Investigation into the circumstances surrounding the death of a man at HMP Liverpool in February 2009

Report by the Prisons and Probation Ombudsman for England and Wales

November 2009

This is the report of an investigation into the circumstances of the death of a man at HMP Liverpool. He was found hanging in his shared cell in February 2009. He was 49 years of age.

I extend my sincere condolences to all those affected by his loss.

The investigation was conducted by one of my colleagues. A clinical review was carried out by the local Primary Care Trust. I should like to thank the Governor of Liverpool and his staff for their co-operation.

The man had been remanded into Liverpool the previous July, charged with the murder of his wife. He was subsequently convicted and sentenced to life imprisonment with a minimum of 15 years. This was his first time in custody and it is clear that he found prison difficult. For his first six months in Liverpool he was maintained on anti-suicide monitoring and support measures until staff felt that he was no longer at immediate risk.

The day before his death the man was told he was to be transferred the next morning to a first stage lifer prison. After his death a journal was discovered in which he had made repeated entries about how much he was missing his wife and that he did not wish to live without her.

Despite the tragic outcome, HMP Liverpool emerges well from this investigation. I make one recommendation. This is about the provision and funding of the crisis intervention service.

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.

Stephen Shaw CBE
Prisons and Probation Ombudsman **November 2009**

CONTENTS

SUMMARY

The man at the centre of this investigation was 49 years old and was found hanging in his shared cell at HMP Liverpool in February 2009.

This was his first time in prison custody. He had been in Liverpool since July 2008, initially as a remand prisoner charged with the murder of his wife. On his arrival in Liverpool, he reported attempting suicide many years earlier when his first marriage was running into difficulties and he also said he had previously received treatment for depression. An ACCT[1] form was opened for him, and for a while he was kept in the prison's healthcare unit for enhanced observation.

In his first few months in Liverpool the man harmed himself on three separate occasions. All of the evidence indicates that he was very confused and distressed about his actions on the night of his wife's death. It is also clear that he was grieving for his wife and was finding prison life difficult. In due course he was discharged from healthcare and moved to a standard prison wing. The ACCT form remained open.

In early December 2008, he was convicted of murder and sentenced to life imprisonment with a minimum term of 15 years. He was moved back into the healthcare unit for a few weeks for close monitoring following his conviction.

He was moved out of healthcare just before Christmas and took a job as a wing cleaner. From around this time, it seemed that he was beginning to come to terms with his situation. On 14 January 2009, the ACCT form, which had been open for six months by then, was closed. The man told the ACCT review panel that he was looking forward to moving on to his new prison, HMP Garth (a first stage lifer prison).

Just over a week later, the man telephoned his daughter (a daughter from his first marriage). He made comments in their conversation that caused her to feel concern about his state of mind and these were reported to Liverpool. A senior officer spoke the man about the conversation but he said that his daughter had misinterpreted what he had said. The senior officer thought that the man seemed fine and that there was no reason to open an ACCT form.

In February, the man was told that he would be transferred to Garth the following day. One of the wing officers spoke to him that afternoon to wish him well and to tell him that she had written a very positive entry in his records about his behaviour.

At the early morning roll check the man's bed was seen to be empty. His cell mate was woken and asked to check if the man was in the toilet. When the cell mate opened the toilet door he discovered the man hanging from a ligature tied to the door. Staff went into the cell and attempted resuscitation. All efforts proved unsuccessful and he was pronounced dead.

[1] ACCT (Assessment, Care in Custody and Teamwork) is the process used for monitoring and supporting prisoners deemed at risk of self-harm or suicide.

A journal kept by the man was subsequently found in the cell which indicated that he had been contemplating taking his life for some weeks. He had written in the journal that he had come to the conclusion that he did not wish to live without his wife.

THE INVESTIGATION PROCESS

1. An investigator was appointed in this case. He first visited Liverpool on 26 February 2009 when he met the Governor-in-charge on the day of the man's death, another of Liverpool's functional Governors, a representative from the Prison Officers' Association and the vice-chair of the Independent Monitoring Board. The investigator also spoke with the man's cell mate.

2. The local Primary Care Trust agreed to carry out a review of the man's clinical care and treatment at Liverpool prison.

3. The investigator interviewed 11 members of staff. Two of these were joint interviews in company with the clinical reviewer. The investigator interviewed the prisoner with whom the man shared a cell in his final week. No other prisoners came forward in response to the posting of notices about the investigation.

4. One of my Family Liaison Officers contacted the man's eldest daughter and one of his brothers.

5. The man's daughter was concerned about a telephone conversation she had had with her father in January in which he had said that he would not be contacting her again. Her concerns were reported to the prison at the time. She understood that her father was being prescribed anti-depressants and she was worried that he might not have been taking his medication. She questioned how such medication is dispensed. The man's daughter also complained that, despite being the legal next-of-kin, she had not been contacted by the prison about her father's death.

6. The man's brother did not raise any specific issues that he wished to be looked into, but did ask to be informed of the findings of the investigation.

HMP LIVERPOOL

7. HMP Liverpool was built in 1855. There are eight wings, all of which are in use having been refurbished and provided with an integral sanitation system.

8. Liverpool is one of the largest prisons in England, accommodating around 1,400 prisoners. It holds category B and C convicted male adults as well as remand and unconvicted male adults.

9. The most recent inspection of Liverpool by Her Majesty's Chief Inspector of Prisons was an unannounced follow-up inspection in February 2007. The Chief Inspector's findings included:

> "Between 25 and 30 … ACCT forms were open each month and most of the men involved felt well supported … There was little multidisciplinary involvement in initial assessments but ACCT reviews usually involved a range of disciplines …"
>
> "In our survey, more prisoners than the comparator and significantly more than in 2004 said they had received information and support for feeling depressed or suicidal on their day of arrival. A crisis intervention nurse was available and used for many prisoners who were at acute risk of self-harm. … A weekly single point referral meeting held primarily for healthcare staff was also a good resource to support prisoners at risk."

10. Prior to the man's death, there had been 17 apparently self-inflicted deaths at Liverpool prison since April 2004. No matters arising in those cases were of direct significance to the circumstances surrounding his death.

11. The Independent Monitoring Board's report for the year 2007/2008 contains no matters significant to this investigation.

KEY FINDINGS

12. On an evening in July 2008, police officers were called to the home that the man shared with his wife. She was found to be dead and the man was arrested and charged with her murder.

13. The man remained in police custody until the morning of 12 July when he was remanded into HMP Liverpool. On arrival in Liverpool, he was seen by a reception nurse for a First Reception Health screening assessment. During the assessment the man reported that he had taken an overdose of paracetamol in 1985 for which he had needed hospital treatment. He also reported that he had been receiving treatment for depression since 2005. The reception nurse opened an ACCT form for him to be monitored and supported against the risk that he might harm himself. She noted on the form that he was: "… very tearful and emotional. No current thoughts of self harm, but states he has no feelings at present he's just numb."

14. The ACCT process requires that the at-risk prisoner be seen for an assessment interview within 24 hours of the form being opened. The man was seen for this purpose later that same day. He gave the assessor similar answers to those he had given to the reception nurse about having a history of depression and of taking an overdose, but told the assessor that he had attempted suicide by overdose on more than one occasion. He told the assessor that this was his first time in prison and he was scared. He said he felt numb and confused about what had happened with his wife. Despite those answers, the man again denied any present thoughts of self-harm or suicide. After the ACCT assessment interview, the reception nurse noted in the man's medical records that his clinical care plan would include locating him in a high observation cell in healthcare until staff considered it safe to relocate him.

15. Part of the ACCT process includes the identification of the problems the prisoner has that might make him feel suicidal, and identification of the actions to address these problems. A "Care and Management Plan" (known as a CAREMAP) should be written to identify the problems and solutions. The man's CAREMAP comprised the lack of contact with his family, his grief over the death of his wife, his lack of interaction with other prisoners and the need for him to settle himself on a standard prison wing.

16. On the early morning of 15 July, the man revealed to one of the nurses that he had used plastic cutlery to inflict some wounds to his neck. He said that he wanted to test the strength of the plastic. The nurse's records describe the wounds as "scratches". The man apologised to the nurse the following day, adding that he had no further thoughts of self-harm.

17. The man was moved out of the high observation cell on 18 July and into a standard healthcare cell.

18. The lifer liaison officer told my investigator that he is. In that role he meets potential life sentence prisoners when first remanded into Liverpool to find out whether they need any help or support at that stage. He has a more significant

involvement once a person is convicted and sentenced. As soon as practical after that he will visit the prisoner to explain how the lifer system works. The lifer liaison officer said that he aims to break the sentence down into manageable chunks by explaining how a life sentence is served (that a certain number of years are served in different establishments; that the sentence usually commences at a category B training prison, then to a category C prison and ending at a category D open prison). At the meeting he will try to identify the support needs of both the prisoner and his family. He said that he first met the man a few weeks after he was remanded into Liverpool. The lifer liaison officer explained his role and told him that he was available if he needed any help.

19. One of Liverpool's doctors spoke to the man on 7 August about a possible move from healthcare to a standard prison wing. He said that he did not feel ready for a move. The prison doctor visited him in his cell the next morning and again raised the issue of a move. The man revealed recently inflicted cuts to both wrists. The prison doctor recorded that he appeared irritable and angry. She also noted that he was not yet fit for discharge from healthcare. By midday he was noted to have consumed a large lunch and to be interacting appropriately with other prisoners in healthcare. The man told the nurse that he did not consider he should be sent to a standard prison wing as he had had a more important job before coming to prison than the other prisoners and so should be treated with greater deference.

20. The man attended an ACCT case review meeting on 21 August with the purpose of discussing his discharge from healthcare. He was noted to be anxious about living on a standard wing but to be aware of the rationale for the move. He transferred to B wing that afternoon.

21. A Senior Officer (SO) from B wing told my investigator that B wing held remand and trial prisoners. He said that the man openly accepted his guilt for the offence but found it impossible to talk about what had happened without breaking down in tears. Although he found it a difficult matter to talk about, what he kept saying was that he wanted the chance to explain in court his side of the story. The B wing SO gathered from what the man said that he found it difficult to understand himself how he had acted as he had. The B wing SO said that staff will discuss a likely sentence plan with remand prisoners who anticipate being found guilty and anticipate lengthy sentences. For instance, where they will be sent to start serving the sentence, what they will do at that prison and the courses they will be undertaking. Staff never got to that point with the man as all he could focus on was his appearance in court.

22. The man had an ACCT case review on 31 August during which he was noted to have become very tearful. He told the panel that he had constant thoughts of suicide and self-harm although he was managing to control these thoughts. A plan was made for him to be seen by the crisis intervention nurse, a registered mental nurse (RMN).

23. At interview with the clinical reviewer and my investigator, the crisis intervention nurse explained that the crisis intervention service at Liverpool is a pilot

scheme. He said that he has an open referral system; any member of staff can refer a prisoner to him or prisoners can refer themselves. The service is not for prisoners in healthcare as they will be managed by the in-patient mental health nurses.

24. The crisis intervention nurse first met the man on 1 September following a referral from a healthcare nurse. On that day, and for the following two days, he spent five hours in consultation with the man. The crisis intervention nurse said that the man was highly tense and highly distressed at these initial meetings. He was suicidal at this time and was receiving Mirtazapine (an anti-depressant medication).

25. The man's ACCT form was kept open throughout his time on B wing. The B wing SO told my investigator that he thought this was appropriate. He said that, while the man did not commit any acts of self-harm during this time, there were a number of reasons for keeping the form open. It was his first time in prison and he was still coming to terms with that, he was grieving, and he did not mix with other prisoners. Following an ACCT case review on 8 September, the B wing SO noted that he became very tearful as it was the time of his wedding anniversary. He mentioned that he was still having thoughts of self-harm although he was keeping those thoughts under control. He also mentioned that he had had contact with his brother, which was helping, as was his contact with the crisis intervention nurse.

26. The B wing SO told my investigator that he tried numerous times to interest the man in taking a job and in coming out of his cell more often. However, he was not interested in taking up any such options. The B wing SO said there was no real change in the man's demeanour throughout his time on B wing. At a case review at the end of October, the B wing SO wrote that the man continued to be tearful when interviewed but was continuing to work with the crisis intervention nurse.

27. The crisis intervention nurse reviewed the man on 22 October. On the following day he made an extensive entry in the man's clinical record detailing their consultations during the previous two months. This included the man's reports of a difficult childhood which included a very poor relationship with his father, the breakdown of his parents' marriage, and difficult relationships with some of his siblings. He spoke extensively about his own marriages including the breakdown of his first marriage that resulted in him attempting suicide by taking an overdose of paracetamol. He also spoke about his use of alcohol in dealing with life crises. The man described how his second marriage also began to run into difficulties, and spoke about his wish of expressing at court his sorrow about what he had done while also giving an explanation for his actions.

28. The man's trial was due to commence in early December 2008, and with the trial approaching staff were concerned about how he would cope. Arrangements were made for him to be moved into healthcare once he was convicted and sentenced. The B wing SO said that the man thanked him personally for these arrangements.

29. On 5 December, the man was convicted of murder and sentenced to life imprisonment with a minimum term of 15 years. On his return to prison from court he was readmitted to the healthcare unit.

30. The lifer liaison officer visited the man on 8 December. He told my investigator that the man was accepting of his guilt and of the sentence that had been imposed. He did say, though, that he still needed to understand in his own mind why he had done what he did. The lifer liaison officer told the man that he would now be allocated to a category B training prison (a first stage lifer prison) where there would be provision for him to speak to psychologists to help him gain an understanding. He told the man he had checked and found that all seven of the suitable prisons in the country had spaces available so he gave him the option to choose which he wished to move to. The man opted for HMP Garth (near Preston) as that would be the most convenient prison for his visitors.

31. An RMN chaired an ACCT case review on the morning of 15 December during which the man reported ongoing feelings of self-harm or suicide although he was not feeling that way at that moment. In fact, he said, that day was a good day for him. The RMN told my investigator that later on that morning he was sitting with the man in the healthcare dining room when he became upset and asked to speak in private. They went to his cell where he disclosed that he had cut his groin at the site of his femoral arteries. The RMN examined the injuries and noted that they were clean with no need for a dressing as they were almost healed. The man said that his trial and conviction had upset him and that was when he had cut himself. He also said that he had not been talking to staff. The RMN advised him to speak to staff if he became upset again.

32. On 19 December, the man was reviewed by another of Liverpool's doctors to assess his fitness for discharge from healthcare. He told the second prison doctor that his mood and levels of anxiety had improved, but he feared that he would deteriorate on returning to a standard prison wing. The second prison doctor explained to him the danger of growing dependent from a prolonged stay in healthcare. It seems that the man acknowledged that there was at least some merit in that argument.

33. On 23 December, the man was transferred from healthcare to I wing. The RMN saw him for a review before discharge. The RMN noted that the man was not happy about moving out of healthcare, while also realising that this was something that he had to do. The RMN told my investigator he had seen the man on most days while he was in healthcare and, towards the end of his stay there, there was no longer a reason for him to remain.

34. My investigator spoke to Liverpool's healthcare in-patient manager, about the RMN's view that the man should have remained in healthcare throughout his time in the prison. That way, he would always have had mental health nurses available to him. The in-patient manager told my investigator that the in-patient unit only has 27 beds with a prison population of 1,400. Healthcare beds are allocated according to clinical need and the man did not have such a need.

35. I wing's cleaning officer told my investigator that she was responsible for managing the 20 or so prisoners whose job it was to clean the wing. The cleaning officer's first dealings with the man were to move him from the cell where he was initially located on arrival in I wing. As he was on an open ACCT, the cleaning officer thought he should be located in a cell where he would be more visible. The cell she moved him to was opposite the wing managers' offices as well as being close to the stairs. The new cell was also close to the Listeners'[2] cell. In addition, the cleaning officer wanted him to have more contact with other prisoners so his new cell was a double cell to share with one of the wing cleaners. This meant that the cell door would be unlocked for most of the time. The cleaning officer spoke to him about working as a cleaner. She told him that he could give the cleaners a hand if he liked and then, if he wanted to, she could get him a job as a cleaner. The cleaning officer told my investigator that the man was very enthusiastic about working and he started a cleaning job soon afterwards.

36. The cleaning officer said the man was a very quiet person who gave no problems to the staff and who worked well with minimal supervision. Although he was always grateful for anything that officers did for him, he did not seem to confide in them. He mentioned one of his daughters to her, but when she asked if she would be visiting he said that he did not think so as it would be awkward for her. He did not say any more than that and she decided that it would not be appropriate to pry any further. The cleaning officer thought that the longest conversation she had with the man was following a visit that he had from his brother. It seems that one of the matters he had discussed with his brother was about the disposal of his car and this had saddened him a little.

37. The lifer liaison officer was not on duty when the man was transferred from healthcare to I wing. On his return to work he went to see the man to tell him that he would arrange for him to be transferred to A wing. (The lifer liaison officer told my investigator that A wing was probably the quietest wing in Liverpool whereas I wing is probably the largest and busiest.) The man replied that he was fine. He said that staff had already got him a cleaning job and he was perfectly happy where he was.

38. From the moment of the man's discharge from healthcare he ceased collecting his anti-depressant medication. This was noticed by staff and on 27 December a nurse made the following entry in his records:

> "Spoken to the man as not attended for his anti-depressants since returning back onto normal location, states he does not feel he needs them anymore, advised against stopping his medication but says he does not want to take them … advised if any change in mood to speak to surgery staff."

39. At an ACCT case review on 31 December, the man was noted to be in good spirits. He said he was now coping much better with his situation and that his job as a cleaner was really helping. He also reported having monthly visits from

[2] Listeners are prisoners trained by the Samaritans to provide the same service as Samaritans offer in the community.

his brother. He said he had not had any thoughts of self-harm since 5 December.

40. On 2 January 2009, the lifer liaison officer made the following entry in the man's ACCT form:

> "Spoke with the man for [one hour] about his sentence and how he is settling down. Seems a lot more at ease with himself and is accepting things a lot more easily. No concerns about [self-harm] or mental issues."

41. The I wing SO told my investigator that as the man was a cleaner he would see him every time he was on duty. He would usually exchange a few words with him about how he was getting along. The I wing SO said the man was a quiet and private man. He thought that that was his natural demeanour rather than an indication that he was depressed.

42. The I wing SO was the case manager at an ACCT case review on 14 January 2009. The man told the review panel that he had come to terms with his sentence and was looking forward to moving to Garth. He was already aware of the facilities at Garth such as the education courses available there. The I wing SO told him that because he had a good security history he would be able to get a good job at Garth. At interview, the I wing SO said that all of the issues identified in the ACCT CAREMAP had been addressed and the man gave no indication that he was struggling. Everyone at the review was content that the ACCT form could be closed.

43. An officer who was also on the ACCT review panel that day told my investigator that she did not know the man very well as she mainly worked on the third or fourth landing of I wing and the man had been located on the second landing. She had met him though when helping out on the second landing on one or two occasions. The thing that had stood out to her about the man was how polite he was towards staff. She recalled that at the ACCT review he was quite positive, saying that he was getting on well with his cell mate and that he was coming to terms with his sentence. She said that all members of the panel were content that the ACCT form should be closed.

44. My investigator spoke to the co-ordinating chaplain for the chaplaincy team who was also the full-time Church of England chaplain for the prison. The co-ordinating chaplain attended the ACCT review on 14 January when the chaplaincy team were contacted by wing staff and asked to send a representative. He said he had received ACCT training and had previously been an ACCT assessor. His recollection of the review was that the man spoke very positively about his relationship with his brother and the panel agreed that the ACCT form could be closed.

45. Another officer at the ACCT review that day told my investigator that he was a probationary officer in training at that time and he attended the review mainly for developmental reasons. The probationary officer's recollection was that it had been a fairly unremarkable review. He said that he would have been prepared to express his opinion had he objected to the ACCT being closed.

46. At an ACCT post closure interview the following week the man said he was feeling okay. He said that he had some "bad days, but no black days." He said that he was now feeling more optimistic, he was starting to come to terms with his sentence and was thinking of doing a degree.

47. On 23 January the man telephoned one of his daughters. He commenced the conversation by remarking on the fact that she had not been in touch. It emerged during the conversation that his daughter was still trying to come to terms with her father's offence and she seemed to indicate she was uncertain whether or when she might be able to re-establish a relationship with him. He told his daughter that he was going away and that he would not contact her again. She asked him several times where he was going, but he responded each time that he was just going away. He ended the conversation by telling his daughter that this would be the last time he would speak to her and that he could not "take any more".

48. The man's daughter is a police officer and she was at work at the time of the call. Following the call she spoke to her sergeant to tell him of her concern at the words her father had used. The sergeant telephoned the prison's security department to relay the man's daughter's worries. A member of staff in the security department listened to a recording of the conversation between the man and his daughter and wrote a report to say it was apparent that he was going to make an attempt to take his own life. I wing were informed of this.

49. The I wing SO took the message from the security department and went to speak with the man. The Operational Support Grade[3] (OSG) had come to the wing to pass the message in person as the security department were unsure that the original message had reached the wing, so they both saw him. The man's response was to say that his daughter had "got the wrong end of the stick". He said that he was fine at present and was looking forward to his move to Garth. From that conversation, the I wing SO had no cause for concern for the man's safety and did not think that the ACCT form should be re-opened. The I wing SO did not go to the security department to listen to the telephone conversation for himself and my investigator asked him whether he should have done. The SO said that he did not think that was necessary. He said that all the time people say things on the telephone that they do not necessarily mean. He added that had he listened to the conversation and come to the view that the man sounded suicidal, the man could still have convinced him on the wing that that was not his intention. Nor, he said, does it follow that it was his intention in January to take his life despite what subsequently happened. The I wing SO said that, until 24 February, there was nothing to suggest that he was at risk.

50. The OSG also felt that there was nothing about the man's demeanour to indicate he was at risk. Even so, he told the man to speak to the chaplains or to Listeners if he needed support.

[3] Operational Support Grade staff do not receive the same level of training as prison officers staff and have limited direct contact with prisoners.

51. The Principal Officer (PO) was the manager in charge of I wing at the time. He told my investigator that in that role he was responsible for around 200 prisoners and 30 members of staff. He explained that he avoids having too much daily contact with individual prisoners as that would undermine the authority of the officers and of the senior officers. The PO acknowledged that prisoners who have committed a capital offence against a loved one are at high risk of self-harm or suicide. Staff were therefore careful to monitor the man when he first arrived on I wing. The PO's fear had been that, if it were his intention to attempt suicide, he would make the attempt soon after arriving on the wing. It was for this reason that staff located him close to the wing office and close to the Listeners. It was for the same reason that staff wanted him to take a job as a cleaner, meaning that he would have to come out of his cell and mix with other prisoners. Within a few weeks the PO grew less worried. The man settled onto the wing, he was working and he was getting on well with his cell mate who was both a mature man and a Listener.

52. The crisis intervention nurse went to I wing to speak to the man on 26 January in response to a referral from the prison wing that he was feeling anxious and wanted to speak to someone. The man told the crisis intervention nurse that he was angry as he had been expecting a referral for counselling. He wanted counselling as he still felt a need to understand why he had killed his wife. The crisis intervention nurse told the man about the therapies that were available and the likely time it would take to complete a course. The crisis intervention nurse told the man that his transfer to Garth could be put on hold until he had completed therapy. However, the man said that his priority was to "put Liverpool behind him" and to move on to Garth as soon as possible. The crisis intervention nurse closed his case that day, but told him to ask to see him again if he felt he needed further support.

53. On 27 January, the man's daughter wrote to the prison requesting that staff speak to her father to ask him what he wanted done with various belongings that were still at the marital home. The PO told my investigator that he was asked to speak to him about the letter. When the PO read the letter for himself he wondered how the man would react. The PO called him into his office. He did not allow him to read the letter. Instead, he told the man what the letter was about and then read out each of the questions asked, noting his responses. The PO told my investigator that, when he first told the man about the letter, his eyes had filled with water. However, no tears actually fell and he quickly regained his composure. In dealing with the matters raised in the letter, it turned out that he had already made arrangements for his property. This included saying that he did not want property brought to Liverpool and put in storage with the risk that items might get lost or damaged. Instead, he would wait until he got to Garth and his brother would then bring in his property. The PO told my investigator that he had been worried beforehand about how the man would react to his daughter's letter. He was relieved when it turned out that he seemed to be making plans for the future.

54. On 4 February, the man consulted one of Liverpool's doctors. He complained about insomnia and low mood but said that he did not have any plans or

thoughts about self-harm or suicide. The doctor prescribed Mirtazapine and Promethazine as night-time sedatives.

55. Nothing of any significance occurred during the course of the following few weeks. The man had no significant contact with healthcare and did not ask to see the crisis intervention nurse. He continued to work as a cleaner and nothing occurred to cause wing staff any concern.

56. Confirmation of the man's transfer to Garth came through on 23 February with the transfer to be made the following morning. The lifer liaison officer went to his cell just before lunch to tell him the news. The lifer liaison officer told my investigator that the man seemed happy to go. He mentioned though that he had a number of visiting orders[4] for HMP Liverpool and he asked what he could do with those. The lifer liaison officer told the man that he could reassign those orders for Garth. The lifer liaison officer understood that it was mainly his brother from whom he received visits. The man had spoken about his daughters but in a way that indicated he did not expect to receive visits from them. The lifer liaison officer told the man that in circumstances such as his it was common for family members to sever contact for a while. However, over time, most families tended to come to terms with the situation leading to them resuming contact.

57. The cleaning officer discovered that lunchtime that the man was going to be transferred to Garth the next day. She decided to write an entry in his records explaining how well behaved he had been and how well he had worked as a cleaner. Later that afternoon she went to see the man to wish him well for his move. She thanked him for the work he had done and told him about the positive entry she had written in his file which the staff at Garth would read. The cleaning officer told my investigator that she and the man spoke for 20 to 25 minutes and that had been their longest conversation. He talked about his work before coming into prison. She again mentioned to him, as she had done on an earlier occasion, that he would have more in common with the prisoners at Garth compared to those at Liverpool. This is because he would have been with other life sentence prisoners in Garth rather than prisoners who would come in and then be out again within a few months. Similarly, she reminded him that the staff at Garth were used to dealing with the needs of lifer prisoners. In response, the man mentioned that he was still trying to deal with the grief he was feeling about his wife's death. She said that this was something he had mentioned previously.

58. The last time that the cleaning officer saw the man was around 7.15pm when she was locking the cell doors. As she locked his door she wished him good luck and he thanked her. She said that despite his lengthy sentence, she saw no signs that the man was at risk of suicide.

59. A fellow prisoner shared a cell with the man from around 17 February. He told my investigator that he had known the man for around two months before they

[4] Convicted prisoners are usually given one visiting order per fortnight which they send to those wishing to visit them.

began to share, but they had only exchanged greetings. He said the man was a quiet man who did not associate with other prisoners. However, when they became cell mates, the man began to open up. He spoke about his wife, about the holidays they shared and about how much he loved her. The cellmate said that the man spoke about his wife in a way that a widower would speak of a wife who had died from an illness. He mentioned he had two daughters but he did not talk about them.

60. The cellmate said that the man said a few things which, in retrospect, suggest that he was planning to take his life. He said that he "could not see the end of the sentence" and that he would be 64 before he would be released from prison. The man said that, once he left Liverpool, he would never come back. He also said that he would not be going to Garth which, when he said it, made the cellmate think he would "kick off" when officers came to collect him in the morning. The cellmate said that, as a trained Listener, he tried to reassure the man about his transfer. He told him that at Garth he would find people with whom he had much more in common: people who had long sentences to serve, who were closer to him in age and who had professional backgrounds. The man did not seem to take on board these points.

61. The cellmate said he had a set pattern that he followed each evening. He would go to bed at around 8.00pm and would usually wake at about 1.00am to use the toilet. The cellmate went to bed at his usual time but woke an hour later at which time the man was writing in his journal[5]. The cellmate woke at around 1.00am as usual to use the toilet. The man was in bed, but was awake, and he turned away as the cellmate got out of bed. The cellmate returned to bed and fell asleep again. He told my investigator that he now wondered, in retrospect, if the man might have been preparing a ligature which he concealed when he awoke.

62. At 5.30am, an OSG was making a count of the prisoners on I wing. When he reached cell I2-4 and looked through the observation panel he saw one prisoner (the cellmate) in his bed but there was no sign of the man. The OSG woke the cellmate and asked him to check if the man was okay. When the cellmate opened the toilet door he found him hanging from a ligature tied to the door. The cellmate lifted his body to take the pressure off his neck until officers came in to cut the ligature. The cellmate told my investigator that the man's body was cold and it seemed obvious he had been dead for some time.

63. The OSG told my investigator that when the cellmate opened the toilet door he saw the man hanging. The Night Orderly Officer (NOO)[6], was only about 40 to 50 feet away and the OSG shouted to him that there was an emergency. The Night Orderly Officer responded without delay and opened the cell door. The OSG said that he was carrying a cell key but it was in a sealed pouch whereas the Night Orderly Officer was carrying a set of open keys. They went into the cell, cut the ligature and laid the man onto the floor. While they were doing this, the Night Orderly Officer had also radioed for further assistance. The OSG said

[5] Extracts from the journal appear in the next section of this report.
[6] The Night Orderly Officer is the person in operational charge of a prison at night time.

that nursing staff were nearby and, by the time he and the Night Orderly Officer had lain the man on his back and cut the remnants of the ligature from his neck, two nurses had arrived.

64. A nurse made an entry in the man's clinical notes about the action taken by her and the other nurse in attendance. She recorded that the man was very cold and blue and had deep ligature marks around his neck. There also seemed to be damage to his windpipe. A defibrillator[7] was used and indicated that there was no electrical activity in his heart. The two nurses carried out cardio pulmonary resuscitation (CPR) until ambulance paramedics arrived. They arrived at 5.40am and their examinations confirmed that he was dead.

After the man's death

65. The man had nominated his brother as his acting next-of-kin. Due to the distance to his brother's home in Suffolk, Liverpool contacted HMP Hollesley Bay to ask staff from that prison to visit to break the news. Staff arrived at the home at just after 9.30am and were greeted by the man's sister-in-law. She informed the staff that officers from the local constabulary had already visited and passed on the news. (It seems that the Merseyside Police contacted the constabulary in Suffolk to ask them to inform the man's brother. His daughter was also informed of the news by the Merseyside Police.)

66. The family were informed by Liverpool that they would contribute to the costs of the funeral arrangements. A debriefing for staff was held on the morning of the man's death and the care team were made available. Arrangements were also made for support of other prisoners, the cellmate in particular.

[7] A defibrillator measures electrical activity in the heart and emits audible instructions on management of the patient such as whether or not an electrical shock should be given.

THE MAN'S JOURNAL

67. After the man's death a journal was found amongst his possessions. His cell mate told my investigator that he kept the journal locked in his cabinet. Significant entries in the journal commence just after the middle of January 2009. The man repeatedly commented on his love for his wife and his confusion over why he had done what he had. He also made repeated entries about not wishing to live without his wife and how, by taking his own life, he would meet her again.

68. On 23 January, the man wrote about his conversation that day with his daughter. He wrote that the conversation did not go well and that he had become upset. He speculated that he no longer had a relationship with her and noted that he had told her that he would not contact her again.

69. In an entry dated 1 February, the man referred to changing his mind about taking his life the previous night in the hope that things would get better. But in a later entry that same day, he indicated that he did not think that anything would change.

70. On 8 February, the man made an entry to say that he had intended to take his life the previous night but had not been able to do so as there were too many officers around. I include the last entry below in full:

> "Was told by the lifer liaison officer today at midday that I am moving to Garth tomorrow, I was fully expecting it around about now, but when he told me it hit me like a steam train, I feel totally thrown and totally lost. I know that when I leave here that I will never live in Liverpool ever again and it will be the end of my life as I have always known it. The other thing that hit me very, very strongly was my instinct to commit suicide tonight, the way that I have been feeling I really don't want to even start this other part of my life because to me it signifies acceptance of my prison sentence and in truth acceptance that I am willing to live the rest of my life without [my wife] and that is something that I am still just not willing to do, it's a prospect that I just cannot accept or live with. God give me strength to do what I need to do. Spoke with the cleaning officer for 10 [minutes] or so, she was fine and wished me all the best … I feel really bad about how it may affect her and one or two others but I think that it is bound to affect the cellmate more because he is my Padmate, I just hope that he doesn't take it personally, it's just something that I have to do, it's simply a case of I have had enough of this life now and I really want to be wherever [my wife's] spirit is. My God I miss her so very, very much I now know what life means without her and it's a life I no longer wish to live in I only hope that those closest to me can understand."

ISSUES

The closure of the ACCT form

71. An ACCT form was opened for the man on 12 July 2008, the day of his arrival in Liverpool. He denied any thoughts of self-harm, but nevertheless he had a number of risk factors. At the age of 49 he was in prison for the first time in his life, he was charged with a capital offence, the victim of the crime was his wife, he reported a previous suicide attempt (albeit many years before), and he had previously received treatment for depression. In addition to opening the ACCT form, the nurse decided that the man should be placed in the healthcare unit and located in a high observation cell. The man remained in that cell for almost a week and remained in healthcare until 21 August when he was transferred to a standard prison wing.

72. All of the evidence indicates that the man loved his wife deeply and was extremely confused about what he had done. He had a clearly expressed desire to attend court so he could explain his actions to his wife's family. That had been his main focus and he declined a number of offers of a prison job because of this.

73. The trial concluded on 5 December but the man's wish to explain himself at court did not materialise as the trial process did not present him with this opportunity. He was found guilty of murder and sentenced to a minimum of 15 years imprisonment. On his return to Liverpool he was readmitted to healthcare for closer observation than would have been feasible on a standard wing. The man was discharged from healthcare on 23 December and, on arrival on his new wing, was offered a job as a cleaner which he accepted.

74. The man's ACCT form had remained open for six months. During that time he harmed himself on three separate occasions, each time by cutting himself. Two of the incidents occurred within weeks of his arrival in Liverpool and on both occasions the injuries were comparatively superficial. The other time he harmed himself was just after his conviction. Following his final discharge from healthcare to I wing, he seemed to settle at last. He was working well in his cleaning job and the outward indications were that he was coming to terms with his sentence. At an ACCT case review on 14 January 2009 the man appeared well to the panel members and said that he was looking forward to his transfer to HMP Garth. The panel agreed to close the ACCT form. I consider the decision to close the form that day was a reasonable one.

The man's telephone conversation with his daughter on 23 January

75. When the man telephoned his daughter on 23 January his opening remark was about the fact that she had not been in touch lately. She responded by telling him that she was still finding it extremely difficult to come to terms with what had happened. He told his daughter that he would be "going away", although he refused to tell her where he was going despite her asking him repeatedly. Towards the end of the conversation he told his daughter that this would be the last time that he would speak to her. After the call his daughter, a police officer,

spoke to her sergeant. He then telephoned the prison to report to them that the man's daughter thought that her father sounded suicidal. A member of staff from Liverpool's security department listened to a recording of the telephone call and then informed I wing about the conversation and that the security department was also of the view that he might attempt to take his life.

76. On receiving the report, the I wing SO went to speak with the man. He was accompanied by an OSG. He denied that he was suicidal and said that his daughter must have misinterpreted his remarks. The I wing SO acknowledged in discussion with my investigator that he could have arranged to listen to the conversation, but he did not think that it was necessary to do so. He said that in speaking with the man, he was content that there was nothing about his demeanour to indicate that he was at any risk. The OSG felt the same.

77. My investigator listened to the recording and his view was that both the man's tone of voice and his comments indicated cause for concern. My investigator was particularly struck by the comment indicating that this would probably be the last time he would contact his daughter. However, had the I wing SO opened an ACCT form that day on the basis of the telephone conversation, it is most unlikely that the form would have remained open for very long provided there were no other signs or indications that the man was at risk (and there were none). I would speculate therefore that the form would have been closed a number of weeks before the man's subsequent death.

The man's medication

78. One of the man's daughter's concerns was that her father might not have been taking his anti-depressant medication (Mirtazapine). He was first prescribed Mirtazapine on 8 August 2008 but, after his transfer to I wing in December 2008, he ceased collecting it. the man told a nurse that he did not think he needed to take the medication any longer and the nurse advised him to speak to surgery staff if he noticed any change in his mood. the man was fully entitled to refuse medication if he so wished. His refusal was clearly documented by a healthcare nurse and the clinical review has not identified any apparent change in the man's mood as a result.

The emergency response

79. The man was found by his cell mate after he was woken by the OSG who was carrying out a roll check and was unable to see the man. Once the discovery was made staff responded promptly and attempts at CPR were made until the arrival of ambulance paramedics. I intend no criticism of the nurses who attempted CPR in what must have been emotionally draining circumstances. Indeed, their compassion and professionalism shines through. However, the evidence indicates that he had been dead for some time and, for this reason, CPR could have no effect.

Contacting the family

80. Prison Service Order (PSO) 2710 provides guidance and instruction on notification to families following a death in custody. In general, face to face notification by appropriately trained staff from the prison is the preferred option. Where the family live a long distance from the prison it is usual for contact to be made with the prison closest to the family home to ask that they make the visit. The man's named next-of-kin was his brother and Liverpool made prompt contact with HMP Hollesley Bay for them to break the news. However, when the staff visited they discovered that the news had already been passed on by officers from the local constabulary. It seems that Merseyside Police acted proactively in notifying both the man's daughter (an employee of theirs) as well as the man's brother. I can understand how the family were informed in this way in this unusual set of circumstances.

The support provided to the man

81. From the moment of his arrival in Liverpool, staff recognised that the man's circumstances meant that he was a person who needed support. An ACCT form was opened for him on the first day and kept open for six months. The man was also located into the healthcare unit on that first day and remained there for over a month before being transferred to a standard prison wing. the man was readmitted to the healthcare unit after his conviction for a further period of close monitoring before again being transferred to a standard wing – on this occasion, to I wing. In addition, the man received extensive support from the crisis intervention nurse. The crisis intervention nurse considered that the man should have remained in healthcare throughout his time in Liverpool allowing him constant access to healthcare nurses. I concur, however, with the sentiment expressed by the healthcare in-patient manager that with healthcare beds at a premium their allocation must be based on clinical need. The man did not have an on-going need.

82. When the man arrived on I wing he was located into a cell close to the wing office and close to the Listeners' cell. He was also offered a cleaning job, which he accepted. This allowed staff to keep him under observation.

83. Following his conviction, the man's sentence planning included his transfer to a first stage lifer prison. The lifer liaison officer checked with all of the first stage lifer prisons and found that all had spaces. He spoke to the man to ask him for his preference. He chose Garth as he said that prison would be the easiest for his visitors.

84. The lifer liaison officer also told the man that he would arrange a transfer from I wing to a quieter wing. The man declined the offer as he was now settled on I wing.

85. From the above it is clear that staff at Liverpool took active steps to support the man during what they recognised was a difficult time for him.

Should staff have realised that the man was at risk?

86. The man kept a private journal in which he recorded his thoughts during the final month of his life. The extent to which he missed his wife and how difficult he was finding it to live without her. He repeatedly wrote along the lines that in taking his life he would be with his wife again.

87. In an entry made on 1 February, the man wrote that he had persuaded himself not to take his life the previous night in the hope that things would get better. By the afternoon, however, his optimism had already evaporated.

88. It is apparent that the man felt able to disclose much personal information to the crisis intervention nurse. But with no officer did he establish such a close relationship. All discipline staff described the man as a very quiet and reserved individual. That said, he was certainly prepared to disclose personal feelings at times, such as at ACCT case reviews and at many of these he was recorded as tearful when speaking about his wife. However, the frequency and intensity of such episodes declined. All staff thought that the man eventually settled and, as far as they could judge, he seemed to be looking forward to his move to HMP Garth. The man's circumstances contained many of the characteristics of the high risk prisoner, especially the fact that he had been convicted of a capital offence and his victim was a 'loved one'. Staff were certainly conscious that all these risk factors were present, but I do not believe they could reasonably have foreseen what the man was about to do.

CONCLUSION

89. The man's death raises an interesting issue. With many of the self-inflicted deaths I investigate the motivation and the intent of the individual remain a mystery. But this is not the case with this man who made it very clear in his journal that he no longer wished to live without his wife (staff were not of course privy to the journal during the man's lifetime). After the man had made his decision the evidence suggests that he made some efforts to hide this from staff. To them, he gave out signs that he was coming to terms with his sentence and even said that he was looking forward to his move to Garth. It is very difficult to know what more prison staff can do in the case of an intelligent man who sets out to conceal his true thoughts and intentions.

RECOMMENDATIONS

90. In light of the clinical reviewer's analysis of the crisis intervention pilot, I make the following recommendation:

I recommend that the PCT consider the provision, size and ratification of the crisis intervention service at HMP Liverpool.

This recommendation has been accepted with crisis intervention to be included within a full clinical review of healthcare in Liverpool.

RESPONSE TO DRAFT REPORT FROM THE MAN'S FAMILY

91. Before the final version of this report was issued, a version was sent in draft form to all relevant parties seeking their comments. The man's brother replied with three pages of comments which included:

> "We would question the decision not to allocate [my brother] a healthcare bed … on the basis of adjudged 'clinical need'. This was despite the professional opinion of the crisis intervention nurse that due to the factors pertaining to [my brother's] case, he should remain in healthcare throughout his time at HMP Liverpool [given] that it was the crisis intervention nurse who was in regular contact with him.
>
> "Whilst giving recognition to the obvious difficulties in providing acceptable standards of psychological care within HMP Liverpool, I would ask that in future cases similar to [my brother's], consideration might be given to seeking further background information from close family.
>
> "We wholeheartedly concur with the [clinical reviewer's] comments regarding the crisis intervention nurse. However, we would also, with regret, echo the further observation, "He is on his own."
>
> "We fully accept that [my brother's] suicide was premeditated. Based on our previous knowledge of him, and our conversations with him during our regular visits and during telephone calls following his admission to HMP Liverpool, it is impossible to find otherwise.
>
> "Expanding further the enquiry's comments, we strongly believe [my brother's] 'failure to engage in confronting his problems and issues through psychological therapies' was attributable to:-
>
> "i) Whilst deeply conscious of the necessity for him to engage in such therapies, he was equally afraid that such engagement would, for an unknown period, substantially delay his deep desire to 'put Liverpool behind him' and make a fresh start.
>
> "ii) The profound hopelessness and desperation resulting from his inability to change his acute sense of isolation …
>
> "Other than questioning the decision … not to allocate [my brother] a place in healthcare until his transfer to an appropriate Lifer facility … and accepting the diverse and numerous difficulties inherent in the administration of such a large penal institution, we believe that those members of the medical and operational staff at HMP Liverpool who cared for him, did so proficiently and humanely as circumstances, and he, allowed."