The death of a man at Liverpool prison on 16 April 2004

Report by the Prisons and Probation Ombudsman for England and Wales

September 2004

The sad death at HMP Liverpool on 16 April on which I report here was one of the first apparently self-inflicted deaths in prison to have occurred after I took responsibility for investigating all such deaths at the beginning of that month. I was able to meet many of the deceased's relatives and to offer my personal condolences on their loss. I would like to repeat those condolences here. The man died within a few hours of entering custody. He had never been in prison before.

Under transitional arrangements agreed with the Prison Service, a senior investigating officer is appointed by the service to conduct each investigation. He or she works directly to me for the purposes of the investigation and submits a draft report that I then review and amend as necessary. This final report is to be read as my independent examination of the circumstances leading to the death.

In this case, the senior investigating officer was Mr Bob McColm, Governor of HMP Garth. I have been very fortunate to have worked alongside Mr McColm and commend the way he conducted the investigation. I am in total agreement with the findings he reached and this report differs from his draft at little more than a cosmetic level.

I am unable to say exactly what was in the man's mind during the short time he was alone in his cell. But I would like to underline what this report says about the state of that cell. It was bleak and shabby. Indeed, I was reminded of the term used by a Director General of the Prison Service some 20 years ago – 'an affront to a civilised society'. It may be particularly relevant that the cell contained no television or means of occupation. While I appreciate the difficulties all local prisons face in keeping cells clean when there is a rapid turnover of occupants, the conditions I saw in the cell were some of the most decrepit I have encountered in recent years.

This final version of the report includes three minor amendments as a result of comments received from the Prison Service.

Stephen Shaw
Prisons and Probation Ombudsman September 2004

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1. EXECUTIVE SUMMARY

1.1 This is a report of an investigation into the death of a prisoner, on 16 April 2004 in HMP Liverpool.

1.2 The investigation team reviewed the man's prison records and interviewed prisoners, staff employed by the escort contractor Global Solutions Ltd, Prison Service staff, a member of the Independent Monitoring Board and members of the bereaved family.

1.3 In all, there were 34 interviews as well as a number of statements. Two members of prison staff were on long-term sick and were not available for interview.

1.4 According to his brother, the man had previously tried to kill himself. This information had not been known by any of the agencies responsible for the man after his arrest.

1.5 The man was arrested on 14 April 2004, along with his son and his partner's son, and all three were charged with importing and supplying cannabis having an estimated street value of £35 million.

1.6 The man appeared at South Sefton Magistrates' Court on 16 April 2004 and there were no warnings of risk from the police to Global Solutions Ltd staff.

1.7 The three men were placed together in a holding room and were described by the custody staff as decent.

1.8 The custody staff detected no concerns with regard to the man, even after he was remanded in custody. He had a second helping of lunch and did not expect to receive bail, although he thought his son and partner's son would be bailed.

1.9 Before the three men arrived in HMP Liverpool, the Head of Operations decided that as they would be potential category A prisoners, they would be located on three separate wings in designated cells.

1.10 The reception process met all of the man's immediate needs and the health care reception screen interview did not identify any specific risks. The man had difficulty in reading so the nurse explained the process in detail. However, other information was in written form.

1.11 The man nominated one of his sons as his next of kin and who should be contacted in an emergency. Prison staff were unaware at this stage that the boy was just nine years old.

1.12 The man made two telephone calls to his partner but was unable to speak to her so he left a message.

1.13 Whilst the three men were in a holding room, other prisoners speculated on the sentence they might receive; these ranged from 10 to 25 years.

1.14 None of the eight staff in reception detected any concern about the man with regard to self-harm or suicide. More significantly, neither did his son or stepson who knew him best.

1.15 The staff on B Wing, where the man was located, met the planned staffing profile.

1.16 The cell, B3-09, in which the man was located was bare, dirty and in poor repair. It contained no television and no means of occupation.

1.17 Prisoners in a neighbouring cell had a conversation through the window. They subsequently described the man as sounding 'down'.

1.18 Just five to ten minutes after being placed in the cell, neighbouring prisoners heard a gurgling sound. One of the prisoners was able to see into the cell and saw the man hanging and a wound to his head that was bleeding. The prisoners banged their door and pressed the call bell.

1.19 Staff responded, the man was supported and resuscitation commenced. Paramedics arrived but the man was pronounced dead at approximately 2045 hours. He had been in the prison about three hours before he hanged himself.

1.20 There are inconsistencies in accounts of whether the man's head was pointing towards the window or the toilet. The eight people involved in the discovery of the incident, cutting the ligature and carrying out resuscitation agree that his head was towards the window. Two governor grades who visited later recall that his feet were towards the window.

1.21 The governor in charge of the incident decided to notify the son of his father's death as he was in the prison. Finding out that the third co-accused was the man's partner's son, the governor also informed him of the death. Both men were allowed to make telephone calls.

1.22 The man had contact with numerous experienced staff, none of whom identified any concerns about self-harm or suicide. However, at the end of an emotionally-demanding day, having heard other prisoners' views on how long he might serve, and with his first experience of prison being the grim conditions of cell B3-09, it may not be surprising that his mood changed.

1.23 I conclude from the evidence we have that the man's death could not have been predicted or prevented.

1.24 The report makes ten recommendations.

2. INVESTIGATION

2.1 I appointed Mr Bob McColm (Governor of HMP Garth) to conduct the investigation on my behalf.

2.2 I visited HMP Liverpool, where I received a brief from the Governor, Mrs Cathy James, ahead of visiting the cell and meeting members of the deceased's family. I also met with members of the POA local branch committee.

2.3 We issued a notice to prisoners and staff, inviting anyone who might have information relating to the death to make themselves known to the inquiry.

2.4 We interviewed prison staff, and seven members of staff of Global Solutions Ltd either gave a statement or were interviewed. We also saw the man's brother, his son and his stepson. There were also prisoners from neighbouring cells who were interviewed.

2.5 We examined the man's prison record and a series of prison documents.

2.6 I liaised with North Liverpool Primary Care Trust and they commissioned Ms Jayne McKeown, support clinical nurse advisor, to conduct a clinical audit of the man's care whilst in prison custody.

3. PERSONAL DETAILS

3.1 The man was five days short of his 45th birthday and this was his first time in prison custody. He had minor previous convictions dating back to 1971. Between 1971 and 1977, he had five theft and kindred offences. In 1973, he had an 'offence against the person', in 1977, what are described as 'miscellaneous offences' and most recently, in 2001, an offence of fraud and kindred offences. None of these convictions resulted in a custodial sentence.

3.2 He was unemployed and separated from his wife, with whom he had three children. He was residing in his brother's house with his partner.

3.3 The man was five feet and eight inches, weighed 13 stone and his build was described as stocky.

3.4 According to his brother, the man had previously tried to kill himself. This information had not been known to any of the agencies responsible for him after his arrest.

4. FAMILY DETAILS

4.1 The man who died was separated from his wife and was living with his partner. She has three children, one of whom was arrested and came into custody with the man who died. The man himself had three children, one of whom was also arrested and on remand at HMP Liverpool. The man's nine year old son was named by the man on reception at Liverpool as his next of kin.

4.2 The man and his partner lived in his brother's house in Stoke-upon-Trent. The brother was 14 years older than the man, and the brother describes his relationship as more that of a father than a brother. The staff at Liverpool were unaware of these domestic arrangements when the man was received into custody.

5. SUMMARY OF THE LEGAL CASE

5.1 The charges followed a joint police investigation with Her Majesty's Customs & Excise (HMCE). On 7 April 2004, officers from HMCE had cause to examine two containers at Seaforth Docks that had arrived earlier that day from Portugal. The cargo documentation indicated that these containers held crates of worked polished marble fireplace sets destined for an industrial unit in St Helens. On inspection, the containers were found to have 7.5 tonnes of vacuum-packed cannabis, having an estimated street value of £35 million. As a result, police officers attended the industrial unit in St Helens on 14 April 2004 and found three men present. The police arrested the three men on suspicion of being concerned in the importation of the cannabis resin and they were taken to the St Helens custody suite.

5.2 Following interviews with the police, the three men were charged as follows:

5.3 <u>The man who died</u>

1. Importing controlled drugs on 7 April 2004 (Misuse of Drugs Act 1971 s.3)

2. Being concerned in supplying a controlled drug (class C) on 7 April 2004 (Misuse of Drugs Act 1971 s.4(3)(b))

5.4 <u>His son</u>

1. Importing controlled drugs on 7 April 2004 (Misuse of Drugs Act 1971 s.3)

2. Being concerned in supplying a controlled drug (class C) on 7 April 2004 (Misuse of Drugs Act 1971 s.4(3)(b))

5.5 <u>His stepson</u>

1. Importing controlled drugs on 7 April 2004 (Misuse of Drugs Act 1971 s.3)

2. Being concerned in supplying a controlled drug (class C) on 7 April 2004 (Misuse of Drugs Act 1971 s.4(3)(b))

5.6 All three men remained in police custody at St Helens custody suite, to appear at South Sefton Magistrates' Court on 16 April 2004.

5.7 There is no record of any concern raised by the police in respect of risk of suicide/self-harm by any of the three men.

6. THE TIME AT COURT AND THE ESCORT TO HMP LIVERPOOL

6.1 On 16 April at 0830 hours, two Global Solutions Ltd staff took the three men from St Helens custody suite and transferred them to South Sefton Magistrates' Court. These staff checked the escort documentation and there were no warnings of any risk from the police. The three men were searched, handcuffed and placed on the van. When asked by one of the custody officers, the man who died indicated he was fine and had no problems.

6.2 They arrived at South Sefton Magistrates' Court at 0930 hours and were handed over to custody staff at the court. The man who died was first off the van and the custody officer checked that he was feeling okay. The three men were placed together in cell 8, the biggest room available. This is not usual practice but the three men were co-accused and they were described by custody staff as decent, and the man who died was described as a gentleman.

6.3 The custody record shows:

0930	Arrived in custody, searched and located
1000	Cell checked – OK
1030	Cell checked – OK
1100	The man searched ahead of a legal visit
1110	Returned from legal visit
1200	Cell checked – OK
1230	Cell checked – OK
1245	Lunch
1315	Cell checked – OK
1345	Cell checked – OK
1400	Searched and attended the court and back
1530	Bench retired
1600	Cell checked – OK
1610	Searched and attended the court
1615	Back from court
1645	Left South Sefton Magistrates' Court for HMP Liverpool

6.4 The three men were served a sandwich lunch. There were enough sandwiches for a second helping and the man who died accepted these. Global Solutions Ltd then escorted the three men into court and they detected no cause for concern or anything unusual. One of the staff observed the man 'lipping' words to his partner during the court appearance. None of the custody staff detected any change in demeanour following the remand in custody. According to one of the custody officers, the man was extremely shocked that his son and stepson had not been granted bail but accepted that he himself had 'no chance' of bail. Both his son and stepson confirmed that the man expected to be remanded in custody.

6.5 In all, seven Global Solutions Ltd staff had contact with the man. They describe him variously as relaxed, pleasant, cooperative, talkative, laughing and joking.

6.6 It is clear from the interviews and statements of Global Solutions Ltd staff that they are familiar with the procedures that should be put in place when someone in their care is at risk of suicide or self-harm.

6.7 At 1645 hours, three Global Solutions staff took the three men on the five-minute journey to HMP Liverpool and two of them handed the men over to reception staff. There was no risk identified by Global Solutions staff when handed over to prison staff.

7. HMP LIVERPOOL – BEFORE RECEPTION

7.1 The case involving the three men had a high media profile. As they were appearing at South Sefton Magistrates' Court, it seemed likely that they would come to HMP Liverpool. Even before the men arrived, the Head of Operations assessed that because of the alleged offence and the street value of the drugs, they would be submitted as potential category A prisoners (see section 8). The Head of Operations also decided that they should be located on three separate wings (B, F and I) in cells designated for category A prisoners or prisoners on the escape list. He shared this information with the duty governor.

8. CATEGORY A STATUS

8.1 HMP Liverpool is a category B local prison. It will routinely hold category B prisoners and some category C prisoners.

8.2 On infrequent occasions, a prisoner may be submitted as a potential category A prisoner because of the seriousness of the alleged offence. These prisoners can be held in Liverpool on a short-term basis until their status is confirmed.

8.3 If they are not confirmed as a category A prisoner, they will remain in Liverpool. If their status as a category A prisoner is confirmed, they will be moved to a prison in the high security estate.

8.4 There are four security categories – A, B, C and D. Convicted adult male prisoners can be placed in any of the four categories. Unconvicted adult male prisoners can be placed in category A but if they are not, they are considered uncategorised and are treated as if they were category B.

8.5 The four security categories are defined as follows:

Category A
Prisoners whose escape would be highly dangerous to the public, or the police or the security of the state, no matter how unlikely that escape might be, and for whom the aim must be to make escape impossible.

Category B
Prisoners for whom the very highest conditions of security are not necessary but for whom escape must be made very difficult.

Category C
Prisoners who cannot be trusted in open conditions but who do not have the resources and will to make a determined escape attempt.

Category D
Prisoners who can be reasonably trusted in open conditions.

8.6 The security manual (paragraph 34.58) describes the exception to single cell occupancy outside of the high security estate:

Standard risk category A prisoners held in prisons outside the category A estate must normally be accommodated in single cells. But such prisoners may share a cell if:

- the Medical Officer (perhaps in consultation with other health care staff) assesses the prisoner as a suicide risk who would benefit from the company of a cellmate

- the Governor or Head of Custody, taking advice from the Security Department, approves the Medical Officer's recommendation

- the shared cell is constructed to category A standards

8.7 Paragraph 34.64 outlines the arrangements for category A prisoners:

- Form F1352 must be used to maintain a continuous, auditable record of the supervision, location and movement of category A prisoners, incorporating movements to and from residential units. In the category A estate, this normally applies to high risk category A and E list prisoners, although standard risk category A prisoners can be subject to close supervision at the discretion of management. (The supervision of exceptional risk category A prisoners is set out in the SSU operating standards.)

8.8 The three men were all held in single accommodation that met the current physical security standards. In Liverpool, these are designated category A and E list cells. The E list refers to prisoners who are identified as a specific escape risk above and beyond their security classification. All three had a category A book that listed their movements.

8.9 There is a local security instruction in Liverpool that describes the arrangements for potential category A prisoners. The following is an extract:

- Governors of prisons outside the category A estate must draw up a contingency plan to cover the reception and reporting in of potential category A prisoners in these prisons pending their removal to a more appropriate prison.

- HMP Liverpool has in place the document 'Category A Procedures'; this serves as a guide to staff:

    - how to identify a prisoner to report in as a potential category A
    - action to take when a prisoner is to be reported in
    - completing all appropriate documentation
    - action to be taken when a prisoner is confirmed category A status
    - the treatment of a potential category A prisoner while he is being held at Liverpool

Reporting in potential category A prisoners

HMP Liverpool will only hold potential category A prisoners for the minimum period necessary to effect a transfer to an establishment within the category A estate; these will be submitted to headquarters at the earliest opportunity and moved out as soon as possible if the decision by headquarters is a positive one. A potential category A prisoner will be held in the most secure accommodation available, as directed by the duty governor. This will be the segregation unit unless health care issues require location within the health care centre.

Prison staff must identify on first reception prisoners charged with one of the offences listed below. This is the first indication that a prisoner may need to be reported in as a potential category A case:

- murder
- attempted murder
- manslaughter
- wounding with intent to do grievous bodily harm
- rape
- buggery
- robbery
- attempted robbery
- conspiracy to rob
- importing, producing or distributing drugs
- offences under the Official Secrets Act
- offences connected with terrorism
- any other offence likely to result in sentences in excess of 10 years

8.10 The Head of Operations made the decision to locate the three men on B, F and I Wings. There was limited space in the segregation unit (named the Care & Separation Unit) but the Head of Operations considered that to put all three in the unit would reduce the capacity to deal with any incidents over the forthcoming weekend. A, B, F, K and I Wings all had cells designated as A&E (suitable for category A prisoners or prisoners on the escape list) and he decided to use three of these (B, F and I Wings).

8.11 An officer, a member of the local branch of the Prison Officers' Association, objected to this decision through the Duty Governor and a residential governor. He felt that the Care & Separation Unit was a more suitable location. The Head of Operations was satisfied with his decision and the three men were allocated as he directed on B, F and I Wings.

8.12 Early the following week, it was confirmed that the man's son and stepson were not category A prisoners and they became category B prisoners.

9. HMP LIVERPOOL – RECEPTION

9.1 When the three men were handed over to Prison Service staff, they were located in a holding room. The man's stepson states that they were all a bit quiet initially. The man was called to the front desk and the reception senior officer checked the court warrants and made an identification check.

9.2 The man had no cash or property as he had given them to the police. The staff describe him as 'having a bit of a laugh' and the man said how this contrasted with his time in police custody. His stepson confirms this.

9.3 It was the man's first time in custody and it was also at this stage that the nurse established that he had difficulty in reading. The man was also given a welcome pack that describes the reception process in writing.

9.4 Once all the three men had been dealt with at the front desk, they were located in the same holding room, together with other prisoners. The reception sequence varies depending on the availability of staff and the individual needs of prisoners so the exact order that the man went through the process is not clear. However, all of the following did take place.

9.5 During his first reception screen interview with a Health Care Officer, the following patient details were recorded:

- The man's full name, the date, his GP's name and address, his home address, date of birth, prison number, next of kin, contact details and brief details of the current charge.
- The man stated that he had not been in prison before.
- In the last 12 months, he had not been homeless.
- He had not been seen by his GP in the last few months.
- He was not in receipt of any prescribed medications or medical treatment.
- No physical injuries had been received in the past few days.
- No problems with asthma, diabetes, epilepsy or fits, chest pain or tuberculosis. The man identified that he had an allergy to eggs.
- No personal concerns for his physical or mental health.
- The man identified that he drank alcohol socially.

- No history of illicit drug use.
- No help required in relation to alcohol or drug use.
- The man stated he had never received any help for any form of mental health problem.
- The man had never had medication for his nerves.
- There had never been any incidence of self-harm.
- The man appeared fit and well, he denied any low mood or suicidal thoughts.

9.6 The man was encouraged to see staff if he had any problems or questions. He was asked if there was any reason why he might need to see the doctor; he indicated no.

9.7 No planned action was indicated. The man was identified as fit for normal location, any cell occupancy and gym.

9.8 The continuous medical record (HR005), dated 16 April 2004, indicates that the health reception process had been explained to the man due to his literacy problems. He had denied again any low mood or thought of self-harm. The sick protocol was explained and encouragement was given to seek help for any problems or questions. The man and Health Care Officer signed the statement.

9.9 The statement by the Health Care Officer explained that the man had maintained good eye contact during their conversations in reception. When asked if he would like to see the doctor, he replied that all he wanted was a shower, to clean his teeth and get his head down. The statement clearly indicates that the man gave no indication of his intentions and gave the Health Care Officer no cause for concern. Following her period of duty in the reception department, the Health Care Officer returned to the health care centre.

9.10 An officer completed page 1 of the prison core record, which is a personal summary sheet. Its details include date of birth, age, place of birth, religion, ethnic group, marital status, number of children and a physical description.

9.11 In addition, there is a section relating to home address and telephone number. The man had given the address in Stoke, where he lived with his brother. When asked for a next of kin and the person should be contacted in an emergency, he gave the name of his young son. His stepson believes that the man saw this as similar to a will and that he would want ‘things to go to[his young son]’.

9.12 What was not clear to prison staff at this stage was that the son designated as next of kin was just nine years old.

9.13 An officer took the photographs for the man's prison identity card, which would allow him to move to activities throughout the prison. Extra copies had to be made as the man was a potential category A prisoner.

9.14 At this time, the man made a telephone call but could not get through. He asked for another call and on this occasion (1727 hours), he left a message for his partner. This is the transcript of that call:
'Hiya [name]. It's [name]. I can't ring you now again till tomorrow. Speak to you soon. Just ask [the man's brother and stepsister] if they'll all stick together please. Thanks, bye.'

9.15 An officer gave the man the option of prison clothing but he preferred to stay in his own clothes. He had a shower, then took a hot meal. He had been interviewed by a first night care officer. The night care officer completed a cell-sharing risk assessment and recorded that in his view the man was a low risk and was suitable for cell-sharing. The man was also given a brochure that described the first night centre. At this time, a registered general nurse noted on the back of the cell-sharing risk assessment form that the man did not present concerns following the self-harm assessment.

9.16 As a smoker, the man had been given a smokers pack, as had his son. According to the man's son and stepson, the man had not rolled cigarettes before and his stepson had to show him how to do it. While they were in a holding room, other prisoners asked for tobacco and it was the man who advised that they should not give it away.

9.17 It was whilst in the holding room that the son and stepson say other prisoners were speculating on the sentence they would face if found guilty. The stepson says that other prisoners said they were looking at 10 or 15 years. The son states that other prisoners said that they were looking at 15 years and his father at 25 years. The man was in the holding room when these discussions took place.

9.18 We have interviewed eight prison staff in reception, including a qualified nurse, who had contact with the man. They describe him variously as pleasant, polite, very relaxed, cheerful, not overly concerned, quite articulate, perky and laughing and joking. These are experienced staff who all knew the procedures if they had concern about self-harm or suicide. All expressed their shock at the man's death.

9.19 His stepson describes the man as 'pretty chirpy' at this time. It was he who was telling his son and stepson to keep their heads up and not let anyone get on top of them, and the stepson states that it was the man who was holding them together.

9.20 The man was concerned about whether there were drugs in the prison. He was aware that they were going to be split up but believed this was down to the police seeking to prevent collusion.

9.21 Neither the son or stepson detected anything out of the ordinary with regard to their father.

9.22 Friday is one of the busiest days of the week in Reception. The three men were three of 41 prisoners received into HMP Liverpool on 16 April. Some 52 prisoners went in the opposite direction.

10. MOVE FROM RECEPTION TO THE WINGS

10.1 Following the reception procedures, the three men collected bedding. An officer took the man and his son to their cells (B3-09 and I3-18 respectively) and another officer took his stepson to F3-16.

10.2 The man was taken to his cell first. It was a double-bunked cell (but intended on this occasion for single occupation). Prisoners on B wing were out associating. The officer opened the cell door and expressed the view that he did not think the man would be confirmed as a category A prisoner and that, come Monday, he would probably be able to be with his son. There was no television in the cell. I do not know why it was missing or if anyone offered to replace it.

10.3 The stepson was offered a breakfast pack and hot water and there was a television in his cell. The son did not have a television in his cell but the wing orderly obtained one for him. The last thing that the man said to his son and stepson was, “Right lads, keep your heads up and I will see you in the morning.”

11. **B WING STAFFING**

11.1 The projected staffing complement and actual staff in post figures at HMP Liverpool for uniformed staff are as follows:

End of March	Projected complement	Staff in post	Difference
Principal Officer	11	15	+ 4
Senior Officer	44	51	+ 7
Prison Officer	320	323.5	+ 3.5
OSG – Days	77	78.5	+ 1.5
OSG – Nights	14	14	0

End of April	Projected complement	Staff in post	Difference
Principal Officer	11	15	+ 4
Senior Officer	44	51	+ 7
Prison Officer	320	320.5	+ 0.5
OSG – Days	77	81*	+ 4
OSG – Nights	14	14	0

* Includes casual staff

11.2 Despite these figures, there is a high level of staff on sick leave, resulting in ongoing staff shortages.

11.3 On 16 April, the expected staffing profile would have been 11 staff in the morning, 11 in the afternoon and eight during the evening period. The detail for 16 April show this profile met so there were no staff shortages on B Wing on the day in question.

11.4 The night profile, when the prison is in patrol state, is one operational support grade (OSG) on B Wing and one prison officer on the Care & Separation Unit (B1 Landing). This profile was also met on the day in question, as was the health care staffing profile.

12. **CELL B3-9**

12.1 The cell in which the man was located is on B Wing. The ground floor (ones landing) is a discrete unit called the Care & Separation Unit where prisoners may be located – separate from the rest of the population - as a punishment or for reasons of good order and discipline.

12.2 There are three landings above the ground floor and the man was located in the middle of these, known as the threes landing, in cell number 9. There were cells above, below and either side of his cell, with two prisoners in each.

12.3 One of the prisoners had seen the cell being cleared and there was talk of it being used by a category A prisoner.

12.4 Following the incident, the cell was sealed as a scene of crime. Once the police released the cell, Mr McColm and I searched it. The cell was shabby and I found it dispiriting. The standard of decoration was poor, the furniture was damaged and the cell was dirty and clearly had been so for some time. Plaster was coming away from the ceiling and the mattress cover was torn. The toilet was particularly dirty and so was the area around it. There was poor quality bedding strewn around the room. This was not a safer cell and, as in many of the older prisons, two pipes ran along the rear wall.

12.5 The man's brew pack was unopened and the bed had not been made. As noted, there was no television (nor a radio) and the only reading material was a single page from a week-old newspaper.

12.6 In the toilet area, the window had a pane of glass missing.

12.7 There was a significant blood stain near the toilet bowl and two blood stains on the wall, about five feet from the ground near the window. There were no blood stains on the floor near the pipes.

13. DISCOVERY OF THE DEATH

13.1 After the man had been locked in his cell, he had a conversation out of the window with two other prisoners who were both in cell B3-08. The man told them where he came from, that he was charged with drug offences and that he was 'looking at 25 years'. Both of the prisoners said that he sounded down.

13.2 About five or 10 minutes later, they heard a gurgling sound as if someone was being violently sick. They shouted to the man but heard nothing.

13.3 At the same time, another prisoner, who was in cell B3-10, was watching the start of EastEnders so this sets the time at some point after 2000 hours. He heard a noise and was able to pull the sponge out of the missing pane in the window to cell B3-09. With a mirror attached to a broomstick, he could see directly into the man's cell. He describes the man as 'swinging' and that he had cut his head on the rim of the window sill. The prisoner thought that the man had self-harmed by cutting himself as the blood was dripping down his arm. He also believes that the man knocked himself out.

13.4 The prisoner observed this before any staff had entered the cell. He and his cellmate kicked their door and pressed the call bell to attract attention. An Operational Support Grade was on the night shift and detailed to be on B Wing. He had arrived at about 1950 hours and received a briefing from a member of the day staff which included that there was a category A prisoner in cell B3-09 and that he would be on an hourly watch, which is the standard practice.

13.5 At about 2010 hours, the Officer Support Grade (OSG) heard some banging and saw that the call bell light for the threes landing was lit up. He ran upstairs and was told by the prisoners in cell B3-10 that the prisoner in cell B3-09 was hanging. The OSG couldn't understand how they would know and looked through the observation glass.

13.6 He could only see the torso so he could not confirm that the man was hanging but describes there being a lot of blood. He kicked the door and shouted to try and get a response. When this failed, he used his radio to contact the control room to call medical assistance. This call is logged at 2014 hours.

14. STAFF RESPONSE/RESUSCITATION

14.1 The Officer Support Grade had an emergency pouch that was issued to him when he came on duty. He broke the seal and took out the cell key. There is a log that confirms that he signed for this.

14.2 An offficer was on duty on B1 landing and heard the OSG calling for assistance over the radio net. He reports attending the scene as quickly as possible and that the OSG was outside the cell. Once the emergency pouch was opened, they entered the cell.

14.3 Another officer was based on G Wing. When he heard of the call for assistance, he ran to B Wing and arrived just as the other staff entered the cell.

14.4 Two Health Care Officers were in the health care centre. One had the radio call-sign Hotel 1, which is the designated emergency response to an incident. When he was contacted, he ran over to B Wing, followed by his colleague.

14.5 When he arrived at the cell, the staff had already entered and he took charge of the scene. He directed that the man should be supported while the ligature (a sheet) was cut.

14.6 The two Health Care Officers were getting their scissors from their emergency pouches when the officer from G Wing produced his scissors and used these to cut the sheet while two members of staff supported the man. This was not easy as the space was confined, the man was well-built and there was a lot of blood in the toilet area. It took a number of cuts to get through the sheet.

14.7 A Principal Officer was the orderly officer and, as such, in charge of the prison at that time. He was contacted by radio whilst on H Wing. When he arrived, the man was being supported by two members of staff and then the ligature was cut and the man was laid on the floor to allow CPR (cardio-pulmonary resuscitation) to commence.

14.8 The man was laid down on the floor with his head towards the window and CPR was commenced. Vital signs were checked and at that point, a member of staff was sent to collect equipment from A3 surgery. During the process of CPR, a defibrillator was attached to the man's chest. A Health Care Officer told the investigator that the instruction was 'no shock advised'.

14.9 Chest compressions and mouth to mouth resuscitation were continued until the ambulance arrived and the paramedic team assumed control of the medical care. In total, three ambulances arrived; one doctor arrived with a paramedic team and administered emergency treatment. Death was pronounced by the doctor at approximately 2045 hours.

14.10 Blood was evident at the scene; it appears that the source of the blood was an injury to the man's head.

14.11 There are inconsistent accounts of whether the man's head was towards the window or the toilet. Those directly involved in the discovery of the incident, cutting the ligature and carrying out resuscitation are all in agreement that the man's head was towards the window.

14.12 The prisoner who alerted staff watched the whole incident throughout and states that the man's head was towards the window.

14.13 Most staff agree, as does a member of the Independent Monitoring Board who attended, that the man's head was towards the window.

14.14 The Duty Governor attended the scene later and escorted the police to the wing. He went into the cell but 'couldn't really see the body'. However, he did say that the part he could see showed feet aiming towards the window. The Deputy Governor attended the scene post-mortem and his recollection is 'towards the toilet as I recall, with his feet near the window'.

14.15 The prisoner who alerted staff watched the events throughout and said that the man's feet were dripping with blood. When the cell was examined, there was a significant amount of dried blood by the toilet. The cell window had two panels. As you face the window, the one on the right had the pane missing. It was this window that had the sponge in it that the prisoner who alerted staff removed in order to observe, via a mirror, what took place in the cell. The panel on the left was glazed. It was into the hinge of this window that the sheet was jammed to make a ligature.

14.16 At 2032 hours, the Duty Governor was paged. At 2038 hours, the Head of Operations was telephoned. The Duty Governor contacted the control room at Liverpool at 2046 hours as he arrived home. At 2052 hours, the Deputy Governor was informed. All three governor grades attended the prison. The Head of Operations, who lived nearest, arrived at about 2110 hours and made his way to B Wing. Having established that the man had been pronounced dead, he went to the command suite and followed the contingency plans in informing the Home Office Press Office and National Operations Unit in Prison Service Headquarters.

14.17 They, in turn, notified the Area Manager, who directly manages the prison's Governor.

15. NOTIFYING THE FAMILY

15.1 At about 2130 hours, the Deputy Governor arrived and together with the Head of Operations decided on how the family should be notified. The prison record had the man's nine year old son as the next of kin and the person to be notified in an emergency.

15.2 The Duty Governor states that he knew at that time that the boy was nine years old but the Head of Operations recalls that they discussed who to notify and that, as the man's son was in the prison, he should be informed.

15.3 The Head of Operations went to I Wing, unlocked the man's son and told him about his father. The son was distraught and he himself says it didn't sink in.

15.4 He was offered a telephone call and he phoned his girlfriend on her mobile phone. She happened to be in the man's brother's home at the time so the man's son spoke to his uncle and the man's partner. He was left on the phone for about 15 minutes.

15.5 The son was given a cup of tea and some cigarettes by the Head of Operations. He was asked if there was anyone else he wanted to notify and declined. He then explained about the man's stepson so the Head of Operations went to inform him. The Head of Operations apologised that he did not know that he was related to the man who died and then offered him a telephone call. He tried to contact his mother but initially was unable to get through. When he did get through, his mother was crying.

15.6 The Head of Operations spoke to the man's partner and then handed the phone back to his stepson to speak with his mother.

15.7 The Deputy Governor and Head of Operations decided, in the circumstances, that the son and stepson should share a cell in the health care centre, contrary to the instructions regarding the holding of category A prisoners.

15.8 They received medication to help them sleep.

15.9 Following this, the Head of Operations returned to the control room and found that a relative had been in touch and had left two telephone numbers asking to be contacted. The Head of Operations presumed that this was the son designated as next of kin but it turned out to be the man's brother, who explained that the boy was only nine years old. There was a delay in returning this call as the Head of Operations was tending to the son and stepson.

15.10 The man's brother was angry at the delay and that the family had not been informed directly by the prison. The Head of Operations tried to explain that they had notified the man's son who was also in Liverpool but the brother was not happy. He was also not happy that the man had been issued with a sheet that allowed him to hang himself.

15.11 The brother wanted to attend the prison straightaway but the Head of Operations explained that the man would be taken to the mortuary at the Liverpool Royal Hospital.

16. **POST-INCIDENT**

16.1 The police attended the scene and the Duty Governor escorted the scenes of crime officers to the cell. The cell was sealed at 0049 hours and the key to the padlock kept in a safe.

16.2 There was no note left but there were rumours amongst some prisoners that there was one. The prisoner who alerted staff met with the man's brother and told him this. The prisoner states he never saw a note and dismissed the rumours as ‘just prison talk’.

16.3 The prisoner and his cellmate were locked up throughout this period but once the paramedics had left, the Head of Operations opened the cell to check that they were alright and gave them a cigarette. They were locked up again later when the incident had ended.

16.4 There was no hot debrief. The Head of Operations explains that it was late and a number of staff had already left the prison while he was dealing with next of kin issues. Although the care team were contacted, a number of staff told Mr McColm that they were dissatisfied with the post-incident support.

17. THE EXPERIENCE OF THE BEREAVED FAMILY

17.1 The family are not happy with the handling of the notification of the man's death. They believe that someone should have visited them and they should not have been told on the telephone.

17.2 The man's brother tried to speak to a governor on a number of occasions on the night of his brother's death, and was frustrated that he could not speak to anyone in authority. When he did speak to the Head of Operations, the brother states that the Head of Operations agreed to meet him the following day.

17.3 When the brother arrived, he was introduced to a duty governor who was not on duty the night before. The Head of Operations did not attend the prison.

17.4 The family have also raised concerns about the staff/prisoner ratio on nights. They believe that one member of staff with up to 170 prisoners shows an insufficient level of care.

17.5 The brother has indicated that the man had previously tried to commit suicide and they would have expected his medical history to have been available.

17.6 They are particularly concerned about the condition of the cell and consider that it was not fit for 'a dog or even a pig'.

17.7 The family are also concerned that the clinical review did not commence until some eight weeks after the death in custody (see para 17.19 below).

17.8 When the brother met with the duty governor, he says he was told that the sheet that the man used was torn but the prisoner who alerted the staff said that it was a full sheet.

17.9 The family also believe that because the pane of glass was missing, the man was able to secure the sheet in order to hang himself.

17.10 The family are seeking clarification on why the blood in the cell was where the man's legs were when the injury was to his head.

17.11 Despite preparations that had been made by the Governor and her colleagues, the family had trouble visiting on the day I was in the prison. Those held at the gate included the man's son and grandchildren. It was only after the brother phoned Bob McColm's Deputy Governor, who in turn contacted Mr McColm, that the family were admitted to the prison. I recall and entirely understand their anger. I have been pleased to learn that the family liaison governor followed this up and the relationship between the family and the senior officer concerned is now very good. I have also been pleased to learn that there has been no recurrence of the difficulties.

17.12 Commenting on a draft version of my report, the Prison Service Area Manager for the North West, Mr Ian Lockwood CBE, wrote as follows: “With regard to para 17.11 the Governor would like to clarify that the family were not denied access to the prison, but that the Gate Officer was querying that [the brother] had a mobile telephone in his possession and the prison’s policy is that they are not allowed to be brought into the establishment. As soon as the Governor was made aware of this problem, she gave instructions that he and his family were to be allowed in the prison. It is perhaps unfortunate that [the brother] had to ring Mr McColm to inform of his situation before it was resolved.”

17.13 [The brother] and the man's partner have visited the cell on two occasions. They have also met with the prisoner who alerted staff.

17.14 We have put these points and criticisms to the prison. On the critical matter of how the family learned of the man’s death, the prison points out that the family live some two to three hours’ drive from the establishment. In normal circumstances, it would have been appropriate for a manager to travel to the house or to ask the police if they would attend the family home to break the news to family members. In this instance, because the man’s son and stepson were also in the establishment, it was felt that the news had to be broken to them immediately. They might have found out otherwise by hearing prisoners shouting out of the windows. Having been told the tragic news, the sons wanted to ring the family. It was a judgement call whether or not to allow this but it seemed humane to allow the phone call to take place. The Governor believes that whatever action had been taken, the prison would have been open to criticism.

17.15 The brother is convinced that the Head of Operations told him he would meet him the next day at the establishment. I understand that the Head of Operations is equally convinced that he said the duty governor would meet him, as he had no intention of being in the establishment on the following day. In the light of the brother's insistence, the Head of Operations is willing to concede that he may have inadvertently given the wrong impression through tiredness and stress, although he does not believe this to be the case. More generally, the prison has said to the brother that information given shortly after an incident is often inaccurate and that they are torn between trying to answer questions quickly and accurately. This does not indicate a sinister aspect, just that early information is often incomplete.

17.16 The prison says that the staffing ratios at night reflect the fact that prison is in patrol state and prisoners are asleep. The role of the member of staff on nights is to patrol and observe prisoners’ routines as well as any prisoner who presents a particular risk. B Wing can take up to 182 prisoners and one member of staff to cover this is not unusual at Liverpool, or indeed any other prison. (Although this level of staffing will surprise many members of the public, I have to say that what Liverpool have said is entirely correct.)

17.17 The prison says it does not have access to medical history on reception and the only way they could be aware of previous attempts at suicide is if the prisoner informs them or if a relative or friend brings the matter to their attention.

17.18 The prison acknowledges that the cell was in poor condition, but says it is difficult to maintain standards with such a high turnover. (I agree it is difficult to keep cells clean, but I have already made clear my own view of the state of the man's cell.) The prison says the absent pane of glass made no material difference as the sheet was jammed in the hinge of the other pane. The cell had a number of potential ligature points. (This is true.)

17.19 The prison says that blood dripped down the man's clothing and that there is no evidence that he was turned around. (In fact, as I have shown, there is conflicting evidence albeit the majority of witnesses are of one view as to the direction the body was facing.)

17.20 I personally asked for the clinical review to be commissioned on 22 April – the day after I attended HMP Liverpool and met the dead man's family – and the details were confirmed on 26 April. I am sorry that the family feel that there was undue delay thereafter. The arrangements whereby the NHS has lead responsibility for investigating clinical issues where healthcare in a prison is commissioned by the NHS (as has been the case at Liverpool since 1 April) are new, and it was the first time they had been called upon. I shall be keeping a close watch on these arrangements, but it may be that they will take some time to bed down.

17.21 In these very unhappy circumstances, I am very pleased to note that in their statements both the man's son and stepson praised Liverpool staff for the way they have been treated in the aftermath of their father's death.

18. THE INDEPENDENT MONITORING BOARD (IMB)

18.1 The IMB are members of the public appointed by the Home Secretary to monitor what takes place in Her Majesty's prisons.

18.2 At 2116 hours, and in accordance with contingency plans, a member of the IMB was contacted. He came immediately to the prison. Later, two other IMB members attended. They were all briefed about the incident. In their journal and on interview, they expressed satisfaction with the handling of the incident.

18.3 I am grateful to the IMB for making available to me their draft Annual Report for the period October 2002 – January 2004. I note the emphasis the Board place upon overcrowding and the inadequacies of the buildings. The Report reveals that the man who died was the seventh prisoner to die, apparently at their own hand, since the beginning of 2001. All these deaths were by hanging.

19. LIVERPOOL'S SUICIDE PREVENTION STRATEGY

19.1 Mr McColm attended Liverpool's monthly suicide meeting and examined three sets of minutes.

19.2 The meeting is chaired by a senior governor and is attended by all functional areas within the prison. Its membership also includes prisoner Listeners, the Independent Monitoring Board, Global Solutions Ltd, the Samaritans and NHS Mental Health Services. The average attendance at each of the meetings was 12.

19.3 There are standing agenda items as follows:

- Listeners support meeting minutes
- Audit of self-harm booklets
- A report from Global Solutions Ltd
- Review of deaths in custody, self-harm incidents, perpetrators and any serious injury
- Report from the Samaritans
- Training report

19.4 There was an annual review in March of the suicide and self-harm policy, action plans, self-audit and remedial actions, giving staff ownership and aspirations for the future.

19.5 We reviewed the draft document 'Liverpool Cares', which is waiting for a service level agreement with the Samaritans. It will then be signed off by the Prison Service Area Manager. This is a comprehensive document that includes the Suicide Prevention Management Team's roles and responsibilities, at-risk procedures including support plans, family and community links, prisoner involvement and support for staff.

19.6 The list of prisoner Listeners (prisoners trained to support other prisoners during times of crisis) shows 28 Listeners spread across the establishment.

19.7 We also examined the training records. These show 301 training places attended between 14 March 2001 and 20 January 2004. There have been 10 staff trained since December of last year.

19.8 The last Standards Audit, conducted in October 2002, resulted in a 'good' rating in suicide prevention.

19.9 Liverpool has a full-time suicide prevention coordinator. He is committed and knowledgeable.

20. CONCLUSIONS

20.1 None of the agencies (police, Global Solutions Ltd and the Prison Service) knew of the previous attempts to kill himself by the man who died. In the absence of this information, and in light of the man's demeanour and his answers to questions on reception, I do not think there can be any criticism of the failure to spot his vulnerability.

20.2 There is no record that the police considered that the man presented any specific risk in relation to self-harm or suicide and Global Solutions staff checked the escort documentation to ensure this.

20.3 The charges that the man, his son and stepson were facing were very serious and, if found proven, they would likely have attracted long custodial sentences.

20.4 The Global Solutions staff considered the three co-accused as decent people. It was considerate of GSL staff to allow them to share a holding room.

20.5 The custody record was completed in accordance with instructions and no concern was noted.

20.6 The man seemed at ease at this time, taking a second helping of lunch. It appears he expected to be remanded in custody and there was no noticeable change in demeanour after the court hearing. He was, however, surprised that his son and stepson did not get bail.

20.7 None of the seven Global Solutions staff noticed anything that would give cause for concern. It is clear that they are familiar with the necessary procedures to follow if they do detect any concern with a prisoner relating to suicide or self-harm.

20.8 There were no concerns about the risk of suicide or self-harm in relation to the man passed on from Global Solutions staff to Prison Service staff.

20.9 The three men met the criteria to be submitted as potential category A prisoners and it was right that they were treated as such.

20.10 As Liverpool is not in the high security estate, it was right that they were located in single cell occupancy as there was no identified suicide risk that would dictate otherwise.

20.11 The Head of Operations made the decision to locate the three men on B, F and I Wings on security and operational grounds. The designated A&E cells were suitable in security terms to be used for category A prisoners. However, the local security instruction states that a potential category A prisoner will be held in the most secure accommodation available, as directed by the duty governor. This will be the segregation unit unless health care issues require location within the health care centre.

20.12 Mr McColm contacted other prisons that take potential category A prisoners but are not in the high security estate. Forest Bank and Preston Prisons locate potential category A prisoners in the segregation unit, whereas Altcourse have them on normal location as their cells are built to the required security standard.

20.13 As it stands, Liverpool's local security instruction affords little discretion. In these circumstances, I would have expected the local instruction to have been followed. In the circumstances that obtained, I am not in fact critical of the decisions that were taken. However, if in light of this report the Governor believes that greater discretion is required, then this should be reflected in a new version of the local security instruction.

20.14 The procedures and category A movement and recording were correctly followed.

20.15 It was known by the mid-afternoon of 16 April that the three men would be coming to Liverpool and that they were likely to be submitted as potential category A prisoners. It is a pity that there is no protocol that could direct such prisoners to the high security estate, such as Manchester Prison which is a relatively short distance away.

20.16 The reception process was conducted properly and the man responded in a relaxed, light-hearted way.

20.17 The reception process does not routinely pick up whether prisoners have literacy problems and, with some of the initial information in writing, this can cause difficulties. I would expect this to be identified and for key information to be explained by staff.

20.18 This was the man's first time in custody and the process, although well-handled by prison staff, must have been bewildering.

20.19 The fact that the man lived with his brother, together with his partner - the mother of one of the co-accused - was not clear to prison staff until after the incident. It is not clear why the man named his nine-year old son as next of kin and this contributed to some of the lack of clarity around notification of the family.

20.20 Whilst it is not clear exactly in what order the reception process took place, all of the expected elements, including a health care assessment, shower, food and the issue of a smokers pack, were completed.

20.21 The standard of documentation in the medical records was good. All health care procedures were appropriately followed in the reception department, with clear evidence of effective communications between the man and the Health Care Officer. The man was observed and specifically questioned about his thoughts and feelings; he gave no indication of his intentions to staff, prisoners or his co-defendants.

20.22 I am satisfied that no act or omission by prison or health care staff contributed to the man's death whilst in custody at HMP Liverpool.

20.23 The telephone message the man left for his partner was brief but did indicate that the man would ring again the following day. I am pleased to note that the staff gave him a second opportunity when he couldn't get through initially.

20.24 The speculation of other prisoners on the length of sentence the man and his sons could expect would not have helped when the man considered his future prospects.

20.25 During the day, three agencies (police, Global Solutions and Prison Service) had dealings with the man who died. Seven Global Solutions staff and eight staff in Liverpool's reception had contact with him. These were experienced staff and none of them detected any concern about his well-being.

20.26 More significantly, neither his son or stepson, who knew him best of all, detected any change in mood. They both regarded their father as holding them together and doing what any decent father would do. As he left them, he was still telling them to keep their heads up and he would see them in the morning.

20.27 The staffing profile on B Wing was met on the evening and night of 16 April. I do not consider that staffing levels were a factor in this matter.

20.28 I find the standard of decoration and cleanliness in cell B3-09 to have been totally unacceptable. While I appreciate the challenge, I do not believe that a high turnover of prisoners is an acceptable reason for not achieving basic standards of decency. I would also have expected there to have been a television in the cell.

20.29 Once the man was located in the cell, he had a brief conversation with the prisoners in cell B3-08. He gave them a few details of why he was there, that he was looking at 25 years and, for the first time, he sounded down. At the end of an emotionally demanding day, no longer having to be strong for his son and partner's son, having listened to the speculation about how long he could be in prison for, and with his first experience of prison being the grim conditions in cell B3-09, it is hardly surprising that his mood had altered.

20.30 The prisoner who alerted staff was quick to respond to the noise from the man's cell next door, and he observed the man hanging and the head injury with blood dripping before staff unlocked the door. He acted responsibly and quickly in raising the alarm.

20.31 The Operational Support Grade's response when he heard the noise appears to have been immediate. When he observed the man and could not get a response, he followed instructions to summon medical assistance before entering the cell.

20.32 The response by Liverpool staff was quick and in sufficient numbers.

20.33 It was when the nurse arrived and took charge of the scene that the man was supported and the ligature cut. The scissors were available. I commend the actions of all those staff who attempted to revive the man in the cramped conditions of the toilet recess and in circumstances that must have been extremely stressful.

20.34 I cannot account for the inconsistency in the accounts of which way the man was laid. Those directly involved in the incident, including the prisoner who alerted staff, say his head was towards the window and pipes. Two governors who visited later say that his head was towards the toilet. The statements provided by attending staff at the incident are informative and the sequence of events is clear. The priority during this time was identified as immediate life support and therefore the documentation of the man's head injury was minimal and confined to staff statements.

20.35 The ligature was jammed in the hinge of the window. I do not consider the fact that the other window did not have a pane of glass in it to have been a factor. The ligature could have been attached even if it had been glazed. In addition, there were numerous other points in the cell where a ligature could have been attached.

20.36 The contingency plans were followed as required and the incident reporting procedures completed.

20.37 The response by the governor grades was as quick as practicable. The Head of Operations was contacted at 2038 hours and arrived in just over half an hour.

20.38 The Deputy Governor believes that in his discussion with the Head of Operations, they knew at that time that the designated next of kin was only nine years old. The Head of Operations is insistent that they did not and I do not see how it could have been established at that time.

20.39 Prison Service Order 2710 says the decision on how to inform the next of kin should take into account individual circumstances, especially the distance from the establishment. However, unless inappropriate for geographical reasons (i.e. distance from establishment and time taken to travel), it is recommended that – in the absence of good reasons not to do so – notification should be made in person by a visit to the next of kin by the Governor (or in his/her absence, the deputy) and chaplain/other religious leader.

20.40 The Head of Operations took the decision to notify the man's son face to face. It was at this stage he found out that the named next of kin was only nine years old. He gave the man's son telephone access to his family. The son chose to phone his girlfriend who, by coincidence, was in the family home. This gave the son the opportunity to speak with his family. He declined the offer of notifying anyone else. When he explained the circumstances of the man's stepson, the Head of Operations also gave him the news face to face. In very difficult circumstances, I consider that the prison discharged its responsibility under PSO 2710. The alternative would have been to have kept the news from the son and stepson and hope that they learned nothing via the prison grapevine. I am conscious that other members of the family may not agree with my conclusion on this very sensitive issue.

20.41 Although allowing the son and stepson to share a cell in the health care centre could be regarded as contrary to instructions in respect of potential category A prisoners, the decision was sensitive and appropriate and allowed the two of them to give each other support. I commend the prison for its action in this regard.

20.42 The man who died was not on an F2052SH (at-risk form) and therefore the F2052SH procedures are not directly relevant in this case. I note the good audit rating for suicide prevention, the well-supported meetings and the large number of prisoner Listeners.

20.43 The overall record on staff training is good but the level of training recently has fallen. It is important that the training remains a priority.

20.44 The Governor sent a personalised note of thanks to the Healthcare Officer. This was a kind action that I commend. I have been concerned to learn from our interviews that some other members of staff have felt unsupported and have not had contact with the Care Team.

21. RECOMMENDATIONS

21.1 Liverpool should review its local security instruction (LSI) relating to potential category A prisoners. The LSI should either give greater discretion to the duty governor on the location of potential category A prisoners or, if it is considered that the segregation unit is the most suitable location, then the LSI should mandate that the instruction be followed.

21.2 Liverpool should examine whether it is practical to develop a protocol that allows potential category A prisoners to be diverted to the high security estate.

21.3 The first night care in reception interview should be reviewed in order to identify those prisoners with literacy difficulties. Staff should then explain the first night procedures.

21.4 All cells should meet the basic standards of decency and be clean and well-maintained.

21.5 There should be checks ahead of a prisoner being located in a cell to ensure that it is decent.

21.6 There should be safeguards to ensure that all prisoners have a television on initial reception. Staff should be reminded to check that there is a television in all cells used for a first night in custody and more generally.

21.7 The prisoner who alerted staff, although now discharged, should be commended for alerting staff of the incident. I recommend that the Governor writes to him.

21.8 I recommend that the Governor draws to the attention of relevant staff and managers my comments in paragraphs 17.21 and 20.33.

21.9 In light of the comments from some staff regarding the level of support they received after the incident, I recommend that the Governor reviews the role of the Care Team.

21.10 The draft document 'Liverpool Cares' should be issued and fully implemented as soon as possible.