

**Investigation into the circumstances surrounding
the death of a man at HMP Liverpool
on 9 June 2005**

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

August 2006

This is the report of an investigation into the circumstances surrounding the death of the man at HMP Liverpool on 9 June 2005. The man was found hanging in his cell at approximately 7.10pm that day.

I offer my sincere sympathy and condolences to the family of the man who have suffered the tragic loss of a loved one.

The investigation was carried out on my behalf by Mr Tom Wright and Mr Michael Hopwood. North Liverpool Primary Care Trust, which is responsible for the provision of health care in the prison, were also told of the death and asked to conduct a clinical review of the health care that the man received during his time in custody in accordance with NHS procedures. Since issuing the draft report the clinical review has been received from Mersey Care NHS Trust. It concludes that the service and care provided by the Substance Misuse Service was of a high standard and patient centred.

My thanks go to the Governor and all Liverpool staff. I appreciate their willing cooperation.

I make five recommendations. The clinical review has identified eight further recommendations which I endorse.

**Stephen Shaw CBE
Prisons and Probation Ombudsman**

August 2006

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SUMMARY

1. This is the report of an investigation into the death on 9 June 2005 at HMP Liverpool of The man.
2. The investigators reviewed the man's records and spoke to a number of staff and prisoners. The man was not new to prison life. On this occasion, he had been in custody at Liverpool prison since 8 June 2005. Although there was evidence that the man might have been a suicide risk, no ACCT (documentation in respect of those prisoners perceived to be at risk of suicide and self-harm) was opened on the day he arrived.
3. On the afternoon of 9 June, an ACCT was opened. The man subsequently spoke for some time to a member of staff, and then asked for a Listener (a prisoner specially trained by the Samaritans to assist those in distress). At about 6.30pm, he was told that a Listener would be coming over that evening from A wing and there would be plenty of time for them to talk together. At that time, the man was on the landing, as prisoners were out on association.
4. At approximately 7.10pm, when arrangements were being made for prisoners to be locked back in their cells, the man was found hanging from a vent cover in his cell. Other staff were alerted and cardio pulmonary resuscitation (CPR) was commenced. Healthcare staff and a doctor attended the man, but efforts to revive him were unsuccessful and he was pronounced dead at 7.25 pm.
5. This report makes five recommendations. Mersey Care NHS Trust has identified a further eight learning points.

INVESTIGATION METHODOLOGY

6. The investigation was opened on 15 June 2005. My investigators met with the deputy governor of HMP Liverpool and with other senior staff. They were later given a comprehensive briefing on the events leading up to and after the man's death.
7. Ombudsman's notices were issued to staff and prisoners, identifying the scope of the investigation and inviting anyone who wished to see the investigators to make themselves known.
8. Staff and prisoners in key positions or locations were identified and were invited to speak to my investigators. All responded willingly and fully. The local branch of the Prison Officers' Association were briefed. They were helpful and offered constructive comment and advice. They also met with the chair of the Independent Monitoring Board (IMB), on several occasions and he too was most helpful. Enquiries continued on 28, 29 and 30 June and on a number of days in July for interviews with staff and prisoners. On 3 and 4 November, they re-visited the prison to clarify a number of issues.
9. A particular effort was made by the investigators to speak to the man's cellmate and who had alleged that banging on the inside of their cell door during afternoon lockup on 9 June had been ignored by wing staff. He had been discharged from prison and seemed not to be contactable through his home address. The investigators spoke to his probation officer and an appointment was made for him to be interviewed, but he failed to arrive. It was not possible to contact him to find out why he had not turned up. The probation officer was provided with the contact details for the investigators, and told that they were willing to meet him and hear his allegations.
10. The Liverpool Coroner's office was contacted and additional information was provided to the investigation team by its staff. North Liverpool Primary Care Trust was told of the man's death and appointed a clinician to carry out a clinical review of the medical care the man received.
11. One of my family liaison officers contacted the man's parents, who are his next of kin, and offered them an opportunity to participate in the investigation. They did not want to meet at this time.

HMP LIVERPOOL

12. Liverpool prison was built in 1855. The site covers 22 acres and has a single capped security wall. It is a local establishment serving the Merseyside and Wirral area. It accommodates category B convicted male adults and those held on remand.
13. On 16 June 2005, it held 1,371 men in custody. It has a certified normal accommodation figure of 1,186 and an operational capacity (maximum crowded capacity) of 1,473.
14. Liverpool was last inspected by HM Chief Inspector of Prisons in September 2004. The Chief Inspector reported that, while there had been improvement since the previous visit, it was not thought that the prison offered a safe environment for prisoners. The Inspectorate found that bullying and drugs were rife and that staff needed to develop skills, and assume responsibilities, for managing prisoners who are not locked in their cells for most of the time. The Chief Inspector's report said that the establishment's suicide and self-harm policy was clear and widely understood. However, it was thought that the level of staff training in this area was low.
15. The prison replaced the F2052SH system for supporting suicidal or self harming prisoners with the new arrangements known as ACCT on 5 June 2005. This was later than the planned date of 1 April. It is understood that one of the reasons was to allow staff training to be brought to the required level. By the start date, there were 431 staff trained to foundation level including 24 officers on B wing. There were 68 case managers trained including four on B wing. There were 42 assessors trained, with one on B wing. The requirement was that all staff and prisoners were to be aware that the change was to take place, be familiar with ACCT and be aware of their role in the process. Not all staff had been formally trained by 5 June but subsequent training added another 118 by 18 October. The first phase of training had prioritised first line staff giving good cover to the residential areas of the prison.
16. It is understood that a number of changes have been made to ACCT arrangements at Liverpool in the light of these deaths. They include the appointment of a second full time suicide prevention co ordinator. A second family liaison officer has also been nominated. A suicide prevention action plan is being worked up for inclusion in the Establishment Improvement Plan 2.
17. All prisoners are screened for drug abuse behaviour on reception, and if necessary are seen by the staff of the drug dependency unit. Prisoners who are thought to be suffering the symptoms of drug withdrawal and needing help are admitted to the drug detoxification unit within the prison and treated with the necessary medication. Health care for prisoners is commissioned by North Liverpool Primary Care Trust.

KEY EVENTS

18. In early 2005, the man committed an offence involving an imitation firearm, and as a consequence was taken into custody at Liverpool prison. He was received on 7 February. Soon afterwards, he complained that his medication was inadequate and also that he had not been issued with his canteen (goods from the prison shop).
19. On 12 April, the man attempted to hang himself in his cell in the segregation unit. He appears to have done this as a way of drawing attention to his grievance over the canteen issue. The man afterwards said that he had timed the event to coincide with staff walking past his cell and thus be prevented from hurting himself. An F2052SH was opened for him that day and it remained open until 6 May. The man was referred to the chaplain and the wing Listeners, and the probation department was alerted. He was seen by the doctor that day and, after a night in healthcare on intermittent watch, was moved to shared accommodation on a residential wing. The man told a member of staff that night that he had not meant to take his own life, and that he had no intention of doing so in the future. He said he had staged the episode in an attempt to get his canteen. The man seems to have settled at this point and no further acts of self-harm are reported for the rest of this period of custody.
20. At the F2052SH review on 16 April, the man denied any thoughts or intention of deliberate self harm or suicide. He was, however, still made subject to the F2052SH. At the review on 28 April, he also said that he had no thoughts of self harm, but it was decided again that the F2052SH would stay open and that he would remain in shared accommodation.
21. On 6 May, the man went to court for trial, and on that day he was made the subject of a community rehabilitation order. This meant that he was immediately discharged from prison. Following further offences, the man was rearrested on 6 June. The circumstances were that he had entered a shop, threatened the assistant and taken money from the till. As he made his escape, he was hit in the face by a security guard with a piece of wood and as a result he received facial injuries. It is understood that soon after this the man jumped, or fell, from a building and received further injuries.
22. When the man was arrested he was taken to Belle Vale police station on Merseyside where he was seen by a doctor. Forensic medical examination (FME) register forms were raised on 6 June and 7 June. Following an x-ray examination it was found that he had no broken bones, but his body and face were badly bruised, and he seemed to be in considerable pain. He was treated with analgesia. The man was given a crutch as he had difficulty walking unaided. It was noted on the register form dated 7 June that the man had told the doctor that he had self-harmed in the past and still felt like harming himself.

23. The man was received into Liverpool prison on 8 June, having been remanded in custody by Sefton Magistrates for the offence of robbery. His appearance at Liverpool Crown Court was scheduled for 10 June. The accompanying Prisoner Escort Record (PER) form highlighted the facts that the man had drug and alcohol problems, and that he was at risk of suicide and self-harm. It contained no information on his injuries. However, the accompanying FME medical register form described these and the treatment that he had received.
24. The man was subject to the standard reception procedure. He saw the doctor and was assessed by health care. At the first reception health screen, he told the health care officer that he drank 60 pints of lager a week. He also said that he used cocaine. The man was referred to the doctor who prescribed analgesia for his pain. He was also prescribed a drug to help with alcohol withdrawal. However, it is understood that the man was not displaying withdrawal symptoms. The man was referred to the substance misuse clinic at the prison for assessment the next day. He said that he had tried to harm himself before, but stated that he had no current thoughts of self-harm. He was considered in all other respects to have been healthy and fit for work.
25. While in reception undergoing other assessments, the man was seen by a Listener. The Listener believed that, at the end of their conversation, the man appeared to be more cheerful. Due to the high volume of new arrivals, there was no room on the B wing first night landing so the man was located in a shared cell, 3-1 on G wing. This is an area where kitchen workers are located and has a more relaxed and sociable atmosphere. The night passed without incident.
26. During the morning of 9 June, The man was re-allocated to a double cell on B wing, 3-11. The man spent the morning in induction procedures for new prisoners, including a substance misuse assessment at which it was noted that the man was a polydrug user. However, he showed no evidence of withdrawal and declined the offer of drug detoxification. His injuries were also noted and for which he was prescribed analgesia, which he accepted.
27. At the end of the assessment, the man stated that he did not require the Librium that was offered as he was not experiencing drug or alcohol withdrawal symptoms.
28. Also during the morning, the man was seen by the wing Senior Officer (SO) who noted his poor physical condition and asked him how he was. The man told her about what had happened to him prior to his arrest in what she described as a fairly jocular manner. He seemed to her to be in reasonable spirits. He took his midday meal and then returned to the shared cell.
29. At approximately 2.00pm, the man was interviewed by two prison chaplains, one of whom reports that the man confirmed that he was feeling alright. At approximately 2.20pm, the man was directed to the second landing to await an appointment with the doctor at the drug dependency clinic. He waited outside the designated office

until called, and at approximately 2.30pm he saw the doctor. The man did not appear to the doctor to be obviously withdrawing from drugs or from alcohol, but it was clear from his notes that this had been an issue. The man again declined the doctor's offer of detoxification medication. He was told that should he change his mind he could request treatment in the future. It was noted during the medical interview that he had stated that he had attempted to hang himself earlier in the year. When asked by the doctor if he was currently experiencing any ideas of suicide, the man replied that he was not. He also told the doctor that he was somewhat stressed by the presence of another prisoner on the wing who had threatened him by shouting down from an upper landing on the wing. During the consultation, the man said that he felt he might harm himself. While the doctor found good reactivity and did not think that the man was despairing, he did think that he was anxious and angry. He opened an ACCT document.

30. It was not possible to identify the other prisoner whom the man said had shouted out threats to him. A check of security information records showed two entries for the man, neither of which involved threats or violence to or from other prisoners. There was no evidence that any violent physical contact took place between the man and any other prisoner.
31. The Senior Officer of B wing, who is a trained ACCT case manager, was alerted to the man's state of mind and ACCT status some time after 3.00pm. At approximately 3.20pm, she interviewed him in the wing office. He told her that he was worried about a prisoner on the fifth landing who had made threats against his family. This was playing on his mind and it was her impression that his main concern was for his family's safety, in that he thought they might have come to some harm from criminal associates outside of the prison. The Senior Officer told the man that she thought that he himself would be safe on the wing, but if he was concerned for his own safety he could be given protected status. The man declined the offer. Although it would appear that there was no immediate danger to the man, Senior Officer decided that it would be a good idea to move him to another wing the next day, and she told him this. Exceptionally, because he seemed so worried, she allowed the man to use the wing office to make a telephone call to his father. This was a short conversation, the content of which is not known. The Senior Officer asked the man if he was feeling suicidal and he replied that he was not, and he asked to be taken off of the ACCT. She did not agree to this and the ACCT remained open. The man was taken back to his cell at approximately 3.55 pm. The Senior Officer completed the ACCT immediate action plan which said that the man should be located in a double cell, and had been offered a Listener, which he declined. The frequency of support was set at "regular conversations and observations". This was not noted on the front of the document as required.
32. Some B wing prisoners said that, during the afternoon of 9 June, there was banging coming from B3-11 and that the cell call alarm was activated. Other prisoners who were also questioned by the investigators said that they did not hear any banging from the man's cell. It is understood that the other occupant of B3-11, told staff and

prisoners soon after the man's death that he had been banging on his door and ringing the cell bell. This was, he said, to get access to a Listener that afternoon.

33. A prisoner and a friend of both the man and his cell-mate, said in a later statement that he had told staff that the man wanted a Listener, but that nothing was done. He was unable to name any officers. This prisoner submitted a complaint form to the IMB in which he alleges that the man was banging on his cell door and using his cell call alarm all afternoon, but was ignored by wing staff. He offers no names in this either. This allegation is similar to one which was published in a local newspaper a few days later. The source of this story was unnamed. No staff interviewed could recall that any banging on cell doors happened that afternoon. While there were cell alarm calls, wing staff said that the cell bell in B3-11 was not activated.
34. At approximately 5.15pm, the man, along with the rest of the prisoners on the wing, was unlocked to go and collect the evening meal. While doing so he spoke to a fellow prisoner, and had a conversation with him about how he had come to be back in prison. This prisoner described the man as seeming stressed and rather down, but during their conversation but that he did not express any suicidal ideas.
35. At around 6.00pm, when the prisoners were unlocked for association, the man's cellmate went to the second landing where he spent time sitting with their mutual friend. The man stayed on the third landing. While on patrol, an officer was approached by the man who asked him if he could have a chat. The officer agreed and spent around half an hour talking with him. The man told him the problems that he had, including the difficulties that he was experiencing with a prisoner on the wing. The officer gave him some advice and thought that the man might be in need of a Listener and so offered to get him one. However, when the officer enquired, he discovered that all four of B wing's Listeners were unavailable. Two were on visits and one was comforting the other who had just received bad news from home. The officer asked the man if there was anyone else in particular that he would like to speak to. The man identified another prisoner who was the person to whom he had spoken the day before in reception and it seems that they got on well. His cell was on A wing, and so the officer left the man on the third landing on B wing and went to A wing to speak to this prisoner.
36. When the officer found this prisoner, he was on the telephone. The officer asked him if he could see the man and he said that he was happy to do this later that evening, when he was free. Another Listener, suggested himself but the officer declined to take up the offer. Having arranged with an A wing officer, that the Listener would go across later that evening, the officer returned to B wing. After he left the wing, a discussion ensued that included A wing staff and another Listener. He was said to be upset at a remark allegedly made by the B wing officer to the effect that he needed "someone sensible" to go and see the man. This Listener took this as a personal comment and vented his anger. He believed himself to be a "senior" Listener and therefore should have been taken to see the man. It would appear that at this stage no one on A wing was aware that the man had specifically

asked for the other Listener. When the Listener finished his telephone call he came to the office where the discussion was taking place. At approximately 6.50 pm, when asked by an officer if he was going to B wing, the Listener showed reluctance to be taken. He said words to the effect that he did not want to offend the other Listener. By 6.55 pm, it was assumed that B wing Listeners would be available or, that not being the case, B wing would call for a Listener should one still be required. When, at 7.00 pm, the first Listener asked if the matter had been resolved, he was told that B wing Listeners were now available and that if he was required B wing would ask.

37. At about 6.30pm, the officer found the man on the third landing. Unaware of any of the discussion taking place on A wing, he told him that the identified Listener had agreed to see him, and assured him that there would be plenty of time allowed for them to talk together. The officer's impression was that the man seemed quite pleased about this. There is no record of any further observation or conversation with the man until it was time for lock up.
38. Another officer had been detailed to assist with prisoners going back to their cells after evening association. At approximately 7.10pm, he pushed open the door of B3-11 and as he looked into the cell he noticed that the man's crutch was lying on the bed. He thought that this was odd as he expected the man would have needed it while he was on association. This officer turned back and looked through the cell's toilet area spy hole to see if the man was visible. He saw a part of a body close to the glass window on the wall behind the toilet bowl. He became alarmed and, on entering the toilet area, he saw the man hanging from the ventilator fitting above the glass window in the wall.
39. The officer ran on to the landing and alerted two other officers, who were on the wing, by shouting to them. They ran towards the cell. The communications centre was alerted by personal radio that there was an emergency requiring medical assistance. The communications officer in turn called for health care staff to attend B wing, and called for an ambulance. The officer returned to the man and tried to cut him down using a key from his bunch, but this was unsuccessful due to the taut state of the bed sheet by which the man was suspended. When he entered the cell, an officer took the weight of the man's body and another officer was then able to cut the man down. Once the man was on the floor, an officer used the tough cut scissors which had been brought to the cell by other staff to cut the ligature from the man's neck. It was noted that there was no pulse and that the man's eyes were open and glazed. Two of the officers commenced cardio pulmonary resuscitation (CPR).
40. At approximately 7.12pm, healthcare staff arrived and took over the CPR. The prison doctor arrived at 7.14pm, which was also the time that the control room called an ambulance. The ambulance arrived approximately five minutes later, but the paramedic team who attended the scene were unable to revive the man. The doctor pronounced death at 7.25pm.

41. My investigators spoke to most of the prisoners involved with the man, and checked that they were aware of the sources of post incident support that were available to them. One or two had said that they had been emotionally affected and had spoken to the chaplain and Listeners. Staff who were interviewed all said that they knew of the staff care team, and some said that they had spoken to its members.

42. Two governors visited the home of the man's parents at approximately 9.45pm to break the news of his death. They expressed shock, but no surprise as they had been worried about their son for some time. They had felt that he was ill enough to be held under the Mental Health Act, but this had not happened. They said that they did not hold anyone in the prison responsible for this tragedy. They were given the prison's Death in Custody booklet which contains guidance and contact telephone numbers for bereaved families, and the support that is available from the prison was explained. On 10 June, a governor again contacted the man's father and repeated to him the information regarding support to the family should it be required. On 13 June, the governor telephoned to offer financial assistance with the funeral and to invite the family to the prison. The latter was declined. It is understood that the family wished to deal with their loss privately.

ISSUES

Clinical review

43. On 15 August, my investigator told the PCT of the death, and asked them to carry out a clinical review of the medical care the man received as NHS procedures require. Following the issuing of the draft report, Mersey Care NHS Trust has submitted a review into the care and treatment provided to The man.
44. The review concludes that the service and care provided by the 'Substance Misuse Service' was of a high standard and patient centred. The range, scope, assessment and care was more than could have been expected within the requirements of the contract.
45. The standards of records and record keeping at times fell short of expected standards and they have recommended that expected standards are re-enforced.
46. The review team are of the view that, given the symptoms presented by the man on both 8 and 9 June 2005, the tragic circumstances of his death could not have been foreseen. They have identified eight learning points to further improve services and multi-disciplinary working which I endorse.

General issues considered

47. The man was in poor physical and mental shape upon his reception into custody and it was noted by the police doctor and the escorting staff that he had spoken of harming himself. It is surprising, therefore, in the light of clear evidence of risk, that reception staff did not open an ACCT as soon as the man arrived in Liverpool

The Governor should ensure that suicide prevention training is reviewed so that all staff are aware of the appropriate procedures.

48. The ACCT was opened by the doctor on 9 June, in recognition of historical factors, as well as concern about the man's current state of mind. It was not thought that he was in a very low mood, or that his behaviour was unusual, but the doctor was concerned when the man stated that he felt that he might harm himself. The required frequency of conversations and observations box on the front of the ACCT has been left blank, but the Senior Officer has written in the immediate action plan that conversation and observation should be "regular". It is not clear what level of observation this actually meant, and I would have expected that a clear number of observations per hour would have been specified. In addition, staff should have noted anything that was relevant to the risk that the man posed to himself. In the event, the only recorded contact was at 6.15pm when the man requested a Listener.

The Governor should take steps to ensure that the levels of ACCT observations and conversations are precisely defined, so that there is no room for ambiguity

49. There were allegations made, particularly by his cellmate that the man had banged on his cell door and rung the cell call alarm all the afternoon of his death. Up until around 4pm, the man was engaged with staff out of his cell. This leaves the period between then and about 5.15pm. The majority of those asked about these allegations (both staff and prisoners) said that they did not hear banging or a cell alarm. Certainly, the allegations of banging all afternoon would appear to be exaggerated, and it has not been possible to interview him to obtain further evidence of what he heard. There were two people in the cell and it is impossible to know exactly what took place at that time. Unfortunately, there is no system of recording cell bell calls in Liverpool prison. While my investigators cannot say for certain, on balance I take the view that there was probably no undue commotion to which staff should have responded.

The Governor should consider whether a system of cell bell recording should be introduced.

50. When the officer went to ask the Listener to come over to B wing, it was because the man had asked specifically for him. I think the officer's actions in support of the man reflect well upon him, but it is unfortunate that when he asked for the particular Listener, he did not make it clear that the man had specifically asked for him. It seems that the other Listener suggested himself as the man's Listener and took offence at officer's alleged response to this. It would appear that second Listener felt that he should have gone to B wing because he was the "senior" Listener. His irritation influenced the requested Listener, who did not want to usurp the other Listener's perceived position. This episode reflects little credit on those involved. There are no ranks among Listeners, and it appears to have been a major misunderstanding between staff and Listeners. The man was of course unaware of this controversy, and at approximately 6.30pm was told that he would be seeing the Listener he had specifically requested later that evening.

The Governor should make it clear to all prisoners and staff that there is no hierarchical structure amongst Listeners, and that that the function of Listeners is to respond to need, if they are able, wherever it is required.

51. The man was received into custody having sustained injuries during his arrest. The Forensic Medical Examiner assessed him and arranged for him to be seen at the local hospital. Whilst the FME reports were available, the Prisoner Escort Record makes no note of these injuries. Although this did not cause a problem in this case, the failure immediately to record the nature and extent of injuries on reception into prison custody could leave staff open to accusations.

The Governor should remind reception staff that, when prisoners are received into custody with obvious injuries, it is important that a note of these is made on the Prisoner Escort Record and countersigned by the escorting and receiving officers.

CONCLUSIONS

52. The man appears to have been in an unstable frame of mind following his arrest and reception to Liverpool prison. He had been injured and was in physical pain for which he was being treated. He had failed a community placement that followed his having committed a serious crime involving a replica gun, an offence that would normally attract a lengthy period of imprisonment. The man would probably have anticipated the likelihood of a significant prison sentence when he returned to court.
53. When he was received into Liverpool, the man stated that he was a polydrug user but denied any symptoms of withdrawal. Nor were any observed. He was given an assessment by health care and by the drug dependency unit and declined the offer of detoxification.
54. While it appears to have had no material effect on this case, it is surprising that, given the information that was available upon the man's reception to prison, an ACCT was not opened immediately. I have recommended that anti suicide training is reviewed with a view to ensuring that staff are aware of the appropriate procedure.
55. When deciding the observation and conversation level in the ACCT document, it was set at "regular". While the man was engaged by staff at least once during the association period, it is not clear what precisely the ongoing requirement for contact was. To help staff to be clear on the level of need, it would have been better to specify the number of contacts in 24 hours, and for this to have been written at the front of the document as required by ACCT.
56. Staff made attempts to find the man a Listener on the evening of 9 June and, as far as the man was aware, the arrangements were in place. It was unfortunate that a minor argument over who was senior to whom made one Listener feel uncomfortable enough to decline to go to B wing following his telephone call.
57. The man was able to hang himself using an obvious ligature point. I understand that a person who is determined to end his or her life will often find a way even in the safest of conditions. However, while I make no formal recommendation on this matter, the Governor may wish to consider how plainly visible potential ligature points in cells, such as the ventilator fittings, can be adapted and made safe.

RECOMMENDATIONS

- 1. The Governor should ensure that suicide prevention training is reviewed so that all staff are aware of the appropriate procedures.**
- 2. The Governor should take steps to ensure that the levels of ACCT observations and conversations are precisely defined, so that there is no room for ambiguity.**
- 3. The Governor should consider whether a system of cell bell recording should be introduced.**
- 4. The Governor should make it clear to all prisoners and staff that there is no hierarchical structure amongst Listeners, and that that the function of Listeners is to respond to need wherever it is required if they are able.**
- 5. The Governor should remind reception staff that, when prisoners are received into custody with obvious injuries, it is important that a note of these is made on the Prisoner Escort Record and countersigned by the escorting and receiving officers.**