He attributed his lack of enjoyment in activities to his physical weakness, and again spoke about wanting to go to the gym to build up his strength and walk better. When asked about the future, he mentioned seeing his girlfriend and the importance of seeing his family. He denied any suicidal ideation. The man said that he had been prescribed Zispin two weeks previously but did not take it and was not on any medication. An entry in the man's medical record of the psychiatrist's meeting with him concluded, "Not psychotic, mildly anxious, not suicidal, no aggressive intent." The Prison Community Mental Health Team notes show that the psychiatrist concluded that the man was suffering from mild depression. He prescribed Mirtazapine, an anti-depressant, and recommended that the CPN "review him in two weeks with a view to refer him back to primary care if there are no further problems identified."

52. On 8 August, the CPN contacted the man's aunt and mother to let them know the outcome of the psychiatrist's review. She wrote in her notes that she offered them support up to his trial and advised them that, if there were any problems, they should contact her. The CPN also referred the man to remedial gym for exercise.

53. On the same day that the man saw the psychiatrist, the wing officer wrote in his ACCT plan that the man had refused to go to Education and had seemed

54. During the next few days, the man appeared to mix more with other prisoners. However, on 17 August he was sent back to B wing from Education after saying that he did not feel right mixing with other people, and that he did not want to do Education, or have a job and just wanted to be alone. At lunchtime, he asked an officer if he could see the doctor in the afternoon. She wrote in his ACCT plan that he seemed very low.

55. The man saw a doctor, who is employed at Liverpool as a general practitioner, on his return from a visit with his mother on 17 August. The man had told a member of staff that he felt low and needed help. The doctor wrote in the man's ACCT plan that he did not communicate, was still very withdrawn and should remain in a double cell at all times. He noted that there was still a risk of self harm. He wrote a similar entry in the man's medical record adding that the man was currently taking Zispin, but that it had not taken effect and that he should be closely observed.

56. The man's mother told police that approximately a week before his death, the man told her and his girlfriend during a visit that he had made a noose, put his head in it and attempted suicide. It had not worked and his neck had been sore for a couple of days afterwards. Immediately after she arrived home, the mother contacted her sister who said she would pass the information on to the prison. The mother said that, after a previous visit when the man had spoken of wanting to be in heaven, she had eventually resorted to asking canteen staff to let officers know of the man's state of mind, having had difficulties identifying and alerting appropriate prison staff.

57. On 18 August, CPN wrote in the man's Prison Community Mental Health Team notes that the mother had telephoned Liverpool after her son told her he had contemplated a suicide attempt by hanging but had changed his mind and had not told a member of staff about this. The CPN went to B wing and spoke to a senior officer about the telephone call. She then took part in the man's ACCT review.

58. The CPN told my investigators that, during the ACCT plan review, the man denied he had spoken to his mother about thoughts of suicide and said that he no longer felt that way. He was challenged about not taking his medication and agreed to start taking it. The CPN was concerned about his cell being on the highest landing of B wing (the Fives) both in terms of the problems he had with his mobility and with his being on an ACCT plan. The man agreed to be moved to a lower landing. The man's risk of self harm at the review meeting was assessed as being "low." His next ACCT review was arranged for 1 September. The CPN telephoned the man's aunt after the ACCT review to let her know the outcome and "that I had seen the man and he was fine." She told my investigators that her impression of him was that he had "a problematic personality rather than a serious mental illness."

59. My investigators asked the SO who had also attended the ACCT plan review as the Case Manager, why the man's risk of self harm had been assessed as "low" given his mother's telephone call saying he had made a ligature. The SO said his understanding was that the man was taking his prescribed medication, was feeling better and had no thoughts of self harm at that moment, so did not warrant being raised to high risk. The SO added that he thought the CPN asked the man about the ligature but did not recall the man's response. Whilst it was thought too soon to close the man's ACCT plan, nobody objected to the risk being assessed as low. Asked by my investigators whether, in retrospect, the man did present a low risk, the SO said, "probably not … after what he did I would have marked it at least raised."

60. After the review, the man asked the SO if he could stay on the Fives for the exercise and because he felt better there. He was told he would not be moved but in fact, later that evening, he moved to cell B4-07 on the landing below to share with prisoner A, whom he had known since he was a teenager.

61. A day later (19 August), the man told the duty officer at 12:40pm that he was again happy to be in a cell with a prisoner he knew. At 3.20pm, however, the man was taken to see duty nurse after an officer was concerned about his state of mind. After talking to him, the nurse deduced that the man only wanted to have a single cell. He was told this was not possible. He was also reminded to take his medication regularly. The duty officer wrote in the man's ACCT plan that evening that the man looked "quite down and miserable" but when asked how he was, he said he felt okay and was not thinking of self harm.

62. Prisoner A said to one of my investigators that the man had used a mobile telephone belonging to another prisoner to telephone his girlfriend. The man's girlfriend told him that the prisoner concerned had telephoned her afterwards and they had chatted. The man had been very hurt that this had occurred and was annoyed both with his girlfriend and the prisoner. According to prisoner A, two or three days before his death, the man had confronted the prisoner on the exercise yard about it. Asked by my investigator whether it was possible the man was being bullied by that prisoner, prisoner A replied that the mobile telephone owner was warned off harassing the man by a more high-status prisoner and that had been the end of the matter.

63. On 21 August, prisoner A was told by another prisoner that the man had run along the landing when there were no staff present and rammed his head into a wall. He lost consciousness temporarily. The man's cellmate told my investigator that he had mentioned this to an officer but could not remember which one. The CPN saw the man on the same day. She described his presentation as "fairly morose". The Consultant Psychiatrist also saw the man. He recommended increasing the dose of Mirtazapine to 30 mgs and would review him in four weeks. The man told him he felt tired and could not concentrate. He had headbutted a wall and felt low. He denied any suicidal ideation. The psychiatrist assessed his risk of suicide as low.

64. On 22 August, the man was seen at 8.30am by his personal officer mixing with other prisoners. (A Personal Officer is a prisoner's first point of contact if they have any queries or need information.) The officer told my investigators that at Liverpool, personal officers are allocated prisoners on the basis of their cell location. He did not know the man particularly well as the man had only moved to his landing a few days before when he had not been on duty. At 9.30am, the man asked to speak to a Listener (a prisoner trained by the Samaritans to support other prisoners experiencing anxiety and distress).

65. On 22 August, prisoner A appeared in court via videolink from Liverpool and was successful in obtaining bail. He went back to the cell he shared with the man to tell him he would be leaving and to pack his belongings. The man told his friend he was happy for him but looked "gutted".

66. Prisoner B moved into the man's cell that day. Prisoner B told the police that he chatted with the man and they played cards together. The man told him that he heard other prisoners, not only on B wing but other wings, talking about his girlfriend making pornographic videos and photographs. Prisoner B thought he was "being paranoid" as he had not heard anyone saying these things. He told my investigators that prisoners were shouting out of their windows, but not saying anything that concerned the man. The man complained to him of anxiety and said he had a knot in his stomach.

67. At 4.38pm, the man left a message on his parents' answering machine: "Alright Mum, I'm just phoning to say that I'm sorry and that yeah, no more fucking. My girlfriend is fucking talking about me all the time to [inaudible] and speaking to them all on the phone, telling them everything and saying that she's fucking cracked me up and I can't handle it no more and whatever happens next, I'm sorry I loved her. Ta ta." At 7.00pm, the duty officer asked the man how he was. The man replied that he was okay. The officer wrote in the man's ACCT that he was "morose and very monosyllabic".

68. On 23 August, the man telephoned his parents at 8.06am. He told them of his concerns about his girlfriend communicating with other prisoners and being seen in pornographic videos that other prisoners were talking about. He was also concerned that she had played a role in his father's work van being stolen. His parents asked him for evidence to support his allegations and suggested that he must have been mistaken. The man asserted that his proof was "all these fucking words in my head."

69. Prisoner B later gave an account to the police of their activities that day. He said that he and the man played cards in the morning but the man appeared "quite miserable". Told to cheer up, the man asked whether he could confide in his cellmate and said again that his girlfriend was making pornographic videos and photographs and was sending them to other prisoners so they could laugh at him. He also felt that his girlfriend was involved in the disappearance of his father's van.

70. Two entries in the man's ACCT plan by an officer that morning described him as looking very nervous. He was last seen by an officer at 12.30pm after

71. In the afternoon, the second wing officer unlocked the man's landing for exercise. This meant going from cell to cell asking the occupants if they wanted to go out on to the exercise yard. Although she normally worked on the Fives landing, she was detailed to work on the Twos landing that day but was assisting the Fours landing, where the man's cell was, to unlock for exercise. The officer knew the man as, a couple of days before, she had arranged for a healthcare member of staff to see him because he seemed low in mood and it was difficult to get any response from him. She was aware he was on an ACCT.

72. After lunch, prisoner B lay in the top bunk, covered with a blanket and went to sleep. He recalled a female officer unlocking his cell at about 2.30pm and saying, "Are you coming out lad?" He did not hear the man respond and he did not answer the officer either. She closed the cell door. Prisoner B tried to go back to sleep but could not. He looked under his bunk to the bottom and noticed that the man was not there. He remembered thinking that the man might have gone out on exercise. When he opened the connecting door of their cell washroom, however, he saw the man hanging from the window bars. He described the man as looking very pale. Prisoner B told my investigators that he kicked the cell door to attract the attention of the officers as he had found in the past that it got a better response than pressing his cell bell.

73. The second wing officer told my investigators that, after unlocking the Fours landing for exercise, she began to walk down the stairs at about 2.40pm. She could not remember whether she actually saw him when she had previously opened his cell to enquire about exercise. The officer told my investigators that it was not uncommon to open a cell and find that the occupants were not there because they might have a visit or be in Education. She would not necessarily regard an empty cell as something untoward, even if one of the usual occupants was on an ACCT plan. However, she said that officers usually knew the prisoners on the landing where they normally worked.

74. The second wing officer heard loud banging on a cell door. She described it as being louder than usual. Thinking she might have forgotten to unlock a prisoner, she made her way to cell B4-07. As she approached it, the banging got faster. She unlocked the door and saw the man's cellmate who appeared to be in shock and was unable to make himself understood. She went into the washroom area and found the man. She lifted him up to support his weight whilst the third wing officer, who was behind her, shouted for more staff assistance. This arrived within seconds.

75. The third wing officer was also normally based on the Fives but had been detailed that day to move newly remanded prisoners to the Fours and Fives. He knew that the man was on an ACCT but had not had any specific contact with him. Whilst updating the movements board on a lower landing, he heard

76. The prison officer heard the third wing officer shout for staff. He ran to the man's cell and saw the second and the third wing officers holding the man up by his legs. The man was still hanging from a sheet which was attached to a window. None of the officers present was carrying a ligature-cutting tool. The prison officer climbed on to the heating pipes which run along the back wall of the cell and washroom. Using a pair of nail scissors that one of the officers gave him, he cut the ligature from the man's neck. He told one of my investigators that he found it difficult to cut the sheet with the nail scissors but managed to do so. Along with the other officers, the prison officer placed the man on the floor and began cardio-pulmonary resuscitation (CPR). Healthcare staff arrived two minutes later in response to a Code Blue radio message (a message meaning that a prisoner was not breathing).

77. At 2.41pm, the GP arrived at the man's cell. He was closely followed by three nurses and a healthcare manager. In his police statement, the GP said that on his arrival he asked the officers to stop CPR whilst he made an assessment. He described the man's appearance as pale with no blood flow, no pulse and not breathing. He then recommenced CPR with the wing nurse. Another nurse took over CPR whilst the GP administered adrenaline and monitored the man's condition with the help of a defibrillator and other interventions. No signs of life were detected.

78. The man's medical record says that paramedics arrived after 22 minutes. However, North West Ambulance Service told my investigators that they received an emergency telephone call from Liverpool at 2.46pm. They arrived at the prison at 2.52pm and reached the man at 2.55pm. He was taken to the local hospital at 3.14pm by paramedics. Sadly, he could not be resuscitated and was pronounced dead at 3.25pm.

79. Soon after the man was found, prisoner B, the man's cellmate, was taken to the Listeners care suite. He described his feelings of devastation, having found the man suspended. Two Listeners stayed with him until the next day to provide him with support.

80. At 2.52pm, Liverpool opened their Command Suite (this is used by senior managers to co-ordinate information when serious incidents occur in the prison). It was headed by the Deputy Governor, as he was the most senior governor on duty, and attended by other participants including the chaplain from the Staff Care and Welfare Team. Once the man's death had been confirmed, contingency plans were activated by the Deputy Governor, the last action being confirmed at 4.30pm.

81. The Deputy Governor and chaplain left the prison at 4.40pm to tell the man's family of his death in person. They arrived at the family home in Southport at about 5.30pm.

82. After the man's death was confirmed, B wing post box, which is emptied daily, was checked for outgoing mail. An undated letter from the man to his mother was found. In it, he said he was "fine and I'm goin to try an stay that way." He expressed affection for his mother and said that he missed her. The man spoke about hearing one prisoner shouting to another about his girlfriend. In the letter, the man expressed his concerns about his girlfriend being involved in the disappearance of his father's van. He asked his mother to keep her away from their home and told her not to show his girlfriend the letter. The man wrote that he had wanted to write a nice, long letter but "now my head is battered and I can't think."

83. A post mortem and toxicology analysis of blood and urine were carried out. The toxicology report indicated that Mirtazapine, caffeine and a trace of alcohol (which may have been due to consumption a considerable time before his death or produced after death) were found in the man's blood. The cause of death was given as neck compression and hanging.

84. A clinical review of the healthcare the man received said that the man's background history should have been completed before 7 August 2006 if only to inform those caring for him. It pointed out, "with regard to his anti-depressant medication there appears to be some discrepancy between the notes made in the clinical record and the recording on (sic) medication on the drug sheets. It is difficult to be certain what the man had actually taken." It concluded that, "the level of care offered to the man is appropriate. There was no evidence of enduring mental illness, but he did have mental health issues. These were addressed with medication and psychological support in a sensitive way. The man's character appeared to be such that there was nothing more that could have been done to help him."

85. After considering the notes made by the Community Mental Health Team on the man's case, the doctor assisting the lead clinical reviewer produced an addendum to the clinical review. This said that "Despite his denial of suicide intent he remained on ACCT status and, therefore, under regular observation. I am unaware of the frequency of these reviews, but in view of the discrepancy between what he told his family and what he told prison staff, the prison would be expected to err on the side of caution to cover this uncertain level of risk. This is clearly a difficult judgement call …"

CONSIDERATION

86. The man had been at HMP Liverpool for just over five weeks. For all of that time, he struggled to maintain the appearance of being able to cope in prison.

87. The man's apparent desire to harm himself was noted on the magistrates' court warrant, the suicide/ self harm warning form completed by court escort staff, and on the risk form completed by the court probation officer, yet this information was not seen by the RMN when he completed the man's initial health assessment. It is not clear why the documentation detailing his risk of self harm was not available before the assessment. The man told the nurse that he had not harmed himself before and did not feel suicidal, and he declined to see a doctor. It is fortunate that the nurse's intuition made him insist, unusually, on the man seeing the doctor. The prison doctor assessed the man and decided that he did not need to be in the healthcare centre for observation. The suicide risk forms were filed in the man's medical record. The man was then seen on B wing by the First Night Officer, responsible for new prisoners, who was not aware of the possible risks the man posed to himself. It was only the next day, when his cellmate alerted an officer after blood was found on the man's bed sheet, that an ACCT document was opened.

88. The man's ACCT assessment and case review on 19 July are notable because they crystallise the essence of the pressures within himself. He told the assessor that he was feeling depressed because of the result of his stroke. He revealed that he had tried to hang himself and that the attempt had been real but he had changed his mind. He had decided that he could not go through with it and now wanted to stay alive. He admitted that, although he had contact with his girlfriend and family, he hid his problems from them. The assessment reveals a level of honesty in his interaction with staff and insight into his situation regarding the possibility of taking his own life that, arguably, he did not make visible again so completely at any time whilst at Liverpool. As a result of the assessment, the man's risk of self harm was correctly raised to high.

89. Following concerns expressed by B wing officers, the man was taken to the healthcare centre for a week of observation after the second RMN saw the suicide risk documentation in the man's medical record and showed it to her manager. The nurse became the man's named nurse whilst he was in the healthcare centre. As such, she was his first point of contact for any concerns he might have. The man did not want to be there and talked to the nurse about his frustrations.

90. Whilst in the healthcare centre, the man was badly scalded as a result of an assault with boiling water by another prisoner. Although the second RMN accompanied him to hospital, she did not tell the man's mother of the assault but was sure that another member of staff would have done so. However, this did not occur and the mother only found out after seeing her son's injuries when she visited him at Liverpool. The man had already been identified by Liverpool as a vulnerable young man with low self esteem who, at that time,

91. The man returned to B wing at his own request as he had not expressed suicidal ideation and the episode with the ball point pen was not taken as evidence of serious self harm. The second RMN told the man that he should ask a member of staff to call her if he ever wanted to talk. I am heartened that when B wing staff subsequently had concerns about the man's state of mind, he was able to see a doctor or a nurse without undue delay. However, whilst the named nurse protocol seemed to work well within the healthcare centre, it operated less well outside. It relied on the man specifically asking for the second RMN but she was not mentioned by name in the ACCT plan CAREMAP (except in the Healthcare Centre Discharge Report she had prepared) nor in other documentation relating to the man - except for his medical record which was not accessible to non-medical staff. Therefore, when B wing staff had concerns about him on 19 August, he was seen by a nurse who was not familiar with him. Perhaps not appreciating the significance of his concerns, she missed the opportunity for more positive intervention.

92. The lack of clarity as to the appropriate member of staff to contact existed not only in the prison but was experienced by the man's mother when trying to communicate her fears about her son's state of mind. The mother expressed understandable frustration to my investigators about having to ask a visits canteen worker if they would pass on her concerns about the man to staff in the prison.

    I recommend that the Governor devises an effective system for families of prisoners at risk of suicide to have a specific point of contact if they have concerns.

93. On 18 August, whilst on a visit with his mother, the man told her that he had earlier made a noose and attempted suicide but it had not worked. He added that he had not spoken to a member of staff about this. The man's aunt (although the Prison Community Mental Health Team notes say it was his mother) contacted Liverpool to pass on this important information. Despite her telephone call, at the review the man told the staff present that he had not spoken to his mother about thoughts of suicide and he no longer felt that way. Whilst he was challenged about his suicidal feelings, he was not challenged about the contents of his aunt's telephone call. It appears that his family's concern about his attempt to hang himself was not given adequate weight by the members of the review, and his denial of their conversation was taken at face value.

94. I accept that there are many prisoners who may express thoughts of self harm who do not go on to take their own lives or, conversely, that there may be prisoners who do not voice their intentions but then kill themselves to the apparent surprise of those around them. What concerns me about the man's

I recommend that the Governor reminds ACCT case reviewers to balance carefully what a prisoner *says* about their feelings of suicide/ self harm during the review with evidence of their *actual* behaviour.

95. The man had admitted at his ACCT assessment on 19 July that he hid his problems from his family. So the fact that the prison had been given such troubling information from a family member should have sent alarm bells ringing. I am concerned that at the review meeting on 18 August the man's risk of self harm was assessed as low. This was all the more surprising as in the two weeks since his previous ACCT review his appearance had been variously described in his ACCT plan as "low", "withdrawn" and "distant". This is despite the man replying when asked how he was, that he was "ok", "alright" or "fine". Moreover, the day before the 18 August review, an entry in his ACCT plan said he had told the education department that he just wanted to be left alone. He did not feel right mixing with people and then asked an officer if he could see a doctor as he felt low and needed help. Throughout his period on ACCT, the level of observation (one conversation per shift and three observations at night) did not change. Given the significant content of the man's aunt's telephone call on 18 August, his level of risk should have been raised and increased staff observation put in place.

96. The second RMN told my investigators that she did not know the man had made a noose. She said that, had she known, she would have acted on the information and brought him back to the healthcare centre. The second RMN was asked by my investigators why the frequency of the man's observation had not been increased, especially given the mounting evidence that he was becoming very withdrawn. She replied that she was sure that the man would not harm himself because they had built up a rapport so he could talk to her if he needed to.

I recommend that the Governor puts in place a system to ensure that the frequency of observation written on the front cover of an ACCT document matches the level of risk that the individual prisoner poses.

97. It was good practice for the CPN to update the man's family on the outcome of the ACCT review. I have difficulty sharing her description of the man as being "fine", although I accept that this is the impression he was seeking to convey to the members of the review.

98. During the man's stay in the healthcare centre, he was prescribed Mirtazapine, an anti-depressant. However, his medical record states that it was discontinued after he refused to take it because he did not feel he needed it. On 7 August, Mirtazapine was prescribed again. Although nursing staff understood that he was refusing to take it, and had told staff at his last ACCT review that he had not been taking it, the toxicology report after his death indicates that Mirtazapine was found in his system.

99. The man's family asked about the cause of the scratches seen on his body after he died. The post mortem report lists a number of marks on the man's body. The Comments and Conclusions section of the post mortem report mentions fading bruising in his right fourth and fifth fingers and adjacent knuckle areas. It goes on "Whilst bruising could have a number of explanations, this may have been caused by the deceased landing a punch. The bruising appears to predate the day of death.". . Concerning the photographs that the man's thought had not been returned, Liverpool's Family Liaison Officer provided my investigators with a cell clearance certificate which listed the contents of the man's cell as they were being packed. This included a quantity of photographs. He assured my investigators that he had taken all of the man's belongings to the family home.

100. My investigators visited B wing on several occasions. They found it difficult to readily identify ACCT prisoners from the wing board. ACCT plans were kept in a different part of the office and no photographs of the prisoners were displayed. My investigators mentioned their concerns to the then Head of Safer Custody who indicated that Liverpool was exploring ways of making ACCT information clearer and more accessible for staff. I understand that a pilot scheme for identifying the correct occupants of cells by having more informative cell cards has been developed.

101. The man's mother has asked about the reliability of staff entries in the ACCT document. The man's ACCT booklet was generally completed to a good standard and I have found no reason to question its veracity. It is true, however, that his ACCT plan did not contain any written entries between 28 and 30 July. This was contrary to the specified frequency of observations which should have taken place and been recorded.

I recommend that the Governor ensures that the on-going record within an ACCT document is kept up to date.

102. On the afternoon he died, the second wing officer opened the man's cell for exercise. Although she knew the man by sight on B wing, she did not in fact know that it was his cell and there was nothing to indicate that one of the occupants was on an ACCT plan. She was not familiar with the Fours landing as she usually worked on the Fives and did not recall seeing the man when she unlocked his cell**.**

103. The man's family has asked why the second wing officer did not check the cell toilet. The man's cellmate, prisoner B, said that a female officer had unlocked the cell that afternoon and asked "Are you coming out, lad?" This indicates that the officer may have seen only one prisoner in the cell and, as the cell was occupied, there would not have been a need to check the toilet. In any event, she was not aware that it was the man's cell.

I recommend that the Governor puts in place a system to ensure that staff are easily able to identify the cells and whereabouts of ACCT prisoners.

104. After finding the man, prisoner B attracted the attention of the staff by turning on his cell bell and kicking his cell door. He told my investigators that kicking the door was the best way to capture the attention of staff as they did not always respond to cell bells. My investigators tested random cell bells on B wing. They were unable to hear them ring in the main body of the wing and answering appeared to depend on an officer seeing that a light was illuminated on the indicator panel on the Twos. There is no electronic registering system to record that a cell bell has been activated. (I make no formal recommendation on this matter, but draw my investigators' observations to the attention of the Governor.)

105. None of the staff who were first to reach the man was carrying a ligature cutting tool (despite B wing being issued with three). They had to cut the ligature with nail scissors which, fortunately, one of them was carrying. Since the man's death, Prison Service Instruction 32/2006 requires all uniformed staff in closed prisons (such as Liverpool) to be issued with an anti-ligature knife and carry it when on duty.

106. An entry by the GP in the man's medical record read that paramedics took 22 minutes to arrive. I believe this to have been mistaken. My investigators contacted North West Ambulance Service who confirmed that they received a telephone call from Liverpool at 2.46pm, arrived at the prison at 2.52pm and reached the man at 2.55pm. The NHS standard deems eight minutes as reasonable, so the arrival of the ambulance appears to have been within accepted guidelines. I am a little troubled, however, that although the Code Blue was transmitted over Liverpool's radio communication system at 2.39pm, an ambulance was not called until 2.46pm. I have not been able to determine the reason for the apparent delay. Nevertheless, I remind the Governor that Prison Service policy, issued via a letter to Governing Governors in March 2004, on the access of ambulance and paramedic services, states:

"It is essential in clinical crises that prisoners should have rapid access to emergency paramedical services … It is the responsibility of the Governing Governor to ensure that a protocol exists at each prison to facilitate the immediate access to both the prison and the individual prisoner when emergency paramedic services are summoned. It is also essential that internal procedures should not waste undue time in summoning emergency assistance. It should not, for example, be a requirement in every case for a member of the Health Care Team to attend the scene before Emergency Services are called. However, a subsequent 999 call to the Ambulance Service should be made to cancel the response if, after the original 999 call has been made, a member of the Health Care Team arrives with the patient and deems that an emergency ambulance is not required."

This letter was followed up by a letter in September 2006 to all Governors reiterating the requirement to have a protocol agreed with the local NHS Ambulance Trust

I recommend that the Governor ensures that staff at all levels are aware of the importance of calling an ambulance promptly.

107. The man's mother asked why it took Liverpool over two hours to tell her family of her son's death. I have considered the time span that Liverpool took to complete the necessary procedures when a prisoner has died. As the most senior governor on duty when the man died, the Deputy Governor was in charge of managing the aftermath of the man's discovery. He remained in this role until all the requirements of Liverpool's contingency plan had been fulfilled at 4.30pm. He left the prison at 4.40pm with the chaplain and arrived at the family's house shortly before 5.30pm. It was proper and fitting that the Deputy Governor chose to deliver his distressing news to the family personally rather than by telephone or by asking the police to do so. He would have been able to provide first hand information to the family as to the circumstances of the man's discovery. I am sympathetic to the mother's concern that there was a delay. However, I am satisfied that care was taken not to make news of the man's death public until his family had been told and that the delay in doing so was not excessive.

108. After the man had been found, his cellmate, who was naturally distressed at what he had witnessed, was cared for in a sensitive and supportive manner by staff and Listeners. This was very good practice.

RECOMMENDATIONS

In response to the draft version of this report, the Prison service accepted all the Prison and Probation Ombudsman's recommendations. Its response to each recommendation is below:

I recommend that the Governor devises an effective system for families of prisoners at risk of suicide to have a specific point of contact at Liverpool if they have concerns.

Accepted – HMP Liverpool at present operates a Anti bullying hot line, for concerned offenders and their families. This will now be extended to a point of contact for offenders, family or friends who have concerns about the welfare and safety of those in custody. This line is monitored daily and any issues will be passed to managers for action within their area. Target date for completion September 2007

I recommend that the Governor reminds ACCT case reviewers to balance carefully what a prisoner *says* about their feelings of suicide/self harm during the review with evidence of their *actual* behaviour.

Accepted- Case reviewers will be reminded on their training to make this distinction. In addition, Safer Custody managers will periodically sit in on ACCT reviews to ensure that reviewers are supported in their role and can make appropriate distinctions between self harm feelings and evidence of actual self harm behaviour.

I recommend that the Governor puts in place a system to ensure that the frequency of observation written on the front cover of an ACCT document matches the level of risk that the individual prisoner poses.

Accepted – HMP Liverpool operates a robust ACCT training program, in line with national guidelines. This identifies how to complete the ACCT document. However trainers will emphasise this point in refresher training which is currently ongoing for all staff. All ACCT documents are monitored by Safer Custody Senior Officers daily and any shortcomings identified with the case manager.

I recommend that the Governor ensures that the on-going record within an ACCT document is kept up to date.

Accepted – A robust system exists within HMP Liverpool to ensure that all staff are fully trained in the completion of ACCT documents. However this issue will be emphasised by trainers in the ongoing ACCT refresher training. Safer Custody officers will also be vigilant to this issue during their management checks.

I recommend that the Governor ensures that staff at all levels are aware of the importance of calling an ambulance promptly.

Accepted – The Governor will issue a notice to staff to make sure that staff are aware of the procedure to request the attendance of an emergency ambulance at the soonest possible time.

Good Practice

It was good practice for the CPN to update the man's family on the outcome of the last ACCT review.

Accepted – Liverpool Prison always endeavours to involve families to help support and reduce the risk of self-harming.

After the man had been found, his cellmate, who was naturally distressed at what he had witnessed, was cared for in a sensitive and supportive manner by staff and Listeners.

Accepted – This is normal practise at HMP Liverpool for all offenders exposed to distress.