

**Investigation into the death of a man
at HMP Liverpool in 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 surrounding the death of a man on 26 June 2005. He was serving a six year sentence for manslaughter and had been in Liverpool since August 2001. He was due to be released in August 2005, some ten weeks after he died. He was 40 years old and leaves a wife and three teenage sons.

The investigation was carried out by two of my investigators. My senior investigator and my family liaison officer met with the man's wife and one of his sons to hear their concerns about the man's death.

A clinical review into the man's medical care and treatment was commissioned from North Liverpool Primary Care Trust. I appreciate the pressures on some PCTs to complete clinical reviews in a timely manner. However, I regret that my own report has been delayed because we in turn have had to wait for the PCT.

Everyone spoken to during the course of this investigation was at a loss to explain why the man would kill himself. He had behaved well in prison and had built very good relationships with both his fellow prisoners and staff. He was close to the end of his sentence and had plans to return to the family home. Not the least sad aspect to his death is that he was himself a prison Listener who helped others in distress. I extend my sincere condolences to his family and friends on their sad loss.

I wish to extend my thanks to the Governor and staff at Liverpool for their co-operation during this investigation. I am particularly grateful to the governor who acted as liaison for the investigation team.

The man's death was the fourth to occur by hanging in Liverpool in June 2005.

This version of my report has been anonymised prior to publication on my website.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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Summary

The man was received into Liverpool prison on 21 August 2001. He was later sentenced to six years for manslaughter. His family suffered significant harassment from associates of his victim.

The man was initially monitored under self-harm procedures because of the nature of his charge. In November 2001, he was prescribed anti-depressants due to anxiety over the safety of his family. He remained on anti-depressants throughout his time in Liverpool.

The man was given a variety of jobs in Liverpool in trusted positions. He trained as a Listener in June 2002. He was a respected and popular prisoner. In April 2003, he was judged to be suitable for transfer to an open prison. The night before he was due to move to HMP Sudbury, he was found collapsed in his cell and taken to hospital. There are no proper records of this incident but it is thought that he took an overdose of dothiepin (an anti-depressant). I am critical, more generally, of the standard of record keeping and the absence of key documents.

In October 2004, the man was found in his cell with a wound to his neck. He later told a probation officer that he was worried about another proposed transfer to Sudbury. The man was monitored under self-harm procedures until 7 November. In January 2005, the man's outside probation officer wrote in a report to the Parole Board that he should be regarded as a high risk to himself because he responded poorly to coping with stress. It appears that this information was not passed to, or noticed by, staff in Liverpool. The man was refused parole in April 2005.

The man's cellmate left the prison on 24 June to attend a Listeners' Conference. At about 7.00am on 26 June 2005, an officer noticed she could not get a response from the man when doing her morning roll check. She and another officer entered his cell and found him hanging by his belt from the basin in the toilet recess. Medical staff attended but he was pronounced dead at 7.17am.

The prison's immediate response to the man's death was efficient and sensitive. But unfortunately, the next of kin details were incorrect and there was a delay before his family was informed of his death.

With the benefit of hindsight, I conclude that the signs that the man might harm himself were all in place. However, he gave no overt signal of his intentions and his death came as a shock to both staff and prisoners.

The Investigation Process

I was notified of the man's death on 26 June 2005. My Deputy Ombudsman, visited Liverpool on 30 June, met the Governor and collected the relevant paperwork. Notices were issued to staff and prisoners announcing the investigation and offering them the opportunity to contribute to it.

My investigators first visited the prison on 5 July 2005 and saw the cell where the man died. They reviewed all the relevant prison records and established a chronology of events. The relevant staff and prisoners were interviewed.

My investigators contacted the Chairman of the local branch of the Prison Officers' Association (POA) and the Chair of the Independent Monitoring Board (IMB) to tell them about the investigation.

One of my family liaison officers and my senior investigator met with the man's wife and one of his sons. I am most grateful to them for having this meeting at what must have been a very difficult and distressing time. My family liaison officer also contacted the man's parents and spoke to one of his brothers on several occasions.

The clinical review was commissioned on 12 July 2005. The review was received on 12 January 2006.

Background

HMP Liverpool

Liverpool prison is currently the largest prison in England and was built in the mid nineteenth century. The residential wings are original but the middle cells in every three have been converted to provide toilet facilities for the other two. The prison is a busy category B local and first stage lifer centre. Like too many prisons, it is overcrowded and most cells are shared.

In the recent past, Liverpool has struggled with a poor regime, low level of cleanliness and lack of hygiene for its prisoners. The most recent report by Ms Anne Owers, HM Chief Inspector of Prisons (HMCIP) in September 2004 found noticeable improvements in the regime and environment but expressed concern about the high levels of bullying and drugs.

Prisoners who spoke to my investigators said that staff generally “tried their best” although there were a few “bad apples”. One prisoner who had been there for three years said he had noticed a “big turnaround” in time out of cell. Other prisoners said that the cells were too small and the prison was overcrowded.

The man's time in Liverpool

The man was remanded into custody in Liverpool on 21 August 2001. He was sentenced to five years for manslaughter on 20 November 2001. On 13 May 2003, his sentence was increased to six years on appeal. There are remarkably few written records covering his time in Liverpool. A full account of his medical record while at Liverpool is contained in the clinical review at Annex A of this report.

The man's F2052A wing history file shows that on 22 August 2001 he was admitted to the Healthcare Centre (HCC) "due to nature of charge (murder charge)". His medical notes show he was put on an F2052SH (self-harm monitoring form) due to his previous suicide attempt in 1999.

The record of events shows that the man attained the 'enhanced' level on the Incentives and Earned Privileges Scheme (IEPS - enhanced is the highest level a prisoner can attain) on 23 September 2001. He was employed variously as a landing cleaner, the tea boy and as wing 'number one' – all positions of trust.

The man's medical notes show that, on 12 October 2001, he complained of feeling anxious about problems his family was suffering outside and was given diazepam for three days. On 23 and 30 November 2001, he was seen by a psychiatrist and again presented with anxiety over his wife's situation. He was prescribed prothiadin (the brand name of the anti-depressant dothiepin).

On 8 February 2002, the man volunteered for the Listener Peer Support Scheme. This is a scheme which offers prisoners Samaritan training so that they can provide a support service for other prisoners. The man completed his training and became a Listener on 14 June 2002.

On 23 April 2003, he was re-categorised to category D – which meant that he was deemed suitable for transfer to an open prison. Wing staff contacted HMP Sudbury and it was arranged that he would transfer there as soon as convenient. An entry on his wing file dated 4 May 2003 appears to be directed to receiving staff at Sudbury.

The man's medical notes show that on 13 May 2003 he was found collapsed in his cell. He was taken to hospital where he was found to have an abnormal liver function test possibly consistent with an overdose of dothiepin. The man was discharged from hospital on 23 May 2003. By 17 July 2003, his liver function tests were back to normal.

A Senior Officer (SO) said the man was taken to hospital the night before he was supposed to move to Sudbury. He said he did not know exactly what had been bothering him, but he remembered that he was also offered a move to an open prison later in his sentence and had refused that as well. The SO said he had heard rumours about the man's victim's family and wondered whether the man would have felt more vulnerable at Sudbury because he would have been eligible for town visits and home visits.

On 22 June 2004, the man was found guilty at adjudication of having another prisoner's medication in his possession. The man had tested positive for di-hydrocodeine at a Mandatory Drugs Test (MDT) a few days earlier. As a result of the finding of guilt, the man was given ten added days to his sentence and, as an administrative measure, was placed on closed visits for a period of three months. In his report to the Parole Board, the prison's seconded probation officer said the man had told him that he had taken an unauthorised painkiller from another prisoner to help cope with a migraine.

The man's parole application process was started in September 2003 and completed in January 2005. It appears from the documents that he initially waived his right to be considered for parole and so a second set of reports had to be requested. The prison's seconded probation officer believed this to be because, at the time of the first reports, the man was estranged from his family and did not have a release address. The man's explanation appears to have been that it was an error on his part and he ticked the wrong box on his first application form.

The seconded probation officer's report to the Parole Board was based on two interviews with the man in September 2003 and February 2004, and liaison with the man's home probation officer, and staff on B wing. A first report was prepared on 26 February 2004 and a second written on 20 December 2004. In his first report, the seconded probation officer said that the man had consistently expressed what he believed to be genuine remorse for his offence and appeared acutely aware of the suffering it had caused to his own and the victim's family.

He said the man had told him that, as a result of his offence, his marriage had broken down and that his wife and family had moved home due to harassment from his victim's relatives. He said that the man told him that none of his family including his parents had been in contact with him for six months. The seconded probation officer said that the man had told him he had been depressed and had attempted suicide in 1998, and that he had suffered another bout of depression due to anxiety over his trial and remorse for his offence. He noted the man had been on anti-depressant medication for much of his time in Liverpool.

In his second report of 20 December 2004, the seconded probation officer said that "2052 self-harm records" indicated that on 21 August 2004 [it appears that this was in fact on 26 October 2004] the man had self harmed due to being "stressed out" over the prospect of being transferred to another prison. He reported that the man had told staff he was worried that a transfer to an open prison might aggravate his victim's family and they might harass his wife and children. He said that the man had admitted that self-harming was an inappropriate response. The man's F2052SH (the prison record which documents reviews of a prisoner's risk of self-harm and suicide) was closed on 7 November 2004.

In his report of 20 December 2004, the seconded probation officer also said that the man had now re-established his relationship with his wife and was intending to return to the family home on release.

An undated medical report for the parole dossier comments:

“This prisoner is known to suffer from depression and is currently on px treatment, he has also had an episode of self-harm.”

The man’s medical notes show that, at 6.30am on 26 October 2004, he was seen in his cell with a self-inflicted injury to his neck. The medical notes do not make it clear the extent of this injury. I have not been provided with any other documentary evidence about this incident.

The man’s home probation officer, completed her report for the Parole Board on 17 January 2005. She interviewed the man once, discussed the case with the seconded probation officer and also visited the man’s wife at her home. She also carried out a full OASys risk assessment on the man. The home probation officer had been the man’s probation officer since November 2004 and her only contact with him had been in the preparation of her report.

The home probation officer said that the man’s OASys report showed him to be at low risk of re-offending but at high risk of self-harm. She explained that the man scored high in this respect because of his responses to stress. She noted he had two incidents of serious self harm – when he drove his car into a tree and when he made a deep cut to his throat in August 2004 [October 2004]. She said the recent nature of the man’s self-harm in prison suggested that he had poor coping skills when faced with stressful situations.

The home probation officer said that the man told her that the reason his marriage had “broken down” was that he had decided that his family were better off without him and he withdrew his contact with them. He had received no visits and only limited telephone and letter contact for the previous 12 months. The man’s wife agreed that he had withdrawn from the family. At the time of writing the report, the man had become reconciled with his wife and was planning to move back to the family home on release. The man’s parents later confirmed to the prison that they had not had contact with him in prison at the man’s request.

On 8 April 2005, the man received notification that his application for parole had been refused. The Parole Board panel said that they recognised the man’s good behaviour in prison, and his proven reliability as a worker, but noted his lack of offence related work. They considered he should complete the Enhanced Thinking Skills (ETS) course and that his release plan needed further development. The panel also considered that there was insufficient evidence that the man’s risk of self harm had been reduced to the level “at which it can be safely managed in the community”.

The man’s wife told my family liaison officer and my investigator that the man was upset that he did not get parole and had thought the comments made by the home probation officer were unfair.

What happened on 25 and 26 June 2005

The man shared a cell with another prisoner who was a Listener on B2 landing. On Friday 24 June, the cell mate left the prison to attend a Listeners conference at Newbold Revel (the Prison Service training college). He was due to return to the prison on Sunday 26 June.

The officer who was on evening duty on Saturday 25 June 2005 said he went off duty at about 7.45pm. He said he knew the man very well because he was the 'number one'. The officer said that the man had a shower at about 6.30pm and was out of his cell until about 7.00pm. He said he spoke to the man for about 15 minutes. He said he had taped TV coverage of the Glastonbury festival for the man and they talked about the group *Coldplay* and borrowing a CD. He said the man was his usual, bright, talkative self and his behaviour was no different from any other day.

The night patrolman said he came on duty at about 7.45pm and spoke briefly with the officers going off duty. He said he was told that there was a problem with the water and the electricity on one of the landings but that otherwise all the prisoners were okay. He then did the first check of his night duty which involved going to every cell and checking that the numbers tallied with the last check made by the out-going evening staff.

The night patrolman said he knew the man and liked to talk to him. On the evening of 25 June, after he had done his check on the prisoners, he spoke to the man as usual for about five to ten minutes. The night patrolman said he had a general conversation with the man about how long he had left to serve and what he was going to do when he was released. He said the man seemed "very steady" and "at peace" about his future.

The night patrolman said that at about 11.00pm, another prisoner on an upper landing asked him to pass the man a request form for him to attend the chapel the following day, Sunday 26 June. The night patrolman said he gave the form to the man and the man told him that it was "no problem" and he would put the form in "in the morning". The night patrolman said that he had no further contact with the man that night. The man was not on a self-harm monitoring form and so there was no requirement for him to be checked regularly throughout the night.

The night patrolman said that he began his regular morning check of every cell at about 5.10am. He remembered looking through the man's observation hatch and seeing that his cell was empty. He called out to the man and said the man was in the toilet and replied that he was okay. The night patrolman said that he moved on to check other cells because he was satisfied the man was fine and he wanted to give him a bit of privacy. The night patrolman said he went off duty at about 6.45am. He reported to the day staff as he left that there had been no problems with any of the prisoners during the night and went home.

A female officer came on duty at about 6.45am on Sunday 26 June. She said she spoke to the night patrolman who told her that the problems with water and electricity on the wing had been fixed. She then let him out into the grounds and began her routine check of every cell on the wing. The female officer said she started with the 'twos' landing [B2 landing] and the first cell she came to was the man's. She said she could not see the man in the cell and assumed he was in the toilet. She said she decided to give him some privacy and counted the rest of B2 landing. She then returned to the man's cell and looked through the observation hatches on the cell door and the toilet wall. She said she could not see the man through either hatch and called out to him to ask if he was alright. She said she got no answer. As she turned away from the door, she saw another officer walking onto the landing. She said she told the other that she could not get a response from the man and he immediately went to open the cell door.

The female officer said it was difficult to open the cell door because the locker drawers had been pulled out causing an obstruction. The other officer had to reach in and close them before entry to the cell could be gained. She said that the other officer entered the cell first and immediately they saw the man's legs on the floor of the toilet. She said the other officer looked into the toilet and told her that the man was hanging from the tap on the basin. [the man had used his leather belt and two screws to form a ligature. The two screws were used to make a loop to fasten the belt securely around the hot tap on the basin.] She said the other officer used her radio to put an emergency call out and then went to hold the man up. She went onto the landing to call for more officers to help. She said she went back into the cell and took the leather belt from around the tap. The female officer said she tried to take the belt apart but as it was held together by two screws, she had some difficulty in removing it from the tap. She said the man was laid on the floor. Other staff then entered the cell. The female officer saw they also had some difficulty in removing the belt from the man's neck. She was then taken out of the cell.

The other officer said he arrived for duty at 7.00am on 26 June. He said when he arrived the female officer was already checking the prisoners on B2 landing. He said he went up to her and told her he would begin to check B5 landing and she said that she could not get a response from the man. He said he opened the door to the man's cell and found that the cupboard drawers had been pulled out and were obstructing the opening of the door. The other officer said he forced the cell door open and went into the cell where he saw the man hanging face down from the sink. He said the man had used his leather belt to form a loop and fastened one part of it to the hot tap using two screws. He said he used the female officer's radio to call for emergency assistance and then supported the man's body. The female officer removed the belt from the hot tap and they laid the man on the floor. The other officer said he was removing the belt from the man's neck when assistance arrived. He said other staff took over and he began keeping a log of who entered the cell.

A third officer said that he responded to the emergency call over the radio and arrived at the man's cell as the female officer was leaving it. He said the

female officer was very distressed. He went into the cell and saw the other officer removing the belt from around the man's neck. He said he advised the other officer to disturb the scene as little as possible and then a Healthcare Officer (HCO) arrived. The HCO told them they had to establish an airway for the man and the three of them turned him over onto his back. The third officer said the HCO found it very difficult to establish an airway because the man was very stiff. He said the HCO left the cell briefly to get a defibrillator. Soon after, paramedics arrived in the cell and he left the scene.

The HCO said he was finishing his night duties in the Healthcare Centre when he heard an emergency call for Hotel One (the radio call sign of the person designated to respond to a medical emergency) to attend a "code blue" on B wing. He said his understanding of a code blue was that someone had been discovered with breathing problems. He said he went first to the surgery on A3 landing and collected an Ambubag which contained oxygen masks and equipment. He then went straight to B2 landing and into the man's cell. He said he helped remove the leather belt from around the man's neck and checked for a pulse. He could not find one and decided to retrieve a defibrillator from A3 surgery. He said the man was turned over and he tried to establish an airway but could not because the man's neck was very stiff and his jaw was rigid. The paramedics arrived very quickly and put an ECG on the man. He said he saw the machine give a flat line reading and he left the cell.

The paramedics pronounced the man dead at 7.17am.

The prison's immediate response to the man's death

The Control Room log shows that the other officer called for emergency help at 7.04am. The Orderly Officer and the Duty Governor were informed immediately and an ambulance was called at 7.05am. The call for Hotel 1 to attend was also made at 7.05am. The ambulance arrived at 7.15am and the Duty Governor told the control room that the man had died at 7.18am.

The incident log compiled at the scene shows that the paramedics pronounced the man dead at 7.17am. The police and scene of crime officers attended the cell at 10.33am, and the Coroner removed the man's body from the prison at 12.20pm. The cell was then sealed.

The Duty Governor, said that he went to B2 landing when he heard the emergency call. As soon as the paramedics pronounced the man dead, he went to the Control Room to implement the death in custody contingency plans. The control room log shows that all the relevant agencies were contacted very quickly. Members of the Independent Monitoring Board (IMB), Prison Officers' Association (POA) and Care Team were available in the prison very quickly.

Notices were issued to staff and prisoners. The Listeners were all told of the man's death personally, and all prisoners subject to self harm monitoring procedures were given an individual case review.

Contact with the man's family

The Duty Governor said in a memo to the Governor of 27 June that, on the morning the man died, a governor and the Chaplain had travelled to the man's parents' address to break the sad news. Unfortunately, there had been no one in at the address and the family were not informed until 4.15pm when the Chaplain contacted them by telephone. It later transpired that the man's parents had moved house and the original address was incorrect.

The governor who was the nominated family liaison officer from the prison visited the man's parents with the Chaplain on 27 June. The family contact log shows regular contact was kept with the man's family. Several staff and the man's cellmate attended his funeral. The governor personally delivered the man's property to his wife.

The man's wife told us that she had only found out that the man had died when her sister drove round to tell her the news. The man's parents had told her mother first and she in turn told her sister. The man's wife said she was initially angry that she had not been contacted by the prison first, but later found out that the man had put his parents down as next of kin when he first went to Liverpool. She thought this had been because he would not have wanted people to know her address because of the harassment faced by the family at that time. She accepted that the prison did not know how to contact her but was disappointed that no one from the prison had since been to see her. When the governor was informed of this he contacted her and made every effort to return the man's property to her.

What other prisoners said

The man's cellmate said he had known the man for about two and a half years and worked with him as a Listener. He described the man as "very deep", "very private" and said he did not talk much about his family. The cellmate said the man was not at all excited about leaving prison. He said he rarely received visits and rarely used the phone. The cellmate said he thought the man cut himself off from his wife and children, although he used to get letters from them.

The cellmate said that he got on well with the man, and the man got on with the other lads on the wing although he did not have any particular friends. He described the man as "never in a bad mood" and always joking and whistling, "happy go lucky".

The cellmate said he thought the man would bottle up problems rather than talk to either staff or fellow prisoners. He thought the man would keep his troubles to himself. He said he felt the man was worried about repercussions from his victim's family. He said in the few months before he died, the man had complained of very bad headaches. He said he thought he felt guilty that he did not get a longer sentence for his crime.

The cellmate said he went to Newbold Revel (the Prison Service training college) for the Listeners Conference on Friday morning. He said the man had seemed fine and he saw him talking through the window to the men in the cell next door at about 9.20am. He said he was told at about 9.00am on Sunday morning that the man had died. He said he was shocked. The cellmate said staff had supported him well since the man died and had "bent over backwards".

Another prisoner said that he had known the man for a number of years and described him as a "decent, quiet lad, very level headed" who was well liked and respected. He thought that the man could not forgive himself for the offence that he had committed. He also thought that the man had received threats from "outside". He said he often used to lend the man his PlayStation. At tea time on Saturday 26 June, he said the man had wanted to return the PlayStation to him. The prisoner was upset because he thought he should have seen this as a sign that the man was "not right". He said that he "never thought in a million years" that the man would kill himself.

The prisoner said that the man talked to him a lot about the family of his victim. He said that he was worried that, even if he moved area, they would find him. He said he did not think that the man found it easy to express these concerns. The prisoner said the man had cut himself because he did not want to go to Sudbury open prison. He said this was because the man was worried that there were people in Sudbury who were connected to his victim. He said the man had not told anyone about this.

The prisoner said that he knew that, if the staff in Liverpool had any idea the man had intended to hurt himself, then they would not have left him alone in

his cell. He said he had seen staff visibly upset by the man's death and that several were hoping to go to his funeral. He said staff regarded the man very highly.

A Listener said he had known the man for about two and a half years. He said the man was a "pillar of strength" and was always available to talk to for a bit of advice. He said he had seen him "laughing and joking" two days before he died.

The Listener thought that there was no indication that the man intended to take his own life. He said the man had been fine since his last episode of self harm and he was not one for showing any pain or problems. The Listener said that he had spoken to the man after his previous self harm and the man had told him that "me head went West" but had not said much more. The Listener said he could not believe the man had killed himself – especially because he was so near to release.

A fourth prisoner said he had been in the cell next door to the man for three months and chatted to him a lot about his problems. He said the man never spoke about his family or his offence and did not seem to get many visits or make many phone calls. He said the man never gave him any indication that he was facing any problems. He did think that the man was not keen on walking the landings and preferred people to come to his cell.

He said the man was quiet and played chess a lot. He said he was always there to talk to. He could not understand why the man had killed himself. He said he had been a "happy go lucky" man who was liked by prisoners and staff. He said he thought the man had been a bit down during the Saturday and put this down to the fact that the man's cellmate was away. By the evening, he said the man was his happy go lucky self and had passed him a newspaper.

A fifth prisoner said he had been in Liverpool for five and a half months and had been in the cell next door to the man for two months. He said he had known the man for about four months. He said the man supported him through his first time in prison and talked to him a lot. He said he thought the man "held a lot in" and did not have many visits or phone calls. He said the man had told him about the threats made to his family. The fifth prisoner said he talked to the man about the incident when he cut his neck and the man had told him that he had not meant to do it.

The fifth prisoner said he thought the man had been a bit quiet on the Saturday lunchtime. He had not had a sandwich with him behind the servery as usual and did not seem to be out and about as much. He saw him again at tea time at about 5.00pm however and he seemed fine. He said he saw the man later and he was laughing and joking with the officers and he shouted through the window to him and his cellmate as usual. He said the man passed them a sandwich at about 8.30pm and a newspaper at about 8.45 – 9.00pm. This was when he last spoke to the man.

Consideration and Recommendations

The man was subject to self-harm monitoring procedures twice during his time in Liverpool. The first time was in August 2001 when he first arrived. This appears to have been to a certain extent a routine precaution because of the nature of the charge he faced and because the man had attempted suicide in 1999 and was suffering some anxiety about the safety of his family. On the second occasion, in October/November 2004, the man had made a cut to his neck. The man also spent some time in hospital in May 2003 after being found collapsed in his cell. It seems likely that the man had taken an overdose of dothiepin – the anti-depressant which he was prescribed for most of time in Liverpool. This episode does not appear to have been recognised or treated as self-harm. Both the suspected overdose and the cut to his neck occurred shortly before proposed moves to Sudbury open prison.

My investigation of these issues has been severely hampered by the lack of documentary evidence on the man's prison record and Inmate Medical Record (IMR). I have not been provided with any of the self-harm monitoring forms for either of the two times the man was subject to them. I draw attention to the comments made in the clinical review about the poor nature of the medical record keeping. I note also that the man was prescribed anti-depressants throughout his time in Liverpool with only a single brief review in February 2002. I find it extremely worrying that the man managed to overdose on the drug he was being prescribed in May 2003 without any apparent alarm being raised among medical staff or any subsequent review of either his mental state or his medication. I endorse all of the recommendations made by the clinical review.

The man's home probation officer wrote in her report of January 2005 that the man presented a high risk of self-harm and the Parole Board panel gave this as one of the reasons for refusing him parole. I have seen no evidence that this information was passed on to, or noticed by, any staff in the prison. I have had occasion to say in far too many death in custody investigation reports that, in order for risk to be assessed effectively it is essential that such information is passed to those people with responsibility for ensuring the day to day safety of prisoners.

A copy of this report will be forwarded to the chief officer of the Cheshire Probation Area for his attention by the Ombudsman.

With the benefit of hindsight, there were signs that the man was at risk of harming himself. I do not believe that it was coincidence that the overdose and the incident when he cut his neck occurred so close to proposed moves to Sudbury. Other prisoners have indicated that the man was worried that his transfer to an open prison might have prompted his victim's family to resume harassing his own family. It certainly appears that the man tried to distance himself from his family while in prison in order to protect them. It may therefore have followed that he would be worried about the impact his release would have had on his family.

However, it is also clear that the man was a very private person who did not talk about his personal concerns with either staff or prisoners. He was a trusted and reliable prisoner who actively sought to help his peers through being a Listener. He was obviously respected and admired by those who knew him. None of the staff or prisoners spoken to in the course of this investigation expressed anything other than shock that the man had died.

It would also seem that the man carefully planned the action he took. I note the position he found out of the direct sight of staff and the use of screws to form the ligature. He may have chosen the one time he was alone in his cell. Given all these facts and that concerns expressed by outside probation were not shared with the prison, I do not think that the man's death could reasonably have been predicted or prevented.

The prison's immediate response to the man's death appears to have been very efficient. Medical staff and paramedics were quickly on the scene. All the appropriate agencies were informed in a timely manner and there are good records showing the sequence of events. Notices to staff and prisoners were put up immediately and were worded sensitively. The man's closest friend and the other Listeners were told personally and promptly and staff appear to have reacted sensitively and supportively to those prisoners who were closest to the man.

The way in which the man's closest friend and other Listeners were informed of his death was an example of good practice.

Most of the staff spoken to by my investigators said they were happy with the care provided to them in the aftermath of the man's death. The exception was the HCO. This is not the first investigation in which I have received complaints from Healthcare staff that they have felt overlooked and under supported compared to other staff. I draw this to the Governor's attention.

The man's family were not told of his death for some hours because the next of kin details were out of date. However, I am pleased to note that the prison took responsibility for delivering the tragic news. I note that effort was made to keep in contact with the family and that several staff attended the man's funeral.

Recommendations

Probation Service:

A copy of this report will be forwarded to the chief officer of the Cheshire Probation Area for his attention by the Ombudsman.

Healthcare:

The clinical records were often illegible and it was difficult ascertain a clear picture of the care provided to the man. The standards in relation to clinical records should be urgently reviewed particularly in relation to individual entries and their legibility, use of signatures and filing of correspondence and associated forms.

Accepted: a new protocol is now in place, checked weekly by the Primary Care Manager. An audit trail of a selection of patients' clinical notes will be checked to ensure individual entries are legible and a clear signature is present

The process for secondary health care screening should be reviewed.

Accepted: all new receptions receive secondary health screening within five days.

Six monthly reviews should be established for all patients prescribed antidepressants and appropriate entries made in the clinical notes to support this.

Accepted: Currently, Liverpool Prison has two full time P.C.T. G.P.'s. Both G.P.'s attend the drugs and therapeutic committee and work to the drug formula. Both G.P.'s are fully aware that when reviewing a patients prescription chart this must only be done when accompanied by the patients' clinical notes.

The process for mental health assessments should be reviewed as a matter of urgency.

Accepted: Currently, under a trial period we have a member of staff working in the role of ("Crisis Intervention Mental Health Nurse"). This role has been put in place to clearly make any clinical assessments on any prisoner where clinical concerns have been raised.

Where patient injuries are reported, detailed entries should be included within the clinical record including extent of the injury and subsequent treatment.

Accepted: The audit trail currently in place, involves the primary care manager checking clinical notes weekly is greatly addressing poor clinical documentation. Also we have a new system in place where all injuries are

now being photographed by the clinical staff and the photographs are being stapled into the patients' clinical notes.

For prisoners who self harm, more effect links should be established between clinical records and the F2052SH or revised ACCT procedures.

Accepted: All ACCT Reviews have a member of the clinical team present to support the patient/members of staff during the multi-disciplinary ACCT Review.