The Death in Custody of a man in HMP Liverpool on 2 August 2005

Report by the Prisons and Probation Ombudsman for England and Wales

February 2006

This is the published version of a report of my investigation into the circumstances of the death of a man in custody at HMP Liverpool on 2 August 2005. He was found hanging in his cell.

Apart from a number of minor amendments and the removal of the names of those involved the text of my report remains the same as that originally submitted.

The man who is the subject of this report was 44 years of age and was receiving medication for epilepsy, alcohol dependence and depression. His death was sudden and unexpected. He had been in Liverpool prison for less than 24 hours.

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

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

We would like to thank the management and staff at HMP Liverpool for their assistance and co-operation during the course of this investigation. My report finds that the man gave no indication to either staff or other prisoners that he might be at risk of self-harm.

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

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Summary

1 The man who died did so at some time after 1:30pm and before 4:15pm on 2 August 2005 in a cell on H wing at HMP Liverpool. He was found hanging from the cell window. The ligature used was fashioned from a bed sheet.

2 The man was 44 years old, who had been released from custody at another prison in June 2005 having served a sentence of four years and ten months. He was supervised by the Probation Service and was unemployed. After an initial problem with his accommodation on release he arrived at a Probation Hostel in Liverpool and took up residence. He remained there until 2 July, when he left the hostel and eventually went to live with his sister. During the subsequent weeks, he was unable to abide by the conditions of his release and the Probation Service started the process leading to his recall to prison. He made efforts to modify his behaviour and the recall procedure was stopped. On 26 July, an appointment was made for a meeting on 2 August between him and his probation officer. He did not keep this appointment as by this time he was already in custody at Liverpool prison.

3 The man had been arrested by police in late July for a burglary committed earlier in July. In early August, he was convicted and returned to custody by Liverpool Magistrates' Court, pending a further court appearance for sentencing. He had been refused bail.

4 On his first night in custody at HMP Liverpool, the man was housed on B Wing. During the induction process, it was identified that he needed help with his alcohol and drug misuse and was allocated accommodation in H wing in order to facilitate this. He was prescribed drugs for his epilepsy, depression and alcohol dependence. On the morning of 2 August he was moved from B to H wing. He spent just a few hours in his new cell before apparently taking his own life.

5 He left two notes explaining the reasons for his actions which were found in his pocket at the time of the post mortem examination. One note was to his partner and the other to his daughter. The notes expressed his disappointment at being sent back to prison and his regret for the many years he had spent in custody. He clearly indicated that he intended to take his own life at the time of writing the notes.

6 The death of this man was one of a series of five deaths that occurred at HMP Liverpool during June and August 2005. The circumstances of his death do not appear to have anything in common with the other deaths, although the investigations into those deaths have not yet been concluded.

Investigation Process

7 My investigator first visited HMP Liverpool on 4 August 2005 and met the Deputy Governor. He was given a full briefing about the circumstances surrounding the man's death and the situation regarding family contact and actions instigated by the establishment. Offers to meet with a Prison Officers' Association representative and Independent Monitoring Board were accepted.

8 Notices to staff and prisoners were published inviting anyone who might have information relating to the man to make themselves known to the investigator. Five prisoners who knew him spoke to the investigator. Some staff were interviewed by police immediately after his death; those interview notes form part of the evidence available to my investigator. Other relevant reception and induction staff were spoken to by the investigator, but they were unable to add any information to supplement their records and so were not formally interviewed.

9 The investigator received copies of the relevant files and records relating to the man and commissioned a clinical review from the North Liverpool Primary Care Trust. A doctor was appointed as the clinical reviewer to carry out the review.

10 One of my family liaison officers contacted and visited the man's partner together with the investigator. His partner raised one concern which was about the licence condition requiring him to live in a probation approved premises following his release from prison. She said that such an environment exposed him to bad influences and inevitably lead him astray. She considered that, if he had a serious desire to control his alcohol and drug misuse, putting him in a place with others with similar problems and easy access to both substances would ensure his continued use of them.

HMP Liverpool

12 HMP Liverpool is a category B local prison built in 1855 and is currently used to hold convicted, unconvicted and remanded adult 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.

13 Since April 2004, healthcare at Liverpool has been provided by the North Liverpool Primary Care Trust (PCT). A doctor visits daily. The current prison hospital is being demolished and replaced with a purpose built healthcare unit. Temporary facilities to cover the transition are in place.

14 All staff working within healthcare in Liverpool are qualified for the job that they do. There are currently 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 prisoners who arrive late. Primecare is contracted to provide out of hours medical cover. Appointments to see a doctor are triggered by an application from the prisoner. There are four surgeries in the main prison that are staffed throughout the day by medical staff.

15 My investigator saw evidence of reasonably good relationships between staff and prisoners.

The Man who is the subject of this report.

16 The man was born in 1961 in Liverpool. He had three children with his partner of 23 years. At the time of his arrest they were estranged, and he was living with his sister. The man had a long term history of heavy alcohol consumption and, to an apparently lesser degree, drug misuse problems.

17 He was convicted and remanded in custody by Liverpool Magistrates' Court in early August 2005, charged with burglary. He was due to re-appear at court later in the month for sentencing. This was not his first time in custody and he had a long history of offending. He was in contact with his partner during this short period in custody and, although estranged, she was his main support at that time. He was not in contact with his children.

18 At Liverpool, he spent his first night on B wing, a unit for new receptions into prison. He was transferred the following day to H wing, which caters for those prisoners with drug and alcohol dependencies. His two cell mates described him as a quiet man, who appeared a bit down, but thought this was because he had been committed to prison once again and was expecting a long sentence.

19 On reception into prison, he stated that he was epileptic, had depression and was on medication for both. He also said that he had a heavy alcohol intake, but denied illegal drug usage. He indicated at the same time that he had never attempted to harm himself and currently had no thoughts of doing so.

Events leading up to 2 August 2005.

20 The man was released from prison in June 2005, having served a sentence of four years, ten months. He was supervised by the Probation Service on his release. He had no job and was required to live in a probation approved premises as part of his licence conditions.

21. His supervising probation officer had been allocated his case in February 2005, whilst he was still serving his previous sentence. Following a letter from the man in April 2005 requesting a move out of the Liverpool area, she had attempted to find hostel accommodation outside Liverpool. However, because he was a prolific offender with a high risk profile, she found it impossible to persuade approved premises in London or Manchester to offer him a place. The probation officer met him in prison on 7 June when she explained that he might have to return to Liverpool because of her inability to find alternative accommodation. He told her that his life had been threatened should he return to Liverpool, and she noted that he appeared genuinely frightened. She made further efforts to find suitable accommodation, unfortunately without success. The man himself was unable to provide an alternative address and he was finally accepted by an approved premises in Liverpool, where he agreed to go on release. Late in the afternoon of the day of his release, he telephoned the probation officer to say he was unable to attend her office, as required. She told him that he must go to the hostel as soon as possible to ensure that he did not lose his place. He was also told to report to her office on Monday 27 June.

22 When the man arrived at the hostel, there was some confusion as it was several days before he was expected and he was turned away. He told staff that he would stay with friends over the weekend and finally moved into the approved premises on 27 June. The probation officer visited him at the hostel on 30 June and described him as more relaxed than when they had met previously (he told her he was happier than he thought he would be). He said that he had seen his partner. He had not been threatened and told the probation officer that he felt safer, but still wanted to move away. She told him that he would have to remain at the hostel for four to six weeks whilst he settled in and was risk assessed. His next appointment with her was on 7 July. He remained at the hostel until 2 July when he failed to return. No contact was received from him until he telephoned the probation officer on 6 July to ask whether he “had been breached”.

23 Over the next 11 days the man was absent from the hostel and so lost his place. Because of his inability to abide by the conditions of his licence, recall procedures were considered by the Probation Service.

24 The man went to the meeting with the probation officer on 7 July, and she told him that he could return to the hostel. He was unhappy about this and argued that he should be allowed to change his address to live with his sister. She explained to him that accommodation was not the only factor and weight was also given to other risk issues. A further appointment was fixed for 14 July,

and he agreed to return to the hostel. In fact, he did not do so and went to live with his sister.

25 On 3 July, Police found the man's fingerprints at the scene of a burglary and, on 13 July, a police officer contacted the Probation Service to ask about his whereabouts. The Probation Service began the procedures to have him recalled to prison.

26 At their meeting on 14 July, the man and his probation officer discussed his recent behaviour and the possibility of his being recalled. Later that day, the probation officer and the Senior Probation Officer agreed to stop the recall procedures, but warned him about breaching his licence by failing to live where directed by his probation officer. The probation officer subsequently informed the police where the man was living.

27 The probation officer next met the man on 18 July. She informed him that he would receive a formal warning about the breach of his licence condition but would not be recalled to prison. A home visit was arranged for 19 July to assess the suitability of his new address.

28 By 19 July, several attempts to meet the man at his new address or contact him by telephone had failed. However, on 20 July the probation officer did see him at his sister's address. He admitted that he had missed the previous meeting because he met a friend, went to a pub and got drunk. He agreed that alcohol was a risk factor for him. Another appointment was made for 26 July which he kept and which appears to have gone well. He said that he was happy and settled at his sister's address, and might look for his own accommodation in a few months time. A further appointment was made for midday on 2 August (he did not keep this because by then he was in custody at Liverpool prison). (On 15 August, following his death, the probation officer recorded in her case notes that, during a conversation with his sister, there had been no indication or current concern that he would commit suicide.)

29 At 8:10pm on 29 July, Police arrested the man and took him into custody. He appeared drunk at the time. He gave his address as that of his sister, but when the police checked they were told by her son that the man lived at a hostel. The man was interviewed and risk assessed by the police. He said that he took medication for epilepsy and depression, and had an alcohol problem although he denied drug use. He also told the police that he had never tried to harm himself and was not at risk at this time. He was given bedding and arrangements were made for him to be seen in his cell every 15 minutes.

30 The man was also interviewed by the local Forensic Medical Examiner (FME) at 10:55pm. The FME concluded that he was fit to be detained and was at low risk of harming himself. At 11:00pm the FME gave a 100mg dose of Tegretol and prescribed 100mg of Carbamazepine for his epilepsy to be administered at 7:00am the following morning. At 11:05pm he asked for and ate some cornflakes. At 11:45pm, it was decided that he was not fit to be interviewed and should have a period of recuperation until 7:45am the next

day. At 2:10am he was reviewed and it was decided that he was not fit to be 'processed'. He was detained for questioning and would have his legal rights explained to him when he was fit enough to understand them.

31 Observations at 15 minute intervals were maintained throughout the night and at 7:00am the man received his medication. At 9:20am, his legal rights were explained to him and he made no reply. At 11:44am he was interviewed and admitted burglary. He was charged with the offence and bail was refused because of the risk of him committing further offences. He agreed to be tested for class A drugs, and the results were negative. A short time later, at 2:44pm, he was allowed to telephone his family and a message was left for his solicitor to contact the police station. The man spoke to his solicitor on the telephone at 3:40pm. At 4:30pm, he was seen by another FME. At 10:00pm on 30 July, and 7:00am the next day, his medication was administered and 15 minute observations continued throughout the night. The man took his meals regularly and he appears to have had undisturbed sleep periods.

32 At 5:03pm on 31 July, the man's continued detention was authorised and he asked to telephone his partner which he did at 5:16pm. At 10:30pm on 31 July, and again at 7:00am on 1 August, his medication was administered and 15 minute observations continued throughout the night. Again meals were taken regularly and he had undisturbed sleep.

33 At 7:45am on 1 August, the man was taken to the Magistrates' Court where he was convicted of burglary and remanded in custody until a date later in August when he was due to be sentenced.

34 The man arrived at HMP Liverpool and went through the usual reception procedures. His first reception health screen form indicates that he told staff that he suffered from epilepsy and depression. He was prescribed Librium and Thiamine for 12 days for the alcohol dependency, and Tegretol and Amitryptiline for 28 days for the epilepsy and depression. The Tegretol was administered that evening. The first night locating officer's interview with the man states that he had no concerns about his harming himself and that he was not suffering from drug withdrawal.

35 During the time in the prison reception area, the man spoke to his partner on the telephone. She says that at no time, during this or the earlier conversation from the police station, did she get the impression that he was suicidal. He was depressed, but she felt that under the circumstances this was a normal reaction. His partner said that he had served several prison sentences over the years and, to her knowledge, had never considered suicide or previously been treated for depression.

36 During the evening the man was seen by a life sentence prisoner who works as a cleaner in the reception area and has been a Listener at Liverpool for the previous 18 months. (Listeners are prisoners trained by the Samaritans.) He said that the man was laughing and joking whilst he was in the reception area and at no time was he alerted to a potential problem.

37 In the early evening the man was located in a cell on B wing, which he shared with another man who had also arrived at the prison that day. According to the cellmate they were both tired but polite with each other and not overly talkative. He said that they were both depressed at being in prison but that it is quite normal to feel that way under those circumstances. They watched television in their cell and then went to bed. He said that he could see that the man who died was troubled, but saw no indication that he was suicidal. He described the man as an easy going man, but thought that he might be vulnerable to bullying.

38 A prison intelligence report submitted on 2 August indicates that, during the evening of 1 August, a package of drugs was moved around the outside of B wing on a line swung from cell to cell. The destination was reported to be a prisoner in the Separation and Care Unit on B1. However, the package appears to have been intercepted and retained by a prisoner in the cell which was occupied by the man who died and his cellmate. This was apparently witnessed by other prisoners who according to a prisoner located on the opposite side of B wing, began a loud and increasingly acrimonious commotion which was taken up by other prisoners on adjacent wings. Denials were shouted from the man's cell, refuting the allegation. The shouting and screaming continued for some time. According to the reporting prisoner it contained threats that the shouters would "kill you" and "cut you" and what he describes as "the usual horrible prison banter". He was unable to identify any of those making the threats.

39 The man's cellmate was re-interviewed about this matter but said that he knew nothing about it. Three other prisoners were also interviewed and all confirmed that they saw nothing, but heard the commotion which was directed at cell B3-21. No other evidence is available to enable me to substantiate the allegations and there is no indication that the incident had any bearing on the man's subsequent actions.

40 The post mortem report indicates that the man's body had the residue of a morphine based drug. It is likely this was taken a considerable time prior to his death and would have played no part in his death.

The day the man died

41 Early on the morning of 2 August, the cellmate left their cell on B wing to return to court. The man who died remained in the cell to carry on with the prison's induction procedure. During the interview with medical staff, it was noted that the man said he last had an epileptic fit in 1996, his mood was good and he was not suicidal. He was allocated to H wing for a course of detoxification and mental health assessment and was moved later in the morning and located in a cell on H wing. The man's partner later told one of the prisons Governors that she was not surprised that he was located in the detoxification wing because of his history of alcohol and drugs misuse.

42 Another prisoner was in the same cell on H wing on 2 August and, according to his account, the man who died arrived at about 10:30am after exercise that morning. He said that he and the man did not know each other and so they introduced themselves. They ate a meal together at lunch time, talked and watched a bit of television. During the conversation, the man told him that he had served five years and only been out for five weeks which bothered him. He did not mention his family. He told his cellmate that he was expecting at least seven years imprisonment on the current charge. The man who died could not believe that he was going to prison for a long sentence so soon after the last one. The cellmate reports that the man who died seemed fine did not seem depressed or likely to commit suicide. At about 1:30pm, the cellmate went from the cell to his afternoon computer class.

43 At around 4:00pm, the cellmate returned to H wing from his education class and went straight to his cell where he waited for a few minutes to be let in by a member of staff. When asked if he looked through the spy hole in the cell door or whether there was any noise from within the cell, he said that he had no need to look through the spy hole at the time and had not done so. He also said that there was no noise from within the cell. He said that an Officer arrived to let him into the cell and he asked the officer whether he could get some hot water for a drink. The officer replied that this would be fine, opened the door and moved away.

44 The cellmate said he entered the cell, turned slightly to his left to get a cup and out of the corner of his eye saw the man and asked if he wanted some water as well. There was no reply and the cellmate said that he looked directly at the man and saw him facing towards him. The cellmate said, "his eyes were open and his colour told me there was something wrong". He then shouted for the officer who returned immediately to the door, realised what had happened and shouted for "help on the 3's". Other prison staff arrived on the landing within an estimated one minute. The cellmate was ushered out of the cell immediately and said that he did not touch the man at all. He was re-located into another cell on H3.

45 The first officer supported the man whilst other officers removed the ligature. At 4:15pm, an urgent radio message was broadcast by the Senior Officer (SO) and H wing manager, asking for healthcare staff to attend the wing. The man was laid on the floor of the cell, by which time two Nurses had

arrived with resuscitation equipment. At 4:18pm, the prison control room telephoned for an ambulance. At 4:20pm, three more healthcare staff arrived and assisted with attempts at cardiopulmonary resuscitation (CPR).

46 At 4:23pm, Ambulance Service staff received an emergency call to attend the prison and at 4:33pm their staff arrived at the cell. On examination by ambulance service personnel, the man showed no vital signs and his pupils were fixed and dilated. An electrocardiogram monitor was attached to him, CPR was continued and 2mg of adrenaline immediately administered. At 4:40pm, a further 3mg of atropine was administered and CPR continued. Ambulance staff noted that deep ligature marks were present on his neck and that his larynx felt fractured. The prison duty doctor arrived at the cell at 4:35pm. At 4:42pm, CPR was stopped and at 4:44pm the doctor pronounced the man's death.

47 The ambulance staff left the cell at 4:48pm. The cell was sealed by a Senior Officer at 4:54pm and the key given to the Principal Officer. The police were informed at 4:57pm.

The prison's response to the man's death

48 At 4:23pm on 2 August the Deputy Governor opened the prison's Command Suite in order to co-ordinate the prison's actions following the man's death. The contingency plans for responding to a death in custody were implemented and all necessary people were informed, including the Coroner's officer and police who attended the prison.

49 There were some omissions from the record of the contingency plan in that the Contents section was incomplete, some items in the Mandatory Actions section were not recorded and others did not include the time of completion. The First on Scene and Orderly Officer's Action Sheets were not completed and the log of events at the cell was recorded between 4:15pm and 4:54pm, but was unsigned.

50 The man who died had nominated his partner as his next of kin. The Prison Chaplain telephoned to give her the sad news and asked if he and a Governor could visit her during the evening. She agreed to the visit and asked that it take place at the home of her friend, as she did not want her children to be involved.

51 The Chaplain and Governor left the prison at 7:30pm and met the man's partner as arranged. The Chaplain told her how the man was discovered and the efforts made to resuscitate him. She was very distressed and, before leaving, they ensured that she had family members with her. They also left their contact details and information about organisations providing assistance after bereavement. The Governor and Chaplain then attempted to inform other members of the family about the man's death but were unsuccessful and his partner said that she would tell his sisters later.

52 The Governing Governor issued a notice to inform prisoners of the man's death. The prison offered to pay for the funeral, an offer that was accepted.

53 The Governing Governor followed the visit to the man's partner with letters of condolence to her and to his sister on 3 August. Regrettably, the letters used the wrong name when referring to the man and the following day the Ombudsman's investigator noticed the error and an apology was sent to both.

Post Mortem Examination

54 A post mortem examination of the man was carried out by a consultant pathologist to the Home Office. At the examination, notes were found in the back pocket of the man's trousers addressed to his partner and daughter. The notes expressed his love for them both and stated that he could not bear to return to prison which was the reason he was taking his life.

55 The pathologist's conclusion was that the man died as a result of hanging by a ligature and there was no evidence that any other person was directly involved in his death.

Issues considered during the investigation

Self harm

56 The man who died had received medication for depression for a number of years, but there is no evidence that his mental health had deteriorated to the extent that he was thought likely to harm himself. He had recently been released from another prison under the supervision of the local Probation Area and showed no signs of wishing to self-harm. His life was chaotic in the few weeks between release and reception to Liverpool, and the prison recall procedure was started and then stopped. His life seemed to have steadied a little when he went to live with his sister. He was then arrested for burglary and kept in police custody for three days. Again he showed no indication that he considered harming himself before he was taken to court, convicted and committed to custody awaiting sentence.

57 In hindsight and with much more information than was available to prison staff on 1 and 2 August, it is evident that the man was at a crisis point in his life. His demeanour in the prison and his telephone conversation with his partner did not indicate that he was contemplating suicide. However, the notes left for his partner and daughter are clear and lucid, and indicate that he had made a firm decision to end his life during the afternoon of 2 August. The only time that he made any reference to the possibility that he might attempt suicide was when he told his sister that he would not last more than a day if he returned to prison. She reported their conversation in her statement of 31 August. The man's partner also reported that he had recently spoken to her about being sick of prison and was adamant that he would not go back. She believes that his strength of feeling may have led to the decision to end his life. Her opinion of the suicide letters is that he had simply had enough, and she does not think it was an accident or a cry for help that went wrong.

58 Conversations between the man who died and his first cellmate, on B wing, on 1 August and his second cellmate, on H wing, on 2 August both indicate that he was upset by the likelihood of a further long sentence, but in neither case did they describe him as so upset that they thought he was suicidal.

Bullying

59 The man's first cellmate stated in his first interview for this investigation that he thought that the man might be vulnerable to bullying. Some shouting and threats were made by other prisoners when a package of drugs was allegedly intercepted during the evening of 1 August by the inhabitants of his cell on B wing. It is likely that this episode will have added to the crisis that the man had found himself in. However, no mention is made in the notes for his family that he experienced bullying or pressure by other prisoners and I have found no evidence of bullying having taken place.

Accommodation

60 Substantial efforts were made to meet the man's request to be accommodated outside Liverpool after his release from prison. However, because of his previous criminal record and the fact that he was designated as a prolific offender, this proved impossible. The misunderstanding between the supervising officer and the approved premises was unfortunate and led to a period of several days when he was unsupervised and his whereabouts were unknown. This began a period where the man's life became chaotic until he was arrested. This misunderstanding was regrettable. However, in my view the accommodation and supervision provided by the Probation Area is unlikely to have influenced the man's decision to end his life in Liverpool prison.

Conclusions

61 The man's transition from prison custody to supervision at the Probation Approved Premises was marred by an error that left him without accommodation or supervision for a three day period and began an increasingly chaotic period culminating in his return to police custody and to prison on 1 August. This single event did not directly lead to his ultimate death on 2 August. However, it did appear to begin a series of actions which resulted in his reconviction and imprisonment.

62 I believe that the man made a clear and settled decision to end his life on the afternoon of 2 August 2005. He decided to do so because he did not wish to serve another long prison sentence with all the consequences for himself and his family that that entailed. I believe there was little that the staff on duty at Liverpool could have done to prevent him doing so.

63 Staff at Liverpool were sensitive to the man's needs and problems as they presented. They allocated accommodation on the wing dealing with detoxification to assist with his alcohol and drug dependencies. His medication appears to have been appropriate to his medical needs and this view is supported by the clinical review. The risks he presented were assessed and he was considered suitable to share a cell with another prisoner. Whilst he was described as being depressed about returning to prison, he was not considered suicidal by staff or prisoners whom he encountered on 1 and 2 August. There were no indications that an Assessment, Care, Custody & Teamwork (ACCT) document and support plan should have been opened to monitor any risk of self harm.

64 An intelligence report was submitted about the disappearance of illicit drugs on B wing on the evening of 1 August. It has since been confirmed by other prisoners that a parcel of drugs was intercepted, allegedly by the occupants of the cell on B wing, the man and his cellmate, while it was en route to another prisoner being held in the Separation and Care Unit on B1. Threats were made by unidentified prisoners to the occupants of the cell regarding the taking of the package. This event has been totally denied by the man's cellmate. If it occurred as described by others, it does not seem to have played a part in the man's death, although it must have added to the pressure on him. Subsequent toxicology reports on the man who died show that if he did intercept the parcel the contents were not consumed by him.

65 It is not certain when the man decided to end his life, although he indicates in the suicide note to his daughter that it was on 2 August. Neither is it clear when he wrote the suicide notes, although they are both dated 2 August. However, it is clear that a ligature was fashioned from bedding and he hanged himself during the afternoon of 2 August. No other person was involved in that act. Appropriate and timely, but ultimately unsuccessful, efforts were made by properly qualified staff to resuscitate him when the man was found hanging in his cell at 4:15pm that afternoon.

66 Prompt efforts were made by senior staff at the prison to ensure that close family members were informed of the man's death. The typographical errors made in the letters of condolence were regrettable, but were rectified immediately on discovery. The offer from the prison to pay funeral expenses was appropriate.

Recommendations

I make two recommendations:

- **The Governor should remind staff of the importance of timely, accurate and attributable recording of actions taken following a death in custody.**

- **The Governor should remind staff of the importance of accuracy when letters are sent out to bereaved family and friends.**

HMP Liverpool Responses to Recommendations

Action Plan responses have been received at the Ombudsman's office from HMP Liverpool regarding the two recommendations made. Both were accepted and the responses were as follows:

- **To incorporate into the local Contingency Plans, the need to maintain accurate auditable records. The target date for completion is: 31/03/06.**

- **All outgoing correspondence is personally checked by the Governor for accuracy. The target date for completion is: Completed.**