

**Investigation into the circumstances surrounding the  
death of a man at HMP Liverpool  
In February 2010**

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

**January 2011**

This is the report of an investigation into the death of a man. He was found hanging in his cell at HMP Liverpool in February 2010. At the time of his death he was a remand prisoner. He was 48 years of age.

I extend my condolences and those of my colleagues to the man's family. I hope that my report goes some way to answering any questions they may have.

The investigation into the man's death was undertaken by an investigator. A clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful to him and his review is annexed to this report. I would also like to take this opportunity to thank all of the staff at Liverpool for their cooperation during the investigation and in particular to a Senior Officer for his assistance to the investigator.

This is the sixteenth apparently self inflicted death to have taken place at Liverpool since the Ombudsman started investigating such deaths in April 2004. The last death in custody occurred at the prison just over two weeks before the man's. Although there is no similarity between the two deaths, I made reference in that investigation to the lack of information being recorded in the deceased's case notes, formerly known as wing history sheets, as I do in this report into his death.

The man had no history of substance misuse, mental illness or history of harming himself. Staff and prisoners described him as a stable prisoner, who exhibited no signs of depression and had a positive outlook. It was therefore a shock to all those connected with him that he apparently took the action that he did. His family felt that he may have been bullied whilst in prison. However, my investigation has found no evidence to suggest that this was the case.

The clinical reviewer in his clinical review concludes that the man, who was a diabetic, received care equitable with that he would have received in the community.

Although allegations of a sexual nature were made against another prisoner, who shared a cell with the man, they remain unsubstantiated and have been refuted by the prisoner concerned. Consequently I am unable to comment upon whether they had any bearing upon his death.

I conclude that given the presentation of the man to staff in the weeks leading to his death, staff at Liverpool could not have reasonably foreseen or prevented his apparent actions, irrespective of what his motive may have been.

I make no recommendations but draw the Governor's attention to two points, one on record keeping and one on staff training.

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

**Thea Walton**  
**Acting Deputy Prisons and Probation Ombudsman**

**January 2011**

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## SUMMARY

On 20 January 2010, the man was remanded into custody at HMP Liverpool. Arriving at the prison late that afternoon he went through the reception process. He was considered suitable to share a cell, signed a number of prison compacts and he was informed that his correspondence and telephone calls would be monitored.

He was also seen by a nurse in reception. The nurse noted that he was a diabetic, for which he was in receipt of medication, and had no history of substance misuse, mental illness or of harming himself. Due to a lack of space on the prisons main wings he was taken to the prisons healthcare unit.

Over the following days the man remained in the healthcare unit and his diabetes was monitored by nursing staff. It was noted in his healthcare records that he slept well, was settled in mood and presented staff with no management problems.

On 25 January he was moved to K wing, the vulnerable prisoners unit. He declined a formal induction, but requested an induction to the gym. He continued to settle into the prison's regime, gaining employment in the prisons laundry, and raised no concerns with staff.

Whilst in prison he received numerous visits. Shortly before one such visit, on 30 January, another prisoner alleged that his daughter, who was visiting the prison that afternoon, was a victim of the man. In light of the allegation made his visit took place away from the main visits hall and arrangements were made so the two men did not meet in future.

In the weeks leading to his death the man communicated regularly with his partner. Although little is recorded of him during this time it is apparent that he continued to cooperate with the prison's regime. Officers and prisoners described him as someone who always had a smile, a positive outlook and exhibited no signs of either depression or of feeling low.

On the afternoon of his death he received a visit from his partner. Returning to the wing he was locked in his cell at approximately 3.30pm. He was discovered some 45 minutes later by an officer delivering prisoner's mail.

The alarm was immediately raised and both officers and healthcare staff responded promptly. Staff made attempts to resuscitate him but were unsuccessful. He was pronounced dead by the prison doctor at 4.46pm.

After the man's death allegations of a sexual nature were made against another prisoner, who shared a cell with him. These allegations remain unsubstantiated and have been refuted by the prisoner concerned.

The clinical reviewer in his clinical review concluded that the man's diabetes was treated appropriately whilst in custody and the care he received was equable with that in the community. He also reported that the healthcare team who responded when the man was found acted in an appropriate and professional manner. As a

consequence of his enquiries he made no recommendations.

My own investigation concludes that staff at Liverpool could not have reasonably foreseen or prevented the man from taking the apparent actions that he did. Although I make no formal recommendations I draw the attention of the governor to issues he may want to address about entries in wing history sheets and Assessment, Care in Custody and Teamwork (ACCT) training. (The ACCT system is used to assess, observe and support prisoners at risk of harming themselves.)

## THE INVESTIGATION PROCESS

1. The investigation following the man's death was carried out by one of the investigators. Another of my investigators opened the investigation, whilst carrying out an investigation into another death at the prison. He met with the then Governor of HMP Liverpool, the Head of Safer Custody and a number of the senior managers. Having recently met representatives from the Prison Officers' Association and Independent Monitoring Board, he did not do so on this occasion. (IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.)
2. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Liverpool. The notices were displayed around the prison and invited staff and prisoners to contact the investigator should they wish to do so.
3. The investigator obtained documentation relating to the time that the man spent at Liverpool. He visited the prison to conduct interviews with a number of staff and prisoners who knew him or who were involved with his discovery in February. During the course of the investigation the investigator provided verbal and written feedback to the newly appointed Governor of Liverpool.
4. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review of the man's clinical care whilst in custody at Liverpool. His findings are summarised in this report and the full clinical review is included as an annex.
5. One of the Ombudsman's family liaison officers contacted the man's next of kin to discuss the purpose and scope of the investigation and to give them the opportunity to raise any questions or concerns they had about his death. His listed next of kin at the time of his death, his partner preferred not to be involved in the process. However, his brother accepted our invitation and the family liaison officer and investigator visited him and the man's former partner, on 15 April at his home in Liverpool.
6. The man's brother raised a number of issues during the meeting. He expressed his concern that his brother may have been bullied whilst in custody at Liverpool and in particular after an incident with another prisoner during visits at the end of January. I hope that this report helps clarify the family's concerns and any other issues that remain unclear, helping them better understand what happened to him.
7. The man's brother also sought clarification as to how his brother had attached the ligature to the cell door. He said that he had experienced problems arranging visits and had been treated badly by staff shortly before one such visit. He also said he had difficulty in contacting the prison's family liaison officer. I understand that the Ombudsman's family liaison officer has written to the man's brother addressing these and several other issues raised by the family.

8. The investigator liaised during the investigation with a Detective Sergeant of Merseyside Police who is acting on behalf of the coroner. He has also been in contact with the Coroner's office and a copy of this report will be sent to HM Coroner for Liverpool District to assist him with his enquiries. A copy of this report will also be sent to the National Offender Management Service.

## HMP LIVERPOOL

9. HMP Liverpool is a large local Victorian prison which has a maximum operational capacity of 1359 prisoners. It serves courts from the Merseyside area and holds remanded, unsentenced and convicted adult male prisoners. The prison has eight residential units, including one, K wing, which holds, because of the nature of their offending, vulnerable prisoners.
10. Healthcare services at Liverpool are provided by Liverpool PCT. A purpose-built hospital unit, which opened in 2007, allows healthcare staff to provide both outpatient and inpatient facilities. A doctor is on duty every day during normal working hours, and nursing staff remain on duty throughout the day and night. On occasions when no accommodation is available on the main wings, prisoners may be temporarily housed in the healthcare unit.
11. The last full inspection of Liverpool, by Her Majesty's former Chief Inspector of Prisons, was an announced inspection in September 2009. She reported that overall Liverpool, being one of the largest prisons in the country, had in the past been the subject of poor inspection reports. She commented that it was a better prison than when inspected four years previously but "hoped-for progress" had not been achieved. She reported that at a time of shrinking resources progress would not be easy.
12. The man's death is the sixteenth to have taken place at Liverpool since the Ombudsman's office took over responsibility of investigating deaths in custody in April 2004. Sadly another apparently self-inflicted death in custody occurred at the prison just over two weeks before the death. There appear to be no similarities between the previous deaths at the prison and the circumstances of the man's death. However, I note that my report into the death of a man at the beginning of February also makes reference to the quality of case notes/wing history sheets.

## KEY FINDINGS

13. The man was 48 years old at the time of his death. He had previously received a number of suspended sentences and in 1988 was imprisoned for the supply of controlled drugs. On 18 January 2010, he was arrested by Merseyside Police and later charged with a number of sexual offences against females under the age of 16. Having appeared at Magistrates Court on 20 January, he was remanded into HMP Liverpool.
14. Arriving at the prison at 5.30pm the man went through the reception process. Staff noted his personal details and the name and address of his partner, his nominated next of kin. A risk assessment was carried out and he was considered suitable to share a cell. Reception staff noted that there was no indication that he was at risk of harming himself. During the reception and subsequent induction process he signed a number of prison compacts (agreements with regard to either acknowledging the prison regime or with regard to the use of prison facilities, such as in cell television and use of telephones.) He was also advised that his telephone calls and mail would be the subject of monitoring under child protection measures.
15. The man was given a first night reception health screen by nursing staff. It was noted on his healthcare patient record that he was diabetic, for which he was in receipt of medication, including insulin. The nurse recorded that he had no previous history of mental health problems or had ever harmed himself. He was assessed as being fit to live on a regular wing. However, due to lack of space on the prison's wings, he was admitted to the healthcare unit. That evening he was assessed by one of the prison's doctors who prescribed the medications for his diabetes.
16. On the morning of 21 January, having slept well overnight, the man's blood sugar levels, for diabetic control, were taken by nursing staff and he administered his own insulin with no problems reported.
17. Over the following days he continued to be treated for his diabetes and having been examined by the prison doctor a standard referral to the diabetic clinic was made. He continued to sleep well and it was noted that he was settled in both mood and mental health presentation, with no paranoid thoughts or intention to self harm expressed. He presented staff with no management problems and no concerns were raised by staff with regard to his behaviour.
18. On 25 January, the man was moved from the healthcare unit to K wing, the vulnerable prisoner's wing. The following day staff offered him an induction programme, but he declined, saying that he "knew what he needed to know, and everything else was just common sense". However, he did ask for an induction to the prison's gym.
19. The man received numerous visits whilst in prison. However, on 30 January, shortly before one such visit, another prisoner alleged that his daughter, who was visiting him that afternoon, had been a victim of the man. In light of the allegations made by the prisoner the man's visit took place away from the main

visits hall and arrangements were subsequently made to ensure that the two men did not meet again.

20. Whilst on K wing he continued to be treated for his diabetes. On 6 February, appearing to be in a state of confusion he was treated by healthcare staff. It later transpired that he had not eaten breakfast that morning and his faintness was connected to his diabetes. On 12 February he failed to attend for his diabetes clinic appointment. My investigator was unable to establish why this might have been.
21. In the weeks leading to his death the man spoke regularly with his partner, on occasions several times a day. During many of the phone calls the couple discussed family and other domestic matters and his forthcoming trial. (Due to some of the conversation being inaudible my investigator has been unable to establish with any certainty what was discussed.)
22. On 15 February, the man completed an application form requesting that his brother be recorded as his next of kin. Receipt of the form was made on 16 February at 8.00am and passed to the administration office for processing.
23. During interview Officer A told my investigator that the man was “very quiet, never gave us any problems, always respectful.” She said that he very much kept himself to himself and did not particularly mix with others, apart from his cell mate with whom he seemed to get on well. The officer said he showed no signs of depression or of harming himself. She said she did not believe he was subject to bullying by any of the other prisoners. She told my investigator that he was an intelligent man who was open and who would tell staff if he had a problem.
24. Officer B, the man’s personal officer, told my investigator that the man:

“... was a guy who always had a smile on his face. I’ve never seen him down in the time that I knew him. He never seemed to have any problems. He was just really happy go lucky.....he wasn’t a moaner, he wasn’t a whinger.... good as gold and never a problem at all.”

When asked if there were any signs that he may have been bullied, he said there was no indication that he was, however, he said “... what goes on behind closed doors when we have gone I wouldn’t like to comment on.” My investigator asked him if he thought the man was the sort of person who would have told staff if he was being bullied or whether he would have kept it to himself. He said “I wouldn’t like to say because I didn’t get to know him that well”.

25. The man’s cell mate described him as being a quiet man but “chirpy and chatty”. He said that he would often talk about his girlfriend and other family matters. The cell mate said that on the 18 February, the man was acting as normal and that there had been no change in his behaviour, adding that he never appeared down or depressed.

26. Another prisoner who knew the man told the investigator that he and the man had worked in the prisons laundry together. He described him as a nice guy, who had a positive outlook and with whom you could “have a laugh”. He said that the man was approachable and tolerant, saying nothing seemed to faze him. The prisoner said the man appeared to show no signs of depression and that his death had been a total surprise.
27. On the afternoon of 18 February, the man received a visit from his partner. Returning to the wing at around 3.15pm he was let back into his cell by Officer B at around 3.30pm. The officer told my investigator that there was nothing untoward in his behaviour at that time. The cell mate was not there. (Although he had returned to the wing for lunch he returned to work at around 2.00pm not returning until raising the alarm with other prisoners at around 4.15pm). My investigator asked the officer if he noted any change in the man’s mood or attitude that day. He said there was no change and that he was the same as normal.
28. Later that afternoon, at approximately 4.17pm, Officer C was delivering prisoners’ mail when he was alerted by the cell mate and another prisoner, who were returning to their cells from work, that the man appeared to have hanged himself. On his arrival at the cell door, seconds later, Officer C said he could see what looked like a bolt sticking through the ventilation hole with a nylon string type substance attached to the bolt and leading into the cell. He immediately shouted for assistance from other members of staff whilst he unlocked the cell door.
29. Senior Officer A on hearing the call for assistance made his way immediately to the cell and found Officer C attempting to open the cell door. At first the officer was unable to open the cell door as the man was directly behind it. With the assistance of the SO, he managed to slide away a chair, propped between the cell door and the bed, which had been blocking their entry. Officer D, who heard the shout for assistance, also attended and on arrival at the cell and under the instruction of the SO radioed for an emergency response from healthcare. Officer C entered the cell to find the man hanging from the nylon thread that he had observed earlier. He immediately took his weight and cut the ligature. However, unable to take the full weight, the man fell to the floor, banging his forehead on the cell locker as he did.
30. The officers laid the man on the cell floor. The ligature was removed from around his neck and Officer B checked for signs of life. The SO sought confirmation that an ambulance had been called.
31. Nurse A, a Registered Mental Nurse (RMN), who when the alarm was raised was in the centre surgery, adjacent to K wing, responded immediately. Nurse B, a Registered General Nurse (RGN), who was also in the centre surgery collected the emergency response bag, defibrillator and oxygen and followed Nurse A. On his arrival at the cell he checked for signs of life, but there was none, telling my investigator that the man’s face was cyanosed (a bluish coloration of the skin caused by lack of oxygen). The nurses started cardio pulmonary resuscitation (CPR). Other healthcare staff arrived shortly after,

assisting both nurses with CPR. Oxygen equipment was assembled and a defibrillator attached, although at no stage did it advise to shock, not having detected a rhythm in the heart.

32. The paramedics arrived at approximately 4.32pm and continued CPR on the man. Two prison doctors arrived shortly after and he was pronounced dead by at 4.46pm.
33. In a letter found in the man's cell after his death, and addressed to his partner, he writes about not being able to "fight the system", that people would always believe the worst about him, and that he could not live with a 'label'. In the letter he writes of his children and how he is prevented from seeing them. He asked for his family's prayers in the letter and told them that staff at the prison had been "great".
34. The news of the man's death was broken firstly to his partner, his nominated next of kin, by a governor and other prison service colleagues at around 6.15pm. (Although an application had been received from the man requesting that his next of kin be changed to his brother, at the time of his death the paperwork had not been processed fully and therefore his partner's details were still registered as next of kin.) Having been informed by the man's partner that he had a brother, the governor spoke with him on the telephone and subsequently visited him to talk further about the circumstances of his brother's death. Although the family declined an offer of prison representative attending his funeral, the prison met the full costs of the funeral.
35. A hot debrief was held and was attended by staff who had been involved in the discovery of the man. I also understand that the staff care and welfare team approached those members of staff involved and that this was appreciated by many of the staff with whom my investigator spoke. I understand a review of all prisoners on open ACCTs was also completed by members of the safer custody team.
36. During his investigation my investigator became aware of information alleging that the man's cell mate had forced him to engage in a sexual act with him. A note written by two prisoners with whom the cell mate was placed after the incident alludes to this allegation.
37. On 14 June, Merseyside Police questioned the cell mate with regard to the allegations made against him. He told police that during the 2-3 weeks he had shared a cell with the man they had got on well, that he was a friend and said that at no point did any sexual contact of any nature take place between them.
38. He told the police that after the man had been found other prisoners began shouting things on the wing suggesting that he had had sexual contact with him and that it was his fault that he had taken his own life. The cell mate replied, as a joke, that he had forced the man to commit a sexual act on him the previous evening. He told police that they had not had any sexual contact, adding that his comment was in response to the taunts he was getting from other prisoners. No charges were brought against him in relation to the allegation.

## **ISSUES**

### **Clinical Review**

39. In his clinical review the clinical reviewer reports that on arrival at Liverpool the man was screened in a timely and appropriate manner, by healthcare staff, and that an appropriate attempt was made to identify his key health needs. He says that the screening nurse asked him questions about his mental health and he denied having any problems.
40. He reports that the man was identified as a diabetic and that his medication was correctly identified. He says, having experienced one or two episodes of hypoglycaemic attacks (a condition caused by a lowering of blood sugar and which can result in faintness, sweating, tremor and palpitations), the man received timely and effective care which was equitable with that in the community.
41. The standard of record keeping, the clinical reviewer reported, was satisfactory and there were no issues with regard to communications and or healthcare policies and procedures. He also reports that the members of the healthcare team who answered the emergency call on 18 February acted in an appropriate and professional manner.

In his review the clinical reviewer reports that:

“The man’s healthcare needs were sufficiently and appropriately assessed on reception and in custody at HMP Liverpool. He was assessed (correctly) to have no significant mental health problems. The adequacy of his diabetic control was assessed and plans put in place to improve the control.”

His review overall concludes that:

“... the care and treatment of the man was of an adequate standard ... The conclusion of the review is that what turned out to be his fatal attempt at self harm while foreseeable was neither predictable nor preventable.”

42. The clinical reviewer makes no recommendations following his review.

### **Other Issues**

#### **Concerns re bullying by family**

43. During their meeting with my family liaison officer and investigator, the man’s brother and ex-partner expressed their concerns that he may have taken his own life due to bullying. In particular they referred to an incident on 30 January, when shortly before a visit another prisoner alleged that his daughter was a victim of his. As previously explained, the prison took immediate action with regard to this matter and procedures were put in place to ensure that the two men did not meet again whilst in prison. My investigator could find no evidence

to suggest that he had been bullied as a consequence of this encounter or any other evidence to suggest that he was bullied at any other time whilst in custody at Liverpool.

44. However, as I have already highlighted, during the investigation the investigator was made aware of allegations circulating on the wing that his cell mate had forced him to engage in a sexual act with him. Having been interviewed by the police the cell mate categorically denied that any sexual activity took place between him and the man. Apart from the allegations made against him, my investigator, like the police, has found no evidence to substantiate these allegations.

### **Case notes / wing history sheets**

45. My investigator noted during the investigation that few meaningful entries had been written about the man in his case notes, the electronic replacement of written wing history sheets. Prisoners like him, often because they cause no problems to staff, go unnoticed and as such less is recorded in their case notes. As a consequence information which can form a pattern of behaviour over time is lost.
46. I appreciate that in a busy local prison staff have other, often more pressing demands placed upon their time. However, I believe it to be of great importance that staff record, when appropriate, their interactions and observations of prisoners and any change in their behaviour or demeanour. With the recent introduction of the electronic case notes prison staff should be in a position to record their interaction with prisoners more effectively.
47. Although I make no formal recommendation I would ask the governor to remind all staff of the importance of recording regularly their contact with prisoners and irrespective of whether they are the prisoner's personal officer.

### **ACCT training**

48. During the investigation the investigator was alerted to the fact that one of the officers he interviewed had not received ACCT training. Although I am completely satisfied that this had no bearing on the man's subsequent actions, and again make no formal recommendation, I would ask the Governor to satisfy himself that all staff who have contact with prisoners have received ACCT training to foundation level.

## CONCLUSION

49. Having alerted healthcare staff to his history of diabetes on entering prison the man also informed them that he had no history of substance misuse or of mental illness, including depression, or any history of harming himself. During his time he appears to have settled well into prison, accepting the regime and working in the prison laundry. He received regular visits from his partner and spoke with her daily. His personal officer described him as being “happy go lucky” and “good as gold”. A fellow prisoner described him as a nice guy with a positive outlook.
50. His apparent actions appear to be at odds with his behaviour and demeanour on the wing and his presentation to healthcare staff during his time at Liverpool. In the note found in his cell after his death he talks about not being able to “fight the system” or be able to live with people believing the worst about him. It may be that these thoughts of what was to happen in the future may have been a contributory factor in his death. However, I conclude that staff at Liverpool could not have reasonably foreseen or prevented him from taking the apparent action that he did.