The Death in Custody of a man at HMP Liverpool on 21 June 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2006

This is the report of an investigation into the circumstances of the death of a man at HMP Liverpool who took his own life in the Care and Separation Unit. Given he had a long history of medical problems, he was apparently in reasonable health at the time of his death. His death was sudden and unexpected.

My colleagues and I would like to extend our condolences to the man's family and all those touched by his death.

The investigation was led by one of my investigators. An independent review of the man's medical care in prison was commissioned from the North Liverpool Primary Care Trust. .

I would like to thank the management and staff at HMP Liverpool for their assistance and co-operation during the course of this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2006**

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Summary

The man who died was serving a life sentence for a number of cases of arson with intent to endanger life. The offences had attracted a good deal of local publicity because of their alleged racial undertones. He was initially remanded in custody and was sentenced to life imprisonment in 2002.

He arrived at Liverpool in August 2002 and was allocated accommodation with the rest of the lifer population at Liverpool where he remained until his death.

On arrival at Liverpool the man was suffering from diabetes and arthritis. He told healthcare staff that he was unable to walk unaided and needed constant full-time care. He was examined by a consultant orthopaedic surgeon, as well as other practitioners. They believed that his disability was not as serious as he had thought. A treatment plan was devised that would enable him to lose weight and be more active, thereby increasing the level of mobility he could achieve.

The man did not accept this diagnosis and refused to follow the treatment plan. During his time in Liverpool, there was continual and increasing friction and disagreement between him and healthcare staff about his medical condition. This situation led him to make many complaints, and to refusals and arguments which led to disciplinary offences. His location on an upper landing was a particular cause for complaint. Although it was near to the medical treatment room, a source of hot water and showers, he was required to negotiate stairs if he wanted to participate in other activities. He steadfastly maintained he was unable to do so. This meant that he would spend most of his time inside his cell or in the immediate vicinity.

The man was moved on the morning of 17 June 2005 from his cell on A wing to a cell in the Care and Separation Unit (CSU). This move was deemed necessary for good order and for health and safety reasons because he had started a protest which involved defecating and urinating on the floor of his cell. He maintained that this was due to his inability to use the in-cell sanitation. He also told another life sentence prisoner that it was a protest regarding his medical treatment. He refused to walk from his cell to the CSU when asked to do so and made passive resistance. He was carried by staff in a removal supervised by the Deputy Governor at Liverpool. He was allocated a cell in the CSU.

Whilst located in the CSU, the man would not agree to see the doctor unless a chaplain was present and began to refuse his meals. He told one of the chaplains that his intention was to force the prison authorities to move him to an outside hospital by inducing a diabetic coma, and that he was not trying to kill himself. For this reason and given the observations of other staff, he was not subject to any specific monitoring to prevent self harm.

The man remained in the CSU until he died at some time after 00.30am and before 5:00am on the morning of 21 June when he was discovered hanging from a ligature made from bedding. The duty officer found him in the toilet area of his cell, suspended by his neck from the cell window. The officer raised the alarm and several other officers responded. Shortly afterwards, a prison nurse arrived

with emergency equipment and determined efforts were made to revive him. An emergency ambulance arrived at 5:14am, and paramedics continued efforts to revive him. These proved unsuccessful and the paramedics declared the man dead at 5:20am. He was formally pronounced dead by a doctor at 6.30am.

The man's sister was contacted by local police. She was later offered assistance by the chaplain at Liverpool, and invited to visit the prison should she wish to do so. Her wishes with regard to her brother's property and the funeral arrangements were respected and complied with. The local coroner was informed and a formal police enquiry was started.

A clinical review was commissioned from the North Liverpool Primary Care Trust. It was compiled by the Head of Mental Health Integrated Commissioning (incorporating prison health), with clinical advice provided by the Medical Director and General Practitioner. .

No written notes or other indications were left by the man to explain the reasons for his actions.

The man's death was one of a series of deaths to have occurred at HMP Liverpool during this time period. I have not identified a common feature between his death and the others that took place at this time.

My report concludes that there was no failure of the duty of care owed to the man, nor negligence on the part of individual members of Liverpool staff on the day of the man's death.

I make six recommendations.

Investigation Process

1. My investigators first visited Liverpool soon after the man's death and met with the Governor. They were given a full briefing about the circumstances surrounding the man's death and the current situation regarding family contacts and actions instigated by the establishment to deal with the aftermath of his death. Offers to meet with a Prison Officers' Association representative and IMB were made and were taken up.

2. A family liaison officer from my office contacted the man's family to explain the purpose of the investigation and find out if they had any questions or concerns they wished to raise. A note was taken of the questions raised by his family in order to ensure that their concerns could be addressed. During the investigation these issues were explored, and I hope this report provides answers to their concerns.

3. To ensure that there was no interference or delay to the police investigation, no formal meetings or interviews were held with those members of staff who were directly involved with the man who died during the last few days of his life because these individuals were also being interviewed by the police. Shortly after the post mortem established the cause of death, the police concluded that there were no circumstances which warranted their involvement and that no further enquiry by them was necessary. The Ombudsman's investigation was then able to continue.

4. Notices to staff and prisoners were published in the prison, inviting anyone who might have information relating to the man's death to make themselves known to the investigators. Several prisoners who knew him well spoke to the investigators and these interviews were documented. Some staff were interviewed by police immediately after his death and those interview notes formed part of the evidence available to my investigators.

5. The investigators took away with them copies of the relevant files and records relating to the man. A clinical review was commissioned from North Liverpool Primary Care Trust.

6. The man's sister raised concerns about the medical treatment her brother had received at Liverpool. She said that her brother was not properly cared for by the staff who had day to day care of him. She also felt that he should have been moved to a prison that could cater for his particular disabilities and the limitations on his mobility.

HMP Liverpool

7. Liverpool is a category B local prison. It currently holds adult convicted, unconvicted and remand male prisoners, committed by courts in the Merseyside and Wirral area. Liverpool has a certified normal accommodation of 1,186 prisoners and an operating capacity (maximum crowded capacity) of 1,473. About ten per cent of this population are sentenced to life imprisonment.

8. The "Lifer Unit" holds a maximum of 114 prisoners, the majority of whom are sentenced to life imprisonment. (Some non life sentence prisoners are located on this wing because they require single cell accommodation.) Some life sentence prisoners are located on another wing which is designated as the wing for vulnerable prisoners.

9. Liverpool has a landing designated as a Care and Separation Unit (CSU) where prisoners are segregated from the normal regime. There is access to a telephone for prisoners. During my investigators' visit, the CSU landing was clean and quiet.

10. Healthcare at Liverpool is provided by the North Liverpool Primary Care Trust (PCT).

11. All staff working within healthcare in Liverpool are appropriately qualified. There are 38 in-patient beds including single, double and three bedded wards and two safer cell units. Two full time general practitioners are available each week day, one of whom provides cover, on a rota basis, during the evenings for late receptions. A healthcare company is contracted to provide out of hours medical cover. Appointments to see a doctor are triggered by wing application. There are four surgeries in the main prison that are manned throughout the day by clinical staff.

12. The current healthcare centre is about to be demolished and replaced with a modern purpose built healthcare unit. Temporary facilities to cover the transition period are in place.

13. During the night, an officer is located on CSU. Healthcare for CSU at night is provided by a nurse. On the night of the man's death, she was working in H2 Surgery. An emergency bag containing a defibrillator machine and other equipment is taken by medical staff to all emergencies.

14. At the time of the man's death, 55 prisoners at Liverpool had been trained in the previous year by the Samaritans as Listeners [prisoners who assist other prisoners in distress]. Two were resident on the Lifer wing on the night of his death and were also designated to cover CSU landing. One of the CSU Listeners has since been repatriated overseas and the other has completed his sentence. One of the CSU Listeners, resident at the time of the man's death, was recently commended by the Governor for successfully administering cardio pulmonary resuscitation techniques to a prisoner who had attempted self harm whilst located in the CSU.

15. My investigators saw evidence of reasonably good staff and prisoner relationships.

The man who died

16. The man who died was a single man who lived alone in his own house and had no dependants. He had attained a City and Guilds qualification in bricklaying. In later years, because of his arthritis he was registered disabled and did not work. He was also diabetic. On initial reception into custody he was deemed fit for some sedentary work and initially located in the prison hospital. He did not have alcohol or drug misuse problems and was a non-smoker.

17. The man was convicted for several offences of arson with intent to endanger life and was sentenced to life imprisonment with a six year tariff. This was his first custodial sentence. His main support was from his brother and sister. His sister was his main correspondent. He did not receive social visits.

18. He was clearly a man with health problems. His diabetes and arthritis were well-documented when he arrived in prison, and healthcare personnel were able to obtain considerable information from his GP and other medical records regarding his medical history. Staff at Liverpool arranged for him to be seen by an orthopaedic surgeon who authorised a series of examinations and tests to determine the seriousness of his condition. He was a very heavy man which exacerbated the mobility problems he experienced. However, the full extent of his disability was never fully established. He did himself insist that he was almost completely incapacitated, unable to walk, in continual pain and an invalid. Whilst accepting that he was indeed partially incapacitated and in some pain, the medical staff involved with him throughout his sentence were of the opinion that he was capable of walking to some degree. They also felt his mobility would be considerably improved if he were to lose some weight and make more of an effort to move around and become more active.

19. The man refused to accept that diagnosis and this resulted in friction and a refusal to co-operate with the healthcare department's treatment plan. It also created a continuing air of confrontation that persisted throughout his time at Liverpool.

20. He was located with other life sentenced prisoners on a designated "Lifer Wing". Another man, a long term Listener, knew the man who died quite well and described him as a cantankerous individual. This view was shared by another prisoner on the wing, but they both added independently of each other that in general he was a nice man. The man had long conversations with the Listener. According to the Listener this was not as a result of formal requests to see a Listener but the man would informally approach him and a conversation would take place. The last time he spoke to him as a Listener was about a week before his death. The Listener maintains that the man never spoke about suicide, that he was more a fighter against the "system", and that "suicide just wasn't in him".

21. The man who died was said by one of his contemporaries to be frustrated by his circumstances. As a result of this frustration, he was subject to a number of disciplinary charges at Liverpool following his destruction of prison property and being abusive to staff.

22. Several of the man's other contemporaries and those closest to him on the Lifer wing recognised that his manner, apparent disability and aspects of his personal hygiene made him unpopular with both staff and other prisoners. Several incidents were described to illustrate how isolated the man was, how he was subject to abuse by other prisoners (in one case it was alleged that staff did little to halt the abuse).

23. Some of the incidents described involved the throwing of rubbish into the man's cell by passing prisoners. One prisoner alleged these were the acts of Muslim prisoners who had learned of the offences that had led to the man's imprisonment. Because of his personal hygiene problems, there was name calling and the alleged use of a fire hose on him by another un-named prisoner whilst he was taking a shower. This resulted in him no longer taking showers and a worsening of the situation. The prisoner reporting this incident stated that he saw himself as the man's carer through his own choice. He felt the man was left up on the landing by staff with no support except for those prisoners closest to him. This is contradicted by the wing staff who knew the man who died. They said that he would not speak to some staff, but that those he would speak to helped him when they could.

24. The prisoner carer got on quite well with the man and, at interview, said that the caring did not involve intimate or personal care but that he did ensure the man had food, his letters were written and posted, his bedding was changed weekly and other tasks of a similar nature were carried out. However, he said the man's demeanour and manner made him a target for bullying by younger prisoners. As far as the prisoner carer was concerned, the man was unable to get up and down stairs because he was on crutches. He was located on the three's landing some 20 feet from the medical hatch; the prisoner carer said this was a compromise because the choice was either being located on the ground floor near to the food serving area or on the three's near the medical room. He said that the man never used the telephones because they were situated on the one's, four's and the five's landings and he could not get to them. The Lifer wing has open association throughout most of the day.

25. According to two life sentence prisoners who were resident on the Lifer wing, there was a long standing problem on the wing regarding the alteration of pre-select menus belonging to people like the man who died – older and vulnerable prisoners. The meal ordering system on the wing was that each individual selected from a printed menu the meals for two days hence. The selection would then be placed in an open box on the ground floor landing for listing and eventual delivery to the prison kitchen. Alterations to menus were carried out by younger prisoners on the wing between the time the menus were put in the box and when they were listed.

According to the prisoner carer, the man had complained that his food was being “messed about with” in that he received either no food or spicy food which he could not eat. The man also made a formal complaint regarding the alteration of his canteen order. He cited other prisoners as the culprits, but no names were mentioned. Those people interviewed were also unable to name the prisoners allegedly responsible for altering the menus or canteen orders.

26. Since this man’s death, the open box system has been replaced by a closed and locked box system. I commend Liverpool’s prompt action to address these allegations.

27. The man who is the subject of this report had not completed any offending behaviour work, apparently due to his circumstances. He complained frequently to prison managers and others including the Independent Monitoring Board (IMB), the General Medical Council and his solicitors. These complaints were mainly about his healthcare, a perceived lack of consideration for his disabled status and that medicines he had been prescribed were not issued. He was due to be assessed as to the extent of his disability by a consultant from a major teaching hospital in Liverpool in December 2004.

Events leading up to the man's death

28. The man was seen on initial reception at HMP Leeds and assessed as having physical health problems, including diet controlled diabetes, arthritis and hypertension. He was seen as an isolated man and a further assessment of his mental health was undertaken. He was initially admitted to the healthcare unit. On 28 March 2002 he was noted as having a depressive illness. He felt that his life was now over and that he would die in prison, although he expressed no self harm intentions. The man was assessed by a forensic psychiatrist who reported that there was no clear evidence that he was suffering from any mental illness, impairment or psychopathic disorder at that time. The psychiatrist described the man as highly opinionated, with an eccentric appearance that could be a target of abuse. He saw the man as likely to have some troublesome personality traits but stated that there was no evidence of a personality disorder.

29. After sentence the man was transferred from Leeds to HMP Liverpool in August 2002. His medical problems were noted and he was seen by the prison doctor and healthcare staff. At Liverpool, appropriate medication was prescribed and arrangements were made for the man to be seen by various specialists to ascertain the extent of his disabilities and to devise an appropriate treatment programme. However, he did not accept the medical assessment of his condition and refused to co-operate with suggestions or treatments that he believed were inappropriate.

30. On 18 April 2003, because the man was not attending the prison surgery for his medication, medical staff discussed his problems with him. He stated that he was refusing to collect his medication from the treatment room because of his impaired mobility, claiming that he found it difficult to walk up and down stairs. He asked to be re-located to another wing so that he could attend a more conveniently situated surgery. His status as a life sentence prisoner precluded this move. On the same day, an orthopaedic referral was made.

31. A week later he was still not attending to collect his medication. The possibility of him being transferred into the prison hospital was discussed with the Medical Officer and he was later admitted. Over the following few days he appeared to have settled well, although he did briefly refuse treatment because he was upset with his cellmate. A further letter requesting the opinion of an orthopaedic specialist was sent.

32. On 17 May, the man was refusing advice regarding his diet but was reported to have been more mobile and attending to his personal hygiene. He was again advised about his diet and exercise and three days later again he declined the advice.

33. On 29 May, whilst resident in the healthcare centre, the man was reported to have refused medication and become aggressive to staff. He was non-communicative and gave no reason for this behavioural change. He made two formal complaints regarding his medical treatment by staff at Liverpool.

He believed that the treatment and care he had received was inadequate. The first complaint was about the lack of treatment for what he called fleavitise (believed to be phlebitis). He had requested further antibiotic treatment to clear up a residual inflammation. He detailed a series of requests for antibiotics made to staff over a period of seven days, including an exchange between himself and a nurse culminating in a formal complaint being submitted. In the section entitled, "What would you like to see done about your complaint?" The man has written, "Nothing Just to let you know Give up." The Primary Care Manager at Liverpool responded to the complaint one week later. He advised the man to make an application to see the doctor.

34. The second complaint concerned the fact that the man had been told his blood pressure would be taken on the doctor's instruction. He claimed that this had not been done on the due date in spite of him reminding staff. In the section entitled, "What would you like to see done about your complaint?" The man has written, "Just telling you Nothing Give up." A nurse responded to this complaint. The nurse advised the man that the doctor had told staff to monitor his blood pressure, but had not specified how often it should be done, leaving it up to the judgement of the staff on duty. She also reminded him that his blood pressure was last taken on the day before the due date, and that she had been off duty in the interim. On the day after the due date, the man had spoken to her about the need for him to have his blood pressure taken and she had offered to take it immediately, but he had declined the offer.

35. Soon afterwards the man was assessed as being fit to return to the Lifer wing and he was moved on the following day.

36. On 5 August the man declined an appointment to see a physiotherapist.

37. Then over a period of about six weeks, the man declined his food and medication on numerous occasions.

38. On 21 August, the man saw a consultant at a hospital in Liverpool. The consultant confirmed that the man had multiple problems, both orthopaedic and non-orthopaedic in nature. The issue of the replacement of one or other of his knees was considered, but the outcome was that a replacement would not significantly improve his quality of life and that to do so would present a significant surgical risk. The consultant's conclusion was that the man's problems should be managed by weight control, analgesia and encouragement with regard to his mobility. A treatment plan was devised which included a weight reduction programme. The man decided to disregard the professional advice he was given.

39. Between 22 and 29 September, the man began his longest food and medication refusal. During this time he was offered a place in the healthcare centre by the prison doctor, which he refused. He also refused to sign a medication refusal slip.

40. Some of the man's contemporaries have described incidents where he staged brief sit down protests outside the treatment room, when he thought his medication was being "messed about with". These protests were resolved by wing staff sitting and talking to him until he ceased the protest or when he was physically moved back to his cell.

41. On 25 March 2004, the man became verbally abusive to medical staff. His in possession medication was not available for him to collect despite a new prescription having been written on the previous day. I note from the prescription chart that whilst the script was written on that day, it was not faxed to the pharmacy until the following day. The medication arrived later that day, but was not collected by the man. Four days later, medical staff went to the man's cell to inform him that the medication was ready for collection. He became hostile and abusive for which he was placed on a disciplinary charge.

42. On the following day, he refused medication and refused to sign a medication refusal slip. The dispute was regarding the type of analgesia being issued to him. On the following day, he stated that he was unable to move and asked to be transferred to the healthcare centre and put in a wheelchair "where people can look after me". At this stage, it is reported that the man was able to move from his bed to a chair, could get dressed and was not incontinent.

43. On 4 April, after a nine day refusal of medication, medical staff took the man's medication to his cell and explained in depth why he should take it. He refused and also refused to allow the nurse to take his base line observations.

44. Two days later, a review of the man's treatment was undertaken. He was noted as "evasive when offered physiotherapy" and that the treatment he required was weight control, analgesia and encouragement to mobilise. There is also a note in his records: "Also request Lifer psychological opinion." The doctor instructed that the man should be given all his medication in cell for the next seven days, after which he was instructed that he should present himself at the treatment room for pain medication three times daily. This he did, and during this time he was noted as being pleasant and polite and was seen moving about the wing. One week later the man attended education and had plans to attend two-three times per week. However, two weeks later, his demeanour altered and he began time wasting at the treatment room and began belching whilst he was there. A note records that the prison doctor challenged this offensive behaviour.

45. On 17 November, the man had a meeting with the Primary Care Manager, in his cell regarding his medical treatment and to address his abusive manner when dealing with healthcare staff. The man was shown the hospital consultant's notes explaining that he was a high risk patient for surgery. The man was told that a referral to a visiting dietician would be made when a date for their attendance was known. The issues regarding

his abusiveness were also aired. It was noted that he appeared happy with the meeting.

46. Later that month he was seen at the knee clinic at the local hospital and he was referred to a Consultant Orthopaedic Surgeon.

47. The man was due to be assessed by a consultant from a major teaching hospital in December to establish the true extent of his disabilities. The man refused to go to the hospital in the taxi that had been arranged for him. He considered that the transport was unsuitable. The appointment was therefore rearranged.

48. On 5 January 2005, the man declined to see the consultant in General Medicine, during his out-patients clinic at HMP Liverpool. The purpose of the appointment was to address some issues that the man had raised with medical staff. When he was offered a wheelchair to assist his attendance, he declined the offer.

49. On 3 March, the man refused to attend an appointment at a nearby hospital because in his view the taxi provided was inadequate. This time, the appointment was not rearranged.

50. On 19 April, a request was received from the General Medical Council for a copy of the man's medical records. He had made a formal complaint about a doctor at Liverpool and they were investigating under the Fitness to Practice procedures. My investigator is unaware of any resolution to this complaint.

51. Later that month, the man was due to be taken to the consultant's orthopaedic clinic in the prison mini-bus, which was more roomy and easier for him to enter and travel more comfortably. He refused to attend the appointment, wanting an ambulance to take him. The prison authorities were not prepared to accede to this request and the appointment was once again cancelled. At the time of his death, he had not been to hospital for this assessment.

52. On 16 May, the prison doctor re-assessed the man's single-cell status. The doctor and others were able to observe the man in the wing and noted his ability to walk using sticks and, occasionally, unaided. He decided that the man was suitable for double cell accommodation. No other prisoner was at that time located with him, but he was aware that this was a possibility if accommodation conditions demanded it.

53. The prisoner carer, a life sentence prisoner, said that the man who died was fairly good humoured until he began a dirty protest on 16 June. The prisoner carer described the protest as a small affair, consisting of the man urinating and defecating on the floor. He spoke to the man and offered to clear it up but the offer was refused, the man adding that he had had enough. He said that he was sick of meals and medication being messed about with. Other prisoners had become aware of his actions since the

smell had begun to spread out onto the landing, and they were avoiding passing his cell.

54. At about 8.30am on the morning of 17 June, the duty governor was at the regular morning management meeting. During the discussions he became aware that the man's dirty protest made it necessary to relocate him to the CSU. This was to be done under Prison Rule 45 which allows the Governor of a prison to segregate a prisoner for reasons of good order or discipline. Also present at the morning meeting were the Deputy Governor and the Healthcare Manager. It was clear that there were no medical or psychiatric reasons for not moving him. It was also discussed that the man was likely to refuse an order to walk to CSU when the time came for the move, planned for 9.30am. Should this occur, a planned removal would be initiated using approved control and restraint techniques. The man did as predicted, refusing to walk from his cell to the CSU after being ordered to do so and the offer of the use of a wheelchair being made. Preparations to move him forcibly were therefore put into action.

55. At 10.20am on the same morning, the man was ordered by a Senior Officer to walk to the CSU. Again he refused to move and again he refused the offer of the use of a wheelchair. He was then carried by six officers from his cell on the Lifer wing to the landing below where he was again offered the opportunity to be pushed in a wheelchair for the remainder of the distance to a designated cell in the CSU. The man did not offer any violence, but he refused to walk on his own and refused the use of a wheelchair. He was then carried by the removal team to the CSU. Prisoners who heard the removal take place have reported him to have shouted as if he were in pain all the way from his cell to the CSU. However, no prisoner gave an eyewitness account of the removal to the investigator.

56. The Deputy Governor personally supervised the removal to ensure that it was carried out correctly and the impact on the man was minimised. A Healthcare Officer was present throughout the transfer. The move was carried out and the man was placed on a bed in a CSU cell. This cell was designated as an "ordinary" cell. The cell door was left open so that the man could be observed and monitored by staff. Use of Force forms, statements and a 'Report of Injury to Inmate' form were properly completed by those staff tasked with moving the man from the Lifer wing to the CSU. The Report of Injury form completed by the Senior Officer reports no apparent injury to the man during the removal.

57. At 11am, the duty governor was informed that the man's move had taken place. At 11.05am, the man was examined by the duty doctor and the Healthcare Officer who accompanied him to the CSU. The doctor notes in the continuous medical record that, on examination, the man "looks well to me and well nourished. Also gives a good account of himself. However refuses to discuss his illness in the absence of the chaplain." One of the CSU staff records in the man's file at this time that he was refusing to see anybody unless the chaplain was present.

58. After location in the CSU on the Friday morning, the man made a request to see a member of the chaplaincy staff. The Methodist chaplain attended some 45 minutes later at about 11.50am. The man requested that she come into the cell and that the prison officer who had escorted her should leave the cell and station himself out of earshot. According to the chaplain that is what happened. She then had a conversation with the man in which he stated that he would only talk to prison officers, doctors and nurses in the presence of a chaplain. The reason was that he did not trust anyone in Liverpool. When asked for some background to his complaint, he told her that he was in a great deal of pain and had been refused hospital treatment. He told her that he had decided to refuse food and water until he was taken to Aintree Hospital. During the conversation the chaplain asked what it was that the man wanted her to do and she states that he was quite clear and specific. She then noted the five requests made by the man:

1. He wanted a chaplain present when he spoke to the doctor.
2. He wanted her to check if he had any hospital appointments booked for Aintree Hospitals Trust.
3. He wanted her to ensure that he was taken to hospital by paramedics as he would not go by taxi.
4. He wanted her to write to his sister upon his death to ask her to look into the circumstances of his death.
5. He wanted the post mortem results made public to prove that he was not lying about the amount of pain he was in from the arthritis in his hips.

59. The chaplain asked him if it was his intention to kill himself. He replied that it was not, his intention was to go on hunger strike until such time as the prison had no alternative but to send him to outside hospital by paramedic ambulance. She pointed out that there were better ways of achieving his end than via hunger strike. He replied that he was aware of the risks and that the prison would move quickly once he had refused food for a couple of days because of his diabetes, which was controlled by diet rather than drugs. She tried to persuade him not to take this course of action because of the added problem of his diabetes, but he maintained that he knew what he was doing and refused her advice. The man also had a similar conversation with another senior member of the chaplaincy team.

60. The Methodist chaplain made a note in the man’s record and informed the staff of the conversation she had had. She says that at this time, “I did not consider the man as being at risk of immediate self harm.” At lunchtime on the same day, she reports that she spoke to the duty prison doctor about the man who confirmed that he had refused to speak to him without a chaplain present. She agreed to attend any future interview between them, and further agreed to try to attend CSU on the following morning when the doctor intended to see the man again. She also asked the doctor to check whether any hospital appointments were due for the man. On returning to her office, she checked the LIDS computer which showed that no hospital appointments were pending. The doctor informed her that on two previous occasions the man had refused to go to hospital appointments unless he

was carried, a course of action that he considered unnecessary and an unsafe practice due to the man's size.

61. The man asked for help in writing to his sister whilst located in the CSU. He was told by one Senior Officer that a Listener [a prisoner trained by the Samaritans] would help him, but he said he wanted the Listener from his own wing to do it for him. This was refused and he then agreed to let the CSU Listener help him. In interview the CSU Listener said that about two to three hours after his arrival he went to the man's door and introduced himself to the man and told him that he was the Listener in the CSU. At this time, he noted that the man was naked except for a blanket. Shortly after his introduction, the man asked for his help to write to his solicitor and his family. The CSU Listener said that he sought permission from the SO in charge at the time to do so. He says that he was emphatically refused permission to see the man in his cell. (According to staff duty records, the identified Senior Officer was not on duty in the CSU, although he was on duty elsewhere in the prison. The CSU daily diary sheets show no entry indicating that the identified Senior Officer visited the CSU that day.)

62. According to the CSU Listener, following the first refusal of permission to enter the cell he left the matter at that. He also says that the man who later died subsequently asked him about the letter writing on approximately four occasions over the next few days. The last time was in the late afternoon of the day prior to his death. At some point during that weekend a prison officer on duty in CSU was apparently asked by the CSU Listener to be admitted to the cell. The officer apparently referred the request to the duty Senior Officer, the same man as identified previously. The request was denied.

63. The duty Governor signed to authorise the segregation of the man under Prison Rule 45 at 1.05pm on 17 June, after a prison nurse had completed a Segregation Safety Algorithm. The reasons for his segregation were noted. The form also carries the words "usual monitoring".

64. The CSU Listener says that, from the first day of the man's occupation of the CSU cell clean clothes were left outside the cell and a couple of apples were also left there. During his period of occupation, blank letters and envelopes and menus were posted under the cell door but remained untouched. The man apparently had no pen in the cell. The CSU Listener also states that the man was lying on his bed for most of the time during his stay, with a blanket partially covering him. He says that he was intermittently sitting up against the pipes at the rear of the cell with the blanket around his waist. He saw that his arms, shoulders and upper chest were bruised. The CSU Listener thought that the bruising was as a result of such a large man having been carried to the CSU by prison staff.

65. The CSU Listener describes the man's demeanour throughout the days immediately prior to his death as being subdued, showing little emotion. His impression was that all the fight had gone out of him. He also complained of back pain. The CSU Listener saw medical staff visit his cell on several

occasions. He says he feels that, had he been given the opportunity to do the job for which he was trained, he could have assisted the man over what appeared to him to be a crisis.

66. At 9.45am on 18 June, the man was again seen by the Methodist chaplain immediately following the doctor's round which she had missed. The man had refused to speak to the doctor. She went to his cell and spoke to him, confirming that no hospital appointments were booked because of his previous refusal to attend. He explained his reasons for doing so. The Methodist chaplain told the man that he should start helping prison staff help him "by at least making an effort to help himself, starting with talking with the doctor and taking fluids." He apparently thanked her for her concern and said that he had written to his sister, the Governor and the Prime Minister and that when he died they would all be sorry. He said that it would take about 18 days for the hunger strike to kill him. She asked him again if it was his intention to die. He replied once more that it was not his intention, and that the authorities would not allow that to happen because it would show them in a bad light. He said that he was firmly convinced that the Governor would see sense and grant his wish to be transferred to hospital in an ambulance. He thanked her for listening and requested that she see him on the following Thursday when she was on duty again.

67. At midday the man refused to go to the adjudication room to answer a charge of soiling his cell in the Lifer wing. The Duty Governor adjourned the adjudication until 2.45pm. He then took the option to see him in his cell and adjudicate upon him there. At the man's request, the adjudication was adjourned to allow him time to seek advice from his solicitor. He maintained that the soiling was a consequence of being unable to get out of his bed to use the toilet in his cell. The Duty Governor correctly adjourned the hearing for seven days to give the man time to consult a solicitor. At 2.30pm, he also completed the paperwork required to segregate the man for the maintenance of good order or discipline. A written reason for being placed on Rule 45 was given to the man.

68. At about 9.55am on19 June, the doctor saw the man as part of his normal round. Again he refused to speak to him because no chaplain was available. The Duty Governor saw the man once more between 2.45pm and 3.15pm. The man asked about contacting his solicitor and the need for help in writing a letter to him. The duty Senior Officer in the CSU, said that the prisoner Listener would be able to help with the letter. The man was also seen at around 1.50pm by the senior prison chaplain.

69. On 20 June, the Duty Governor saw the man between 10.45am and 11.15am. He was uncommunicative. The Duty Governor therefore left him to sleep. The man would not allow any examination by the duty doctor and insisted he would not speak to a doctor unless a chaplain was present to witness what was said. He was seen by a registered general nurse (RGN) who noted in his Medical Record that he had stated that he was on a hunger strike and had been for the previous three days. Urine samples were requested for analysis but the man refused to supply a sample.

Despite his stated intention to starve himself, none of the staff who spoke to him felt that his behaviour warranted further action under the Assessment Care in Custody Teamwork (ACCT) procedures designed for those at risk of self-harm.

70. A note was made by the doctor that the man had been seen at 2:50pm on 21 June. At this time, he had in fact already died and the assumption is therefore made that this date is an error and should read 20 June. During the doctor's visit, the man was reported as being talkative but with a negative attitude and refusing to answer the doctor's questions. He refused to allow the doctor to examine him, and was reported as being face down under the blanket but quite animated. The doctor noted that he had not been seen drinking, but a water tap was available in the cell. The doctor recorded that his mental state showed no change, and that he was not too concerned at present. He suspected that he was drinking covertly.

71. At about 7.30pm on 20 June, a prison officer came on duty as night patrol on the wing which encompasses the CSU. The official on duty time is 8.45pm, but custom and practice at Liverpool is that the night duty patrol staff commence at about 7.30pm. The night patrol initially checked all the prisoners in the unit, and received a handover briefing from the daytime officer who then went off duty and left the prison. During the handover the night patrol was made aware that there were two "self harmers" on the wing - neither of them was the man who died. The night patrol officer states that he then began his routine of patrolling and hourly checking of the prisoners.

72. During his time in the CSU, the man who died refused to collect his meals which were taken to him in his cell. They were refused and then logged in the Returned Food Book as "All meals and fluids" and also noted on the man's history sheet. The first entry referring to him in the Returned Food Book on 17 June shows his location as M1-11, which is an error. The second entry on the following day shows his correct location. There are no entries for19 and 20 June, but entries on his history sheet show that he did refuse food. None of the entries in the Refused Food Book was signed by the Medical Officer or the Duty Governor. The man was reported by staff to be sleeping normally. It was also reported that he did not soil his cell, apparently using the in-cell sanitation.

The day the man died (21 June 2005)

73. There were no reported incidents or problems during the night involving the man. However when the night patrol officer was carrying out a routine check of CSU about 5.00am he noted that the man was not in his bed or in the main area of his cell. He went to the observation panel that allowed him to view the toilet area of the cell. He could not see clearly, but thought he could make out a shape against the back wall. He switched on the light and saw the man slumped against the back wall of the toilet area with a ligature around his neck. He immediately sent an urgent message using his radio, requesting assistance.

74. Within a few seconds, another Officer who was on duty in the adjoining wing ran on to the CSU wing. As he entered the wing, the CSU night patrol broke the seal of the security pouch on his belt, took out the cell key and opened up the cell. He ran into the toilet area and saw that the man, who was naked, was suspended by a noose attached to the vertical bars of the cell window. The ligature was made from a piece of a green bed sheet. He was so shocked that he stepped back into the main cell area just as the second night patrol entered the cell. Almost immediately, the Night Manager and another night patrol came into the cell. These two officers had been together in the centre office when the urgent radio call came through and they ran immediately to the wing. The CSU night patrol appeared to be in shock and the Night Manager instructed the third night patrol to take him out of the cell. At 5.02am, the night manager radioed the control room and requested that an ambulance be called. The night manager then went into the toilet area and tried to lift the man to support his weight, but he was too heavy and he could not lift him. The second night patrol took out the cut-down scissors that he carried in his belt pouch and cut the ligature. They were then able to lower the man to the ground and remove the ligature.

75. At 5.02am, the night duty nurse arrived with emergency equipment. She had heard the radio call for assistance and had collected the defibrillator and other equipment and rushed to the wing. The night patrol officer from the healthcare centre had helped her to carry it to the CSU. The nurse asked the two officers to move the man into the main cell area where there was more room for her to work on him. This was done and the staff then began resuscitation procedures. The nurse says that at this time the man was limp and cold and there was no sign of a pulse. She inserted an oral airway tube and began to use the defibrillator. The officers alternated using the mask and carrying out chest compressions until the paramedics from the local ambulance service arrived.

76. At 5.14am, the ambulance arrived and the paramedics took over the resuscitation procedures. They were unable to revive the man, declaring life extinct at 5.20am. At 5.25am, the cell was sealed with the man's body inside. At 5.33am, two Merseyside police officers arrived and a further two detective constables arrived at 5.55am, entering the cell at 5.59am.

77. At about 6.27am, the prison doctor entered the cell with a Detective Inspector and examined the man.

78. The doctor says in his witness statement that the deceased was lying supine on the floor, having already been seen by paramedics prior to his arrival. He also says that he saw a loop made of a strip of bedding sheet lying adjacent to the ventilation window in the toilet area of the cell. Another loop was lying next to the man's body. He states that he was informed (but not by whom) that this was the noose used by the man. The doctor noted that there were no fresh injuries to the man's body and that rigor mortis was not present. He concluded in his statement that: "I formed the opinion that the cause of death was suicide by hanging which was consistent with having taken place within 6 hours of the examination time." The doctor formally certified the man's death at 6.30am.

The prison's response following the death

79. At 5.00am on the morning of the death, Liverpool's contingency plans for a death in custody were implemented. At 5.07am the Duty Governor was informed at home that a serious incident involving the man had taken place. He then made his way to the prison.

80. At 5.20am, when the man was pronounced dead by the paramedics, the control room staff informed Merseyside Police that there had been a death at the prison and the police were asked to pass the information on to the duty Coroner. As noted, the man's body was left in the cell and the cell sealed for later examination by police.

81. A staff debriefing took place at 8.20am and statements from those involved were taken. The Care Team, IMB and chaplaincy were actively involved during the morning in supporting staff. Prisoners told my investigators that they had supported each other and that some staff had also shown concern for their well being. The Lifer wing Listener, who knew the deceased quite well, describes being supported by a former suicide prevention senior officer and being debriefed by two Samaritans. A Critical Incident Debrief was requested for those staff involved six days later. This was facilitated by the Prison Service Staff Care and Welfare Service one month later.

82. At 8.30am, the prison's Police Liaison Officer, reported that he could not contact the man's next of kin (his sister) by telephone. Police in his home area could not get a reply when calling at her address, but agreed to continue trying to contact her. The man's body was removed from the prison at 9.00am.

83. The Coroner was informed of the man's death and the local police began an investigation as is required with any death in custody.

84. During the early morning of 21 June, the Prison Service National Operations Unit, the Area Manager's office and the Press Office were informed of the man's death.

85. After finally being informed by police of her brother's death the man's sister contacted Liverpool on 22 June and spoke to the senior chaplain and a Governor grade liaison officer.

86. A letter of condolence following the man's death was sent to his sister on 23 June by the then Governing Governor of Liverpool. The Governor offered continuing support for the man's sister and explained that my investigators would be in contact with her. Unfortunately, no offer of assistance with funeral costs was made at that time, something that the man's sister confirmed to one of my Family Liaison Officers. Following the man's funeral the prison sent a cheque to the family for costs associated with this. The man's property was returned to his sister a month later by post.

87. Some days after the post mortem had taken place, the prison authorities contacted the funeral director, intending to send a tribute to the funeral.

This was despite the family's request for no further contact with the prison. However, the funeral had already taken place and they were therefore unable to send a tribute.

88. In accordance with the man's wishes, the family did not attend the funeral, but chose to mark the occasion in their own ways.

89. The relationship between the man's sister and Liverpool is not good. According to her, the relationship broke down after she was unable to contact a member of staff who had written to her regarding the man's property. She then requested that the Coroner's Officer contact Liverpool and tell them that no further direct contact should be made with her. At that time, she asked that Liverpool post all of her brother's property to her. Liverpool wrote to her twice following her request and she telephoned Liverpool to re-iterate that she wanted them to post her brother's possessions. The deterioration in the relationship was exacerbated when, according to her, she overheard a comment between two members of staff, one of whom allegedly said words to the effect that 'he should beware; it's the man's sister on the 'phone'.

90. The deceased man's sister has raised concerns about the treatment her brother received whilst he was in prison, and maintains that Liverpool was not an appropriate place for him to have been held. She still does not want direct contact with Liverpool and insists that any contact should be through the Coroner's Officer. She has since moved house and has given her new address to the Coroner's Officer but not to the prison.

91. A Consultant Pathologist to the Home Office carried out the post mortem at a major hospital on the day of the man's death. Samples were retained for further examination. Almost three months on, the post mortem report confirmed that the cause of the man's death was hanging by ligature and that there were no drugs or alcohol in his system at the time of death.

92. The pathologist noted bruising to the man's arms which he says was consistent with his having been restrained, but played no part in his death. It is probable that these bruises were caused by the man having been carried to the CSU by prison staff. The pathologist also says that it is likely that the deceased died very quickly or possibly even instantaneously.

Issues considered during the investigation

Identification of risk of self harm

93. During his reception at Leeds in 2002 and during his time at Liverpool, the man consistently stated that he had no thoughts of self-harm, despite his threat in the latter stages that he would starve himself to death. Later he underwent a mental health assessment with a forensic psychiatrist who identified him as being highly opinionated with an eccentric appearance, but considered that he exhibited no mental illness or personality disorders

94. The deceased was seen by some of his contemporaries at Liverpool as an isolated man, because of his medical conditions which kept him in his cell. They thought he was a fighter against the system, rather than someone who was likely to take his own life. This view is borne out by the long record of his complaints, and attempts to persuade the prison to handle him in a different way and in keeping with his own view of his condition. One trained Listener who knew him well describes the man as being frustrated by his own immobility and the circumstances that had led to his imprisonment.

95. On his forced removal to the CSU, the man exhibited only passive resistance. During his stay, he refused food and told the chaplain that his intention was to go on hunger strike until such time as the prison had no alternative but to send him to outside hospital by paramedic ambulance. At no time did the medical staff, chaplaincy or any other member of staff consider that he needed referral or supervision under the procedure for prisoners at risk of self harm.

96. The CSU Listener describes the man's demeanour in the last few days of his life as subdued, showing little emotion and that the fight had gone out of him. The Listener maintains that, had he been allowed to do his job, he could have got the man over this crisis.

97. No note regarding the man's actions was found on him or in his cell following his death.

Medical treatment

98. A clinical review was undertaken by North Liverpool NHS Primary Care Trust. It was completed by the Head of Mental Health Integrated Commissioning (incorporating prison health), with clinical advice provided by the Medical Director.

99. The review of the deceased man's treatment encompasses the entire span of his imprisonment at both prisons. The review concludes that his physical health care needs were responded to promptly and appropriately. His condition was regularly monitored and appropriate referrals were made for specialist opinion.

100. In the view of the clinical reviewer, there appears to be no evidence that specialist mental health referrals were necessary. All the man's problems were related to his physical health needs.

101. When he did see an orthopaedic specialist at a nearby Hospital, the consultant concluded that replacement of the man's knee would not dramatically improve his quality of life. Indeed, there was a significant surgical risk if the operation was performed. The outcome was advice that his condition would be best managed with weight control, analgesia and encouragement with his mobility. He was to be referred to a consultant orthopaedic surgeon later that year.

102. Throughout his sentence, the deceased periodically refused medical treatment and food when he believed that his needs were not being addressed properly. During the first four months of his final year, the man refused to attend one appointment with a consultant in general medicine at the prison healthcare centre and two other outside hospital appointments including one with the orthopaedic consultant. He refused to attend outside hospital unless transported by health authority ambulance. This would have been unnecessary both from the prison's point of view and - more crucially - there was no medical reason for doing so. Indeed, it would have diverted a valuable resource away from the local community.

103. The man's medication was monitored and reviewed regularly throughout his sentence.

104. The clinical reviewer has commented, "The clinical notes were generally legible; however there are areas of illegibility which are crucial in terms of following the total care provided to the deceased. The notes were often not in order, making chronology difficult." My investigator is of the same opinion.

Management

105. The man who died was a challenging individual who often refused to take advice from healthcare staff regarding the management and treatment of his medical conditions. During the early period of his imprisonment, he was described by a psychiatrist as being highly opinionated and likely to have some prominent or potentially troublesome personality traits.

106. His non-cooperation with his treatment plan led to the cancellation of hospital appointments, delays to treatment and difficulty in arranging a transfer to a suitable prison. Efforts were made throughout 2004 and the early part of 2005 to obtain a move for him, but no prospect of a transfer had been achieved by the time he died. Arranging a transfer was difficult due to the man's physical health needs and on-going hospital appointments.

107. The man was described by those prisoners who lived around him and knew him well as cantankerous. He was abusive to prison staff on a number of occasions and destroyed some prison property as a result of his frustration.

He was subject to disciplinary sanction for some of these events. He was seen by a Healthcare Manager in his cell when his behaviour towards healthcare staff was discussed with him. It is noted by the manager at the time that he appeared happy with the meeting.

108. The man was relocated from the healthcare centre to the wing for life sentence prisoners. He had limited mobility - although the extent of the disability was never definitively established - and he was often confined to his cell. His location was a compromise between placing him close to where he would be able to obtain his medication, hot water for drinks and access to the showers, and the ground floor where he would have been able to obtain his meals and socialise. Given the design of Liverpool, and the man's reluctance or inability to leave his cell, I judge the prison could not accommodate all his needs as they presented and they made the best choice available to them.

109. However, the man became isolated, not mixing with the rest of the wing population although his door was left open during the day. He only saw those staff and prisoners who went to his cell. Meals were taken to him by prisoners who chose to support him or by staff; it is not possible to establish how often this occurred.

110. The man began a dirty protest on16 June. This was described by a prisoner witnessing it as a small affair covering a small area. The same man offered to clear it up but the offer was refused. The man who died said that he had had enough and he was sick of his meals and medication being messed about with. But in a conversation the following day with a member of the chaplaincy, he said that it had happened because he was unable to get to the in cell sanitation. The man's actions made it necessary to relocate him to the CSU, and it was established there were no medical or psychiatric reasons for not moving him. On the morning of the move, he refused to walk to the CSU and pre-planned preparations to move him were put into action. These included giving him the opportunity to be pushed in a wheelchair rather than be carried, but this was refused.

111. During his period in the CSU, the deceased was seen regularly by medical staff, chaplaincy and the duty governor. A Segregation Safety Algorithm in respect of the man and the reasons for his segregation was completed.

112. The man refused all his meals in the CSU. The CSU Listener describes him as lying on his bed for most of the time during his stay, and says that his demeanour during the days prior to his death was subdued, showing little emotion. The Listener is critical of CSU staff who, he claims, would not allow him to enter the man's cell to talk to him and assist him to get over what appeared to him to be a crisis.

113. Despite the difficulties experienced in the man's management, those staff with day to day care of him appear to have tried to help him as best they could, notwithstanding that he was generally uncooperative.

114. On interview, some wing staff were praised by prisoners from the Lifer wing for their approach to handling the man.

Bullying

115. As noted, early in his imprisonment the man underwent an assessment with a forensic psychiatrist who identified him as having strong opinions coupled with an eccentric appearance that could make him the target of abuse.

116. Several of the man's contemporaries recognised that his manner, disability and aspects of his personal hygiene made him unpopular with both staff and other prisoners. Several incidents described how isolated he was and subject to abuse by other prisoners. One prisoner stated that staff would make comments to him to "spark him off" for entertainment and would then laugh about it.

117. Some described the throwing of rubbish into his cell by passing prisoners and, because of his personal hygiene, name calling by others. There was an allegation of the use of a fire hose by a prisoner whilst he was taking a shower. This resulted in the man no longer taking showers and a worsening of the situation.

118. Two life sentence prisoners on the Lifer wing said there was a long standing problem on the wing regarding the alteration of pre-select menus belonging to older and vulnerable prisoners like the man who died. It was claimed that alterations to menus were made by younger prisoners between the time the menus were put in the box and when they were listed. Since the man's death, the open box system has been replaced by a closed and locked box system.

119. The investigator has seen no evidence that the man's case was referred to the anti-bullying co-ordinator, despite ample evidence that a low level of conflict was taking place.

Complaints

120. The man who died made regular use of the internal complaints procedures and also had his solicitors follow up requests for medical treatment, location change and a transfer out of Liverpool to another prison. He complained to prison managers and others including the Independent Monitoring Board (IMB), the General Medical Council and his solicitors about his healthcare.

121. All his complaints made via the internal complaints procedure appear to have been addressed in the normal manner and resolved where possible. His request to be transferred to another prison, where he felt he would be treated in a way that befitted his condition, was made and followed up through his solicitor. The prison corresponded with the solicitor regarding his location within Liverpool, his medical requirements and the possibility of a transfer to another prison.

122. Wing staff told the investigator that the man's non-cooperation led to difficulties in arranging a transfer to a prison where his needs could be appropriately handled. Efforts were made to obtain a move for him, but no prospect of a transfer had been achieved by the time he died. Staff were unable to supply corroborating evidence to support this account.

Listener Access

123. The Area Manager and the Governor at Liverpool co-signed a policy entitled "HM Prison Liverpool Suicide Prevention Policy Statement Governor's Order 132 Re-issued". It is dated the year before the man died.

124. Section 2.5 of the document, "Suicide Prevention Co-ordinator", reads at the 7th bullet point, "To ensure links with Samaritans are maintained and jointly ensure sufficient Listener provision in each area of the prison."

125. Section 3.4, "Care for Prisoners on Normal Location", states at the 10th bullet point that "Access to Listeners will be 24 hours a day."

126. Section 3.5, "Separation and Care Unit" (Segregation), details the appropriate action to be taken in the event of a known self harmer being located in the CSU. It does not mention anything about access to Listeners although a Listener is available in the CSU.

127. Section 4.10, "The Listeners Scheme – Statement of Purpose", says that "HM Prison Liverpool is committed absolutely to the principles of the Prison Listener Scheme. Prisoners who are in distress will have access to a Listener, subject to security requirements. Listeners will be trained by the Samaritans, in accordance with their national standards and practices, and will listen in confidence and without prejudice to any prisoner in distress."

128. Annex H of the policy document states that "The Establishment's aim with regard to staff and Listeners is to demonstrate by their actions the value and importance with which they hold the Listeners Scheme at HMP Liverpool. We respect the principle of confidentiality between Listener and "caller" and where it is necessary we will facilitate any support a Listener may need either from the Samaritans, a fellow Listener or a member of the Suicide Prevention Team. Also available is the dedicated Samaritan phone link." It also sets out in item two of the next section that Listeners will not be locked in the cell with the "caller". The cell door will be left ajar and the bolt sprung. Finally the annex concludes that: "Each individual situation will be risk assessed by those duty staff present, as to meet any overriding security needs but equal consideration should be given to the safety of the Listener and the personal needs of the "caller"."

129. In addition, each prisoner on induction into Liverpool is given a leaflet explaining the Listeners scheme. This gives an overview of the scheme and how to obtain help if it is needed. It also briefly sets out the prison's anti-bullying and race relations policies.

130. The “Policy and Care Programme for Prisoners at Risk of Self Harm or Suicide” appears clear regarding in cell access where it applies to prisoners under normal circumstances and appears to work well at Liverpool. It does not have the same clarity where it applies to prisoners located in the CSU. I believe the policy is intended to cover the CSU in the same manner. The final part of Annex H provides for a risk assessment by those staff on duty where security needs and the safety of the Listener are to be considered.

131. After a request from the man, the Senior Officer (SO) in charge apparently refused permission for the Listener from the Lifer wing to have access to him. Instead, he was granted permission for access by the Listener from the CSU. Some confusion is now evident from the Listener’s notes of interview. The Listener says that he was not allowed to enter the man’s cell at any time, from his location there on the Friday until his death on the Monday. He states that he was initially denied access by an SO who was in fact not on duty in the CSU but elsewhere in the prison. At an unspecified date later that weekend, an officer was again asked by the Listener for access to the man’s cell. The officer referred the request to the same Senior Officer, who was now on duty in the CSU. Again, according to the Listener, he denied the request. This situation continued until the Monday during which time the Listener did speak several times to the deceased through the cell door. No evidence was supplied by Liverpool to show that he was visited in his cell by the Listener. No documented risk assessment for the apparent denial of access to his cell by the Listener was available.

Conclusions and Recommendations

132. The man who died was serving a life sentence for offences of arson with a six-year tariff. He appears to have been a socially isolated individual prior to his sentence and this carried on whilst in prison.

133. When staff arrived at the man's cell on the morning of his death, following the discovery that he was hanging from his cell window, he was treated in a prompt and professional manner. Cardiopulmonary resuscitation techniques (CPR) were maintained throughout the resuscitation attempt. On their arrival, local ambulance service paramedics took over control of the resuscitation attempts but were unable to achieve a positive outcome.

134. During his sentence, medical services at both prisons that cared for the man did so in a normal way. That care was comparable to that which he would have received in the mainstream community. The management of the man's health at Liverpool was sympathetic to his needs, given his age and medical history, but may have been compromised by his refusal to abide by an individualised health and social care plan.

135. The man was assessed by a psychiatrist early on in his sentence as having strong opinions, an eccentric appearance and potentially troublesome personality traits that might make him vulnerable to abuse by others.

136. During his initial health screening, it was noted that the man had no thoughts of self-harm but felt that he would not come out of prison alive. He refused food and medication periodically during his sentence in an attempt to alter a course of action that he disagreed with. In the last few days of his life, he again refused his meals. On this occasion, he told a prison chaplain that his actions were designed to force the Prison Service into transferring him to an outside hospital by paramedic ambulance rather than an attempt to commit suicide. He was consistently described by those prisoners who knew him as a fighter against the system.

137. In the time that the man was in the CSU, the Listener described him as being subdued, showing little emotion and that the fight had gone out of him. At no time did any member of Liverpool staff consider that he needed referral or supervision under the procedure for prisoners at risk of self harm.

138. It seems most likely that the man settled on his course of action during the last few days of his life, having exhausted all other attempts to be treated in a way befitting his own view of his circumstances. It is regrettable but unsurprising, given the man's attitude and character, that prison staff were unable to see a change in him and view it as a possible precursor to a serious attempt at self harm.

    All staff should be reminded of the need to treat seriously any demeanour or action that could lead to self-harm in accordance with paragraph 3.1.2 of PSO 2700.

139. Whilst PSO 2700 requires that any attempt at self harm should be taken seriously it does not require that food refusal be reported on a self-harm/attempted suicide form.

140. All the man's problems were related to his physical health needs rather than any underlying psychiatric problem. He suffered from and was treated for arthritis, diabetes, high blood pressure and high levels of cholesterol. He maintained that he was severely disabled and unable to walk. Subsequent observations by prison staff, and examinations by those medically qualified to do so, suggested that his level of disability was not as severe as he claimed. A treatment plan involving weight loss, analgesic drugs and activity to increase his mobility was advised.

141. The man's rejection of these diagnoses, and his refusal to co-operate with the treatment plan, caused continuing friction between him and healthcare staff at Liverpool. He was warned several times about his aggressive and abusive behaviour towards nursing staff. In turn, he made many complaints about what he felt was the poor level of care he received.

142. His non-cooperation with his treatment plan led to the cancellation of hospital appointments, delays to treatment and difficulty in arranging a transfer to a suitable prison where his health and social care needs could be appropriately handled. Efforts were made to obtain a transfer for him, but nothing had been achieved by the time of his death.

143. The clinical reviewer concluded that the man was not an easy patient and that he received appropriate care and treatment from the healthcare team. However comment was made regarding the legibility of the clinical records.

The standards in relation to clinical records should be reviewed particularly in relation to individual entries and their legibility, use of signatures and filing of correspondence and associated forms in order to ensure that records are legible and easy to follow.

144. Whilst at Liverpool, the man who died presented with challenging behaviour to those who had dealings with him. He was often abusive to staff, particularly those from the healthcare department whom he formally complained about. Some wing staff were able to handle him successfully. But for other staff this was not the case, which led to further confrontation and frustration on both sides. The man's frustration sometimes resulted in him destroying prison property – actions for which he was reported under the internal disciplinary process.

145. On 17 June, the man was removed to the CSU, where he remained until his death early on the morning of21 June. He appears to have been treated appropriately during his stay in CSU, having seen medical staff, the chaplaincy and the duty governor regularly. He was spoken to on several occasions by the resident Listener in the CSU through the cell door. The Listener had some concerns about the fact that he was not allowed into the cell to speak to the man and write a letter for him.

A review of the "Policy and Care Programme for Prisoners at Risk of Self Harm or Suicide" document should take place to ensure that its application in the CSU is consistent with that throughout the rest of Liverpool. In the case of denial of access to a prisoner requesting a Listener, the reasons should be fully documented.

146. The man's adjudication was adjourned in order that he could contact his solicitor by telephone. By the time of his death several days later, he had not done so.

147. Whilst located in the CSU, the man insisted that he would only speak to the doctor, if a member of the chaplaincy were present. The chaplaincy team member involved spoke to the duty doctor about this. They agreed that she would be present during his next consultations. This was not always possible, but the man continued to be seen by medical staff and his demeanour and condition were noted. He refused to eat his meals and this was sometimes noted in the Returned Food Book. His personal history sheet shows that he did in fact refuse all meals. The refused meals entries were not signed by the Duty Governor or the Medical Officer.

148. Some prisoners interviewed felt that staff had not done enough to combat the problem of bullying of weaker personalities on the wing. According to the prisoners, wing staff were aware that this was happening because the man and others complained about it. He made a formal complaint about the alteration of a canteen order but the situation regarding the dietary menus was not resolved until after his death when the routine for ordering meals was altered.

The anti bullying strategy should be reviewed to ensure that low level activity in this area is addressed and does not become endemic either for staff or prisoners.

149. The man who died was verbally abusive to other prisoners and to staff, and according to one member of staff this could include a racial element. There seem to have been some incidents of prisoners returning this abuse on a like for like basis.

150. The investigator could find no evidence, other than during an interview with a prisoner who was transferred from Liverpool during the year before the man died, that staff made comments to "spark him off" for entertainment. But needless to say, such a situation is one that prison managers at Liverpool should be aware of and guard against.

151. The man's complaints made via the internal complaints procedure appear to have been addressed in the normal manner, and were resolved where possible.

152. The man’s request to be transferred to another prison was followed up through his solicitors. However, there were difficulties in arranging a transfer and there was no prospect of such a transfer at the time he died.

153. I have found no evidence of negligence or failure with regard to the duty of care owed to the man by those staff who dealt with him.

154. It would appear that the deceased took his own life in his CSU cell following a long period of increasing frustration at not being able to serve his sentence in the way that he believed he should. Given the early hour and the lack of senior staff on duty, it is unlikely that his hanging was an attempt at drawing attention to his plight. Once the ligature was in place, he died very quickly.

155. The man’s family, particularly his sister, were understandably upset and angry at the events that had played out at Liverpool. The man’s sister says that the strained relationship over her brother’s property was exacerbated by a regrettable incident where she overheard an unguarded comment made by a member of staff. This led to a breakdown in communication between her and the prison.

Staff should be reminded that bereaved relatives should be treated with sensitivity and dignity at all times.

The Governor must ensure that following the death of a prisoner in custody an offer of financial assistance for funeral costs is made to the next of kin.

List of Recommendations

- **All staff should be reminded of the need to treat seriously any demeanour or action that could lead to self-harm in accordance with paragraph 3.1.2 of PSO 2700.**

- **The standards in relation to clinical records should be reviewed particularly in relation to individual entries and their legibility, use of signatures and filing of correspondence and associated forms in order to ensure that records are legible and easy to follow.**

- **A review of the "Policy and Care Programme for Prisoners at Risk of Self Harm or Suicide" document should take place to ensure that its application in the CSU is consistent with that throughout the rest of Liverpool. In the case of denial of access to a prisoner requesting a Listener, the reasons should be fully documented.**

- **The anti bullying strategy should be reviewed to ensure that low level activity in this area is addressed and does not become endemic either for staff or prisoners.**

- **Staff should be reminded that bereaved relatives should be treated with sensitivity and dignity at all times.**

- **The Governor must ensure that following the death of a prisoner in custody an offer of financial assistance for funeral costs is made to the next of kin.**