Investigation into the circumstances surrounding the death of a prisoner at HMP Liverpool in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

June 2007

The man who is the subject of this report was 30 years old when he died in June 2006, after hanging himself in his cell at HMP Liverpool. Any death is distressing, but none more so than when the person is in custody, alone and vulnerable. My colleagues and I offer our sincere condolences to the man's family and friends.

The man who died had been recalled to prison, having breached the conditions of his parole licence.

Two members of my team carried out the investigation. I wish to thank the Governor for making the necessary facilities and information available to my investigators, and for the assistance of the Liaison Officer.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by the man whilst in custody. I am grateful to the local Primary Care Trust for its assistance.

Ordinarily, as a mark of respect and to avoid further distress to the family, I do not disclose the offences committed by someone who has died. However, in this man's case, my report includes some information which will help the reader understand what was on his mind when he apparently took his own life. It is no coincidence that a previously apparently happy-go-lucky man, with much experience of prison life, was worried when he learnt about further allegations and licence conditions. He thought that he faced a life sentence and his response was to put a ligature round his neck and call for help. Appropriate monitoring began, but was reviewed in little more than 12 hours and brought to a close. Within two days, the man was dead.

I am concerned at the way the self harm procedures appear to have failed the man and make nine recommendations relating to this and other findings.

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2007**

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SUMMARY

On 16 September 1999, the man who later died received a 42 month prison sentence following a serious assault. The sentencing judge added four years of extended supervision to the sentence, which meant that his actual sentence, including the period of licence, would not expire until January 2007. Due to the nature of his offending behaviour, he was subject to the Multi Agency Public Protection Arrangements (MAPPA). (I explain later in my report the purpose of MAPPA.)

In May 2001, the man was released from prison on licence. However, on 10 June that same year, he was recalled to prison after breaching his licence conditions.

On 27 March 2006, he was again released on licence. Unfortunately, it appears that once again he did not comply with the licence conditions. After being seen by police officers on 3 May entering an area from where he was barred, an emergency MAPPA meeting was convened the following day. The meeting agreed to recommend that the licence be revoked, as the man was in breach of the conditions. On 5 May, confirmation was received that the licence had been revoked. The man was re-arrested and the next day he returned to prison custody.

On 19 June, a police officer based at HMP Liverpool met the man on behalf of Merseyside Police and issued an application for a Sexual Offence Prevention Order. The application was due to be heard by Birkenhead Magistrates on 19 July. Although the police officer said that the man did not appear to be concerned about the application, a wing manager recorded in the wing file that he was unhappy. He spoke to the man the following day, and described him as being worried about the application. In addition to the Sex Offender Prevention Order, the man was aware that two prisoners had made allegations that he had sexually assaulted them and that the matter was being investigated by police.

Two days later, in the early hours of the morning, the man pressed his cell call button. The wing night patrol officer went to see him and, when he opened the cell door observation panel, he saw the man standing with a ligature around his neck. The officer summoned assistance and, when the night manager arrived, they entered the cell. The man who later died said that he wanted to go to either the healthcare centre, HMP Altcourse, or to be removed from the wing. He also told the manager that he had received a letter the previous day and expected a life sentence.

After talking to the man, the manager promised that he would leave a message for the morning staff to facilitate a telephone call to his solicitor. He also said that he would open the document, known as Assessment, Care in Custody and Teamwork (ACCT), used to monitor prisoners considered to be at risk of suicide or self harm. The manager then persuaded the man to remove the ligature.

The ACCT document was opened. It noted the agreement about the telephone call, and recorded that the man was to be observed every hour until he was seen

by a member of wing management. Unfortunately, the morning staff failed to take the promised action, the man was not observed after 8:00am, and did not make the telephone call.

A visiting locum doctor, who had not been trained to use ACCT, was asked by an officer to complete the assessment section of the form. Although the doctor realised that the request was unusual, he completed eight sections of the ACCT document and did what he thought was right. The report shows that his assessment was poor and on two occasions factually incorrect.

At 4:00pm that afternoon, just over 12 hours after the man had been found with the ligature, a case review meeting was held. The panel had the ACCT form and two members knew that the doctor was not a trained assessor. However, they continued the review, decided that the man was not at risk of self harm, and closed the ACCT document.

Less than 24 hours later, an officer checked the wing roll and looked into the man's cell where she saw him hanging from the window bar. Other officers and medical staff responded very quickly. Resuscitation attempts started and continued until the arrival of the paramedics. After carrying out their own tests, the paramedics confirmed that he had died.

THE INVESTIGATION PROCESS

1 Once my office had been notified of the man's death, the investigation was allocated to one of my senior fatal incident investigators, who was assisted by another member of my team.

2 On 26 June, the senior investigator went to HMP Liverpool and met one of the senior managers at the prison. He gave the senior investigator a brief outline of what had occurred. Representatives of the local branch of the Prison Officers Association and Independent Monitoring Board were invited to the meeting, but did not attend.

3 The senior manager escorted my senior investigator to the cell where the man died. He also provided his prison records. When the investigation was completed, the majority of the records were secured at the prison and only those considered necessary were taken away.

4 On 24 July, the investigators met the Coroner's Officer and later met the Coroner. He gave permission for the team to have a copy of the probation documents relating to the man that were in the Coroner's possession. The Coroner told the investigators that he hoped to hold the inquest in about eight weeks time. The investigator advised that, in order to allow sufficient time for the man's family to be consulted, it was unlikely that the investigation and report would be finalised before the hearing. In the event, the inquest has been postponed.

5 The investigators also met a Detective Inspector and Detective Sergeant at Lower Lane Police Station. Both officers confirmed that they were not treating the man's death as suspicious, and were content for the investigators to continue with their work.

6 On 25 July, the senior invetigator and one of my family liaison officers met the man's parents and brother. The purpose of the meeting was to allow the family the opportunity to raise any concerns about his care and treatment by the prison. Both of my staff received a very warm welcome from the man's family. They asked a number of questions which I have done my best to address. These questions were:

- what medication the man received in prison?
- whether a statement made by a named Detective Constable was returned to the man?
- whether anyone was present with the man when issued with an application for a Sexual Offence Prevention Order?

Subsequently the investigators became aware of the man's first use of a ligature, two days before he died, and passed the information to his family. They were very distressed that prison staff had not shared this information when they told them of his death.

7 The investigators interviewed ten prison staff, six medical staff, two probation staff and one prisoner.

8 On 22 September, the investigators received the Clinical Review from what is now the amalgamated Liverpool Primary Care Trust. The Trust had been asked to examine the man's medical record and to offer a medical assessment of the care he received whilst in custody, and if necessary, make their own recommendations.

9 Although the man had been imprisoned previously, for the purpose of this report I have concentrated on the period from May 2006 when he was alleged to have breached his parole licence and was returned to prison.

THE MAN WHO DIED

10 The man who died was born in 1976, and lived with his parents and brother in the Merseyside area. He was educated locally and enjoyed playing football and boxing.

11 In 1992, he sustained a serious head injury when he fell from a drainpipe. This resulted in him being in hospital and unconscious for approximately three weeks. He was admitted to a specialist hospital for people with head injuries and, although in a wheelchair at first, he made a good recovery and was able to walk when finally discharged. The Clinical Review has identified that, as a result of the injury, the man suffered a personality disorder associated with sexual inhibition. However, he was not diagnosed as having a mental illness, sectionable under the Mental Health Act.

12 Following the injury, the man did not work again. On one occasion when he had offended, he was assessed as being unfit to be sent to prison and was instead admitted to Scott Clinic, which is a secure psychiatric hospital.

13 The man's first conviction was in 1992, when he was found guilty of being in possession of a controlled drug and received a 12 month conditional discharge. Over the next seven years his offending behaviour became increasingly serious, with a number of violent and sexual offences recorded against him. In 1995, he was given a three month custodial sentence in a young offender institution, and later that year a three year custodial sentence in a detention centre. He further offended in January 1999 and was given a 12 month probation order. In March that year, he was given two three month prison sentences, and again in September he was given a further two year prison sentence. In September 1999, he returned to court and was given an additional 42 month prison sentence following a serious assault.

14 In November 1999, a psychiatric report was completed. The report said that the man began using cannabis at the age of 13 and abusing alcohol from the age of 16. The man also experimented with substances such as LSD, amphetamines and cocaine and regularly took temazepam.

15 In May 2001, the man was released from prison on licence. On 9 July, police officers informed his probation officer that the man had been held in police custody over the weekend. Due to concerns about the risk he presented, the senior probation officer recommended to the Secretary of State that his licence should be revoked. On 10 May, he was recalled to prison under Section 39 of the Criminal Justice Act 1991.

16 Whilst in custody at HMP Acklington in May 2004, the man was thought to be at risk of self harm or suicide and was monitored under the F2052SH procedures which preceded the current ACCT arrangements. The reason for the attempt to harm himself was that he did not want to be transferred to another prison.

17 In March 2006, the man was again released from prison on licence to be supervised until January 2007. He was to be supervised under the MAPPA procedures, level three. This meant that senior representatives of the local police, probation, social, and housing and health services were actively involved in the case. The MAPPA panel had previously agreed 12 conditions to the man's licence, which outlined what he could and could not do, where he must live and the places he was allowed to go. They also agreed that that an additional condition should be inserted into the licence prohibiting him from entering or remaining in sight of any children's play area, swimming bath or school.

18 Six weeks later, police officers saw the man enter an area where he was not allowed to be. The next day an emergency MAPPA meeting was convened. It recommended that the man's licence should again be revoked. The following day, the Home Office confirmed that his licence was revoked, and he was arrested on 6 May and taken to Liverpool prison to continue his sentence. At the time of the man's death, the recall had not been formally confirmed by the Parole Board. The man had contacted his solicitor in anticipation of lodging an appeal in the event of the Board recommending his continued detention.

HMP LIVERPOOL

19 There are two prisons in Liverpool, HMP Liverpool (Walton) and HMP Altcourse. Liverpool prison was constructed in 1855 and replaced a much older prison situated in the centre of the city. There are eight wings, all of which have been refurbished and provided with integral sanitation. The prison serves the courts of the Merseyside area and has an operational capacity of 1,377 beds.

The cells

20 The cells are mainly for two prisoners, with bunk beds and integral sanitation separated from the cell by a door. All cells are fitted with internal lights which can be switched on or off by the occupants, and can also be operated from outside. Each door has an observation panel which can be opened to look inside and check the whereabouts of the prisoner.

21 Also within the cell is a cell call button, which the prisoner can press to request the assistance of an officer. Pressing the button lights a bulb outside the cell and activates a buzzer in the wing office. It is only when the officer goes to the cell to see what the prisoner wants that the cell bell is cancelled.

22 Prison Service Instructions (PSIs)

Prison Service Instructions are mandatory instructions which have a definite expiry date. They are also used to introduce amendments to Prison Service Orders. Each PSI is given a title and unique reference number.

Prison Service Orders (PSOs)

23 Prison Service Orders are long term instructions. As with PSIs they have a title and unique reference number. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics.

PSI 26/2002, Cell Sharing Risk Assessment

24 The cell sharing risk assessment form is used when deciding where a prisoner should be located. The document is completed as part of the reception procedures and later reviewed by the induction board.

25 The person completing the assessment form is required to answer a number of questions about the prisoner, and assess their likely attitude towards other prisoners with whom they might share. The person completing the form assesses the level of risk as high, medium or low, and is asked to tick one box to show the level of risk.

PSO 0500 (Reception)

26 PSO 0500 concerns reception procedures and sets out the standard actions to be completed in the first two to three hours after a prisoner arrives in an establishment, leading on to the first night procedures and induction. Section 1.1 of the PSO states that the procedures apply to those entering the prison for the first time, and each subsequent time thereafter.

27 One of the requirements is a first reception health screen assessment which should identify any immediate physical or mental health problems, significant drugs or alcohol abuse and, risk of suicide and/or self-harm.

PSO 2700 Assessment, Care in Custody and Teamwork (ACCT)

28 ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The document should be available to all the staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by an assessor and have a case review meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers take on the role of case manager, oversee the management of the ACCT document and attend case reviews.

29 As well as the CAREMAP, the document includes an on-going record of significant events, conversations and observations. There is an assessment section which covers eight specific areas, each requiring a comment. The section is designed so that each area includes the action to be taken in response to the assessment, with a judgement informed by information gathered earlier. The PSO says that the person carrying out the assessment should have been trained to do so. There are three training courses for staff, the first being Foundation training which is a half day to show how to open and complete the basic requirements of the document. Also there is a one day course for case managers to learn how to complete the Immediate Action Plan. The plan includes decisions about support for the prisoner, including the frequency of monitoring. The third course is for ACCT assessors. It lasts four days, including three days on mental health issues and one day on completion of the documentation. Assessors are trained to restrict their recording to what has actually been said by the prisoner.

30 Liverpool prison operates a rota system for assessors and provides at least one trained assessor every day.

Listeners

31 Listeners are selected prisoners who have been trained by the Samaritans to support someone who is considered to be at risk of self harm or suicide.

They work on a rota providing 24 hour cover, and their support is confidential.

Vulnerable Prisoner Unit

32 K wing is the vulnerable prisoner unit at Liverpool prison. Prisoners may ask to be allocated to the unit and explain why they feel unable to live in the normal accommodation. The selection criteria are usually the nature of their offence, although some men are located because of their age, inability to cope on other wings, or threats from other prisoners.

Wing History Document (F2052A)

33 There is a wing history document for each prisoner, often referred to as the wing history sheet. It is part of the main prisoner record and is used by staff to provide a continuing picture of the prisoner's behaviour as a source of reference for colleagues.

Wing Observation Book

34 Wing observation books record any information about events that staff should be aware of. Staff are required to check the book when they come on duty to update themselves. In addition, Liverpool prison has an identical document, kept in the centre office, where managers may make entries. Managers are also expected to read the book to familiarise themselves with events in the prison or their own area of work. The centre office is only accessible to staff and is the base for each day's duty manager.

Wing patrol, roll checks and observations

35 At certain periods during the day, the prison is in patrol state. Prisoners are locked into their cells, and staffing levels on each wing are reduced to an officer on patrol. During the night, staffing levels are also reduced to a single officer who is responsible for ensuring that cells and prisoners are secure, and responding to any cell call bells.

36 Unlike officers on duty during the day, night patrol officers are not issued with security keys. Instead they are issued with a cell key, carried in a sealed pouch secured to the officer, and only to be used in an emergency. The officer must be satisfied that it is safe to unlock the door and enter the cell. Otherwise, they must wait for assistance to arrive.

37 Roll checks are carried out at least five times per day, normally prior to first unlock, lunchtime, evening meal, final lock up and when night staff take over at 9:00pm. To confirm the roll, an officer should look through each cell's door observation panel to confirm that the prisoner is inside and the door is securely locked.

Operational Support Grades (OSG's)

38 Operational support grades are uniformed members of staff. They are issued with security keys and carry out a number of tasks, but not the full range of duties given to an officer.

Anti Ligature Knives

39 Staff in contact with prisoners are issued with specially designed knives, known as fish knives, to use in an emergency and remove a ligature. They have a concealed blade which is placed against a ligature and pushed forward to cut it without harming the prisoner.

Code red and code blue

40 In the event of urgent medical assistance being required, the prison has a radio code system to alert medical staff to the emergency. Code red informs the medical staff that the patient is bleeding, and code blue alerts them that the patient is experiencing breathing difficulties. The system ensures that medical staff take the correct emergency equipment, and can provide the necessary medical care, as quickly as possible.

Critical Incident De-brief PSO 8150

41 Following any serious incident in prison, PSO 8150 Post Incident Care for Staff section 1.2 allows the Governor to arrange a "Critical Incident De-brief" for those staff involved. Critical incident de-briefs should be arranged within seven days of any serious incident and all staff involved invited to attend.

Performance Planning and Appraisal

42 Performance Planning and Appraisal is the system used by the Prison Service to report on individual staff performance. The Governor issues managers with a generic set of objectives to be agreed with each member of staff at the beginning of the year, and reviewed at its end. There is a standard objective that all staff, of whatever grade, receive ACCT training.

43 The investigator examined the prison's Performance Planning and Appraisal objectives for 2006/7. There are 22 generic objectives in each manager's plan, two of which relate directly to ACCT and give clear instructions:

- as a manager you should be aware of the ACCT Managerial Checklist and should monitor the ACCT documents accordingly

- managers should ensure that all staff are trained in ACCT procedures and take appropriate action to open an ACCT document once a prisoner at risk of self harm/suicide has been identified.

Multi-Agency Public Protection Arrangements (MAPPA)

44 The MAPPA is a formal partnership between police, probation, prisons and other statutory and non-statutory agencies which assesses and manages offenders in order to minimise the risk of serious harm they may pose to the public. There are four core functions:

- Identification of offenders with the potential to commit serious violent and sexual offences
- sharing relevant information between agencies
- assessing the risk of serious harm
- managing that risk.

45 Offenders who come within the MAPPA remit are classified according to the nature of the risk and its management. The higher the risk, the higher the level at which they are managed. Level one offenders are managed by one agency, usually the police or probation service. Level two offenders are managed jointly by all the MAPPA agencies and level three offenders are managed by the Multi-Agency Public Protection Panel (MAPPP), which is made up of senior managers from the MAPPA agencies.

Release on Licence

46 All prisoners sentenced to more than 12 months' custody are considered for release on licence, which means they are supervised by the Probation Service until the expiry date of their sentence. There are standard conditions for all licences, which include:

- keep in touch with the probation officer in accordance with any instructions that may be given
- receive visits from the probation officer at their place of residence
- permanently reside at an approved address
- only undertake approved work
- not travel outside the United Kingdom
- be well behaved, not commit any offence and not do anything which could undermine the purposes of supervision, which are to protect the public, prevent re-offending and help successful resettlement into the community.

Further conditions can be added by the Secretary of State if they are deemed necessary for an individual.

47 If a licencee breaks any of their conditions, they are deemed to have breached their licence and the probation officer submits a report to the Secretary of State (in practice, the Home Office acts as the Secretary of State's agent), who has the authority to revoke it. When the licence is revoked, the person is subject to arrest by the police and return to the nearest prison.

Sexual Offences Prevention Order (SOPO)

48 The Sexual Offences Act 2003 gives the courts the power to impose civil preventative orders against individuals convicted of sexual offences whose behaviour suggests they may commit further similar offences. One of the orders is the Sexual Offences Prevention Order (SOPO), which is intended to protect the public from serious sexual harm and is applied for by the police. Offenders subject to the order are prohibited from engaging in specified activities, such as entering schools or swimming pools. Orders last for a minimum of five years. A breach of any of the conditions constitutes a criminal offence punishable by up to five years imprisonment.

KEY FINDINGS

3 May – 20 June

49 On 3 May 2006, contrary to his licence conditions, police officers saw the man entering a children's play area in Merseyside. An emergency MAPPA meeting was convened the following day to discuss the police information. The man was re-arrested, and on 6 May he was taken to Liverpool prison where he went through the reception procedures and should have been treated as a new prisoner. However, the procedures were incomplete. My investigator has been unable to find any documentation to show that the first reception health screening document procedure was carried out.

50 An unidentified member of staff completed the cell sharing risk assessment. After completing sections one and two, he or she recorded "on this sentence [the man] has been single cell because of alleged sexual assaults on cell mates". Unfortunately, and contrary to instructions, the person completing the assessment did not identify themselves or sign the document. The man was assessed as high risk, which meant that there was a clear indication of the high level of risk that he might pose to others if sharing a cell.

51 Section three was completed by a member of the healthcare team, also unidentified, who was asked to assess the medical evidence for risk. The staff member ticked the box to show they had identified evidence of agitation or aggression, and current acute psychosis. As with the previous assessment, the level of risk to others was assessed as high.

52 The fourth section of the document was completed by a governor. He recorded that, in view of his history of sexual offences against fellow prisoners, the man was to remain in a single cell until a full assessment had been carried out. The governor considered that the man was suitable for allocation to K wing, the vulnerable prisoner unit which is where he went from reception. He was allocated a single cell, K3.2, according to the governor's instructions.

53 Until 13 May, the man appears to have settled into the wing routine, as there are no entries other than the initial reception procedures recorded in his wing history sheet. However, during that afternoon a member of staff made a weekly report entry in the man's wing history sheet. The officer wrote that the man was trying to be over-friendly with staff, and was not observing wing rules and regime, although no details were given. The entry added that he was slow to get out of bed, including at dinner times, and slow on the landings. The officer also recorded that the man who later died had been playing his television and radio loudly, for which he had received numerous warnings. He had also been warned for smoking whilst on the wing landing.

54 On 14 May, the same officer recorded that the man had been warned again about smoking on the landing and playing his radio too loud. That

afternoon, the same officer recorded that when his cell was unlocked, the man was in bed and was abusive to the officer when he told him to get a move on.

55 On 23 May, the man had a meeting at the prison with his solicitor. One of the supervising officers recalled that the man was upset about MAPPP papers which he said had been taken away by his probation officer. The officer said that he asked the probation officer why the papers had been taken away, and was told that the man was not allowed to have them. However, after clarification from the Chief Officer of Merseyside Probation, the documents were returned to the man. Since the man's death, his family have asked why a police statement, apparently included with the original MAPPP documents, was not returned. The probation officer has confirmed that everything taken from the man was returned to him.

56 The following day, 24 May, a senior officer recorded on the man's wing history sheet that a prisoner had alleged that he had been sexually assaulted by the man, and the matter was referred to the prison's police liaison officer for investigation.

57 On 4 June, a prison officer recorded in the history sheet that the man was again over-familiar with staff, and had said to staff that they were all friends together.

58 Two weeks later, at 3:00pm on 18 June, another officer recorded that he saw the door of the man's cell being closed, and the cell observation panel covered over. He went into the cell, where the man was with another prisoner, and warned him about covering the panel. The officer also recorded that, a few minutes earlier, another prisoner said he had tried to enter the cell but the man prevented him. The officer recorded that the information was also forwarded to the police liaison officer.

59 Soon afterwards, at 3:55pm, the same officer saw the man go to another prisoner's cell and again cover up the observation panel. He returned the man to his own cell and locked him in, recording that he had been told by other prisoners that sexual activity had been taking place.

60 At 5:30pm, a further entry was made in the observation book to inform staff that, after consulting a principal officer and a governor, was to be given his evening meal alone rather than with other prisoners. The decision was taken in the interest of preserving good order and discipline, which meant that there would be a more controlled regime. The aim was to prevent the man or other prisoners reacting to the earlier allegations, and reduce any tension that might occur.

61 The next day, 19 June, the man went to the healthcare department as usual to collect his prescribed medication. He complained that the prescription was incorrect and he should have received a full day's dosage. The nurse told him that the prescription was correct, and he became abusive which resulted in him being returned to his cell again.

62 The man's parents asked my investigator whether the man's medication had been changed when he arrived at Liverpool. I can confirm that, prior to his arrival at Liverpool, he was prescribed Stelazine, which is an anti-psychotic drug. When he arrived at the prison, his prescription was changed to Trifluoperazine. However, I understand that they are the same generic drug with different trade names.

63 Later in the day, the police liaison officer interviewed the man and issued an application for a Sexual Offences Prevention Order (SOPO). The application was due to be heard on 19 July at Birkenhead Magistrates' Court. It listed a short description of the allegations relating to the man's conduct whilst on licence, and contained the following prohibitions which would apply on his eventual release:

- approaching, enticing or communicating, whether written or verbal and whether in any public or private place, with a minor person (of or under the age of 17 years)
- remaining in the company of any minor person (of or under that age of 17 years) whether in any public or private place. For the purposes of this part of the order the word "company" denotes any social interaction between defendant and the said minor, which is more than merely accidental and shall not be taken simply to include being present in the same vicinity of the minor, for example when both are on a bus
- residing or staying overnight in premises in which a minor person (of or under the age of 17 years) is residing or staying overnight
- drinking alcohol in a public place.

64 My investigator met the police liaison officer and asked him if he had considered how the man would react to the application, and what his reactions were. He said that when he is required to issue documents on behalf of the police, he simply confirms the prisoner's identity and, once satisfied that he is talking to the correct person, he hands them the document. He said the whole process takes no longer than thirty seconds. The police liaison officer said that the man did not show any signs of emotion or distress. The investigator asked him if he had considered informing the man's solicitor about the application and whether he was alone with him. He confirmed that he and the man were alone, and said that it was not normal practice to involve solicitors in the routine work of issuing a SOPO. This means that the man did not have the benefit of legal advice. I cannot be certain that he was able to understand the implications of the order, and suggest that in future it would be preferable to arrange for the prisoner's solicitor to be present.

65 The investigator asked the police liaison officer if the prison had included him in the ACCT training. He said he had not been trained. He said that,

if he was concerned about a prisoner, he would speak to a member of staff and pass on his concerns.

66 Later that day, a principal officer recorded that the man had been interviewed by the police liaison officer and issued with a summons for Birkenhead Magistrates' Court which he was unhappy about. He also told staff that the liaison officer was dealing with the allegation of indecent assault on another prisoner, who was to be interviewed on 20 June. The principal officer instructed that the man was to remain in a single cell and have no contact with the prisoner making the allegations.

67 The next day, 20 June, the same principal officer spoke to the man and made a further entry in the observation book. He described the man as very worried about the application for a SOPO, and said that the liaison officer had told him that a telephone call would be allowed to enable him to contact his solicitor and arrange a special visit. (Special visits are separate to normal domestic visits and allow the prisoner and the person visiting to meet in privacy, in sight, but out of hearing of an officer.)

68 The investigator interviewed the principal officer in question and asked how well he knew the man. He said that he had been the manager of K wing for about six weeks, and recalled his first meeting with the man who introduced himself. He said that the man who died was not a difficult man to manage. He said the man was aware of two allegations that he had sexually assaulted other prisoners, but appeared unconcerned about them. The principal officer described the man as being annoyed by the interview with the police liaison officer, but giving no indication of intending to harm himself. He advised the man to take legal advice, but the man could not remember the name of his solicitor so the principal officer told him to return when he remembered the name. Either a visit or telephone call was to be arranged, but the principal officer said that the man did not return with the information.

69 A prison officer from K wing, described the man as being a larger than life character, jovial and a prisoner who would engage with staff. He said that the man had talked to staff about the SOPO, questioning the legality of the proposed conditions. The officer said he was not concerned for the man's safety.

70 At about 9:00pm that night, the man was locked into his cell and, once the prison roll was confirmed as correct, the prison was placed into patrol state. An OSG was the night patrol officer on K wing that evening and started his duty at about 8:45pm. His duty was due to be completed at approximately 7:45am the following morning. He carried a prison radio and the sealed pouch with a cell key.

21 June

71 At approximately 3:45am on 21 June, the OSG heard a cell call buzzer activated and saw that it came from cell K3.2. He went to the door and

opened the observation panel to see the man standing towards the rear of the cell with a ligature looped around his neck. At interview, the OSG said that the ligature was not tight or attached to anything, and he thought that it was part of a bed sheet. The man was conscious and spoke to the OSG saying that he wanted to transfer from Liverpool to HMP Altcourse.

72 The OSG did not use his radio or the cell key, but instead decided to leave the man in order to obtain assistance. He left the man with the ligature around his neck, and went to the centre office to find the night manager.

73 The investigator asked him where the centre office is located in relation to the man's cell, and how long he was away from the cell. The OSG said that the office is at the bottom of the stairs, and that he was away from the cell for about two minutes. He said he knew where the night manager was, as he had seen him in the office just prior to answering the man's cell call bell. I can confirm that the centre office is located just outside the entrance to K wing.

74 A senior officer (SO) was one of the two night managers on duty. The OSG told him about the man, and together they returned to the cell. The SO unlocked the cell and introduced himself to the man, whilst the OSG remained at the door.

75 At interview, he said the man appeared very upset and kept saying that he wanted to go to the hospital wing. The SO asked the man to remove the ligature, but he refused and remained standing with his feet apart. The SO explained that he was trying to relax the situation, and invited the man to sit with him on the bed. The man sat down and told the SO he felt neglected on the wing and wanted to go to the hospital where he could see a doctor and talk about his situation. The SO continued to ask the man to remove the ligature, which he eventually did.

76 The man told the SO that he had received a letter from his solicitor and felt he was going to be "lifed off" and said he could not handle it. He wanted to talk to his solicitor. The SO said the man had a letter in his hands, which he kept pushing towards the SO but not allowing him to read it. He said the man told him that if he were to read the letter he would see why he was going to "get lifed up". He said the man added that he could not face a life sentence.

77 The man who is the subject of this report said he had asked for a telephone call, but it had not happened. The SO told him that he could not facilitate a telephone call to the solicitor at that time, but would ensure that it was in place at the earliest convenience the next morning. The SO said they continued to talk for about 15 to 20 minutes about the man's feelings. He said that he told the man he would more than likely have to go to court, and that he should speak to his solicitor and take guidance. He added that the nursing staff would direct him towards any professional medical help that he needed.

78 The SO said they continued to talk for a further five to ten minutes. The man said “the wing is crap” and that he did not like people shouting at him. The SO told him to ignore it and to concentrate on what was happening to him, be positive and to think about his family. The man told the SO that he had a young son, whom he had not seen and did not think he would get to see because of the sentence he was going to get. The SO said he told the man the issues could be dealt with. He said the man’s reply was, “I’ve heard all this before and nothing happens.”

79 The SO also told the man that, due to the risk of him harming himself, he would arrange for an ACCT document to be opened and that the staff coming on duty the following day would act on the information. He assured the man that he would be given a telephone call to his solicitor and also said that the wing manager would deal with everything later that morning. Apparently reassured, the man agreed not to make any further attempts to harm himself.

80 The SO told my investigator that the man had been on self-harm risk monitoring previously and that he knew the implications of being on an ACCT. The SO said that it was his way of reassuring the man, that it was an avenue for things to happen and said the man understood. He said the man was happy for the document to be opened.

81 A nurse was on duty that night. At interview, she said that she had been called to the man’s cell. She knew the man from his daily visits to the medical area to collect his medication. She remembered that the man was prescribed Trifluoperazine and Amitriptyline, and thought that it was morning and tea time when he collected the medication but was not entirely certain.

82 When the nurse went into the man’s cell, she saw him talking to two officers. He did not raise any medical issues, but wanted to see his solicitor.

83 My investigator asked the SO what he expected to happen in the morning. He replied that he expected the man to be seen by a member of the wing management and allowed a telephone call to his solicitor. He believed that either the principal officer or senior officer on duty would deal with the man’s identified needs.

84 The SO asked the OSG to open the ACCT document, which he did at 4:00am. The OSG confirmed to my investigator that he had been trained in ACCT. The third page has a section headed ‘Concern and Keep Safe’ which includes six boxes to record alternative levels of concern about an individual. The OSG ticked the first box, which indicates either a suicide attempt or statement of intent to kill himself. The same page asks for a description of the concerns, and the OSG recorded that the man had threatened to kill himself if he was not moved off the wing and his problems were not sorted out. The OSG did not record in the ACCT document that the man had been found with a ligature around his neck,

but did include the information in the wing observation book. He signed the document and passed it to the SO to complete the immediate action plan on the fourth page.

85 The prison has a number of prisoners known as Listeners. They offer a confidential service to prisoners and are available for prison staff to call on at any time of the day or night. The OSG said at interview that, during the time that they were talking to the man, the use of a Listener had not been suggested. The investigator asked if a "safe cell" was available and if so, had it been considered as an option. The OSG said that safe cells are available in the prison, including one on K wing. He said he thought the K wing cell was unavailable that night, but others would be available in the prison. He confirmed he had not been part of the decision making process to leave the man in his own cell, and that it was the SO and the nurse who made the decision.

86 The SO completed four of the five available sections of the ACCT form, including written instructions that the man should remain on the wing and his problems dealt with by wing management the following morning during office hours. He set the level of observation at hourly, until the man was seen by wing management, and left instructions for him to be given a telephone call to his solicitor. Finally, he wrote that the man did not require a Listener and had not requested one. The SO did not sign the ACCT document or record the time that it was completed.

87 The OSG recorded in the wing observation book that the man had been placed on an ACCT document, having been found with a bed sheet tied around his neck. The SO recorded in the centre observation book that the man had been found with a torn sheet ligature around his neck, and said that he wanted to move to the healthcare centre because he felt neglected. The SO also wrote that the man had issues which should be addressed by wing staff, and that he should remain on K wing until he had been seen by a wing manager and given a telephone call to his solicitor.

88 The investigator asked the OSG about the level of observations that he had been instructed to carry out. He said the level of observation had been set as hourly. The record shows that he began recording his observations at 4:20am, with a second entry at 5:30am. At interview, he said he was concerned for the man and whenever he passed the cell, he looked in to be certain that he was asleep. He said he looked into the cell about every fifteen or twenty minutes. Unfortunately, the ACCT record does not reflect the additional observations. The investigator asked the OSG why there are no entries to support the additional observations. He said to do so would mean filling in sheets and sheets of paper.

89 The entries made by the OSG do not agree with the timings given by the SO. He said he had been with the man for about one hour, whereas the OSG has recorded his observation at 4:20am. The SO believes the OSG has made a mistake with the timings. My investigator has been unable to establish the exact timing of events.

90 The OSG was asked what time he had gone off duty that morning. He said that he could not remember, but thought that it was about 7:00am. He was asked if he had handed over to the day staff before going off duty. He said that he would have done, because of the new ACCT form, but could not recall who had taken over from him. The investigator has been unable to establish who it was that the OSG handed over to.

91 Another SO took over responsibility for K wing that morning. At interview he said that he read the wing observation book and knew about the ligature and that the night SO had instructed that the man should be observed every hour. The day SO said that, as part of his normal duties, he would read all ACCT documents and brief his staff.

92 The day SO was asked to explain his understanding of hourly observations. He said that, as K wing has an open cell door policy, he thought that hourly observations were only required when prisoners were locked in their cells. He said that he considered that the night SO's instruction was for the man to be seen during the night until the wing manager came on duty the following morning, and not that he should be observed hourly until he had been assessed by a manager.

93 The day SO said that he had not been trained in the ACCT procedures and had not requested training. He also said that he had not been trained in the previous suicide prevention system (F2052SH). When my investigator checked the prison training records he found that the day SO had received F2052SH training on 12 March 1999.

94 Following the 5:30am entry, no further records were made for the next two and a half hours. At 8:00am, a prison officer recorded that he had spoken to the man at unlock. (The man apparently said that he was fine at the present.) The officer recorded in the ACCT document that the man appeared agitated and had asked for a transfer to Altcourse. The officer said that he told the man the procedure for applying for a transfer and he went away happily. At interview, the officer told my investigator that he had known the man for about four years. He described him as a unique character and that he would have a laugh with staff. He added that the man did not often let things get him down, but if he did he usually talked to staff about whatever was concerning him.

95 The investigator asked the officer why no further observation entries had been made after his 8:00am entry. He said that he should have made an entry at lunchtime, but due to an oversight did not. He added that a further entry should have been made at teatime. The officer confirmed that, at the time, he was unaware of the requirement for hourly observations.

96 During the interview, the officer said the man had been concerned about new licence conditions and was telling anyone who would listen. He said the man was not happy with the conditions imposed.

97 Later that morning, the officer took the man to see the prison's duty doctor, a locum GP who has not been trained as an ACCT assessor. The officer handed the ACCT document to the doctor and asked him to complete the assessment interview section, starting at page seven. The doctor completed all eight sections as requested, based on information from the man. He did not have the man's full prison record with him and was unaware of an attempt to harm himself during a previous sentence.

98 Two entries made by the doctor were factually incorrect. In section one, he wrote that the man's cell mate had alerted staff when in fact the man was in a single cell. At section three, he said there were no previous attempts of suicide or self harm.

99 At interview, the doctor said he asked a nurse to arrange for him to see the man again the following day as he wanted to ask further questions. He said that the man who later died was concerned about leaving prison and said he would have no life outside. He thought that the man was worried by a letter about a sex offender's order. The told the doctor that he apologised for putting the ligature round his neck, was sorry for wasting people's time and did not want to be on ACCT.

100 Another SO is one of the prison's trained ACCT assessors and was one of two trained assessors on duty that morning. He was aware that the ACCT document had been opened on the man and also knew that he had seen the prison doctor that morning. At interview, he said that the ACCT document accompanied the man to the healthcare centre and was later passed to him to set up the assessment review that afternoon. He confirmed that the ACCT document was on his desk for about two to two and a half hours, and was not available for wing staff to read or make entries. He confirmed that he knew the man and described him as a larger than life character, gregarious, very outward going and who could be rather loud but not in a threatening way. He said the man was very forward in trying to make friends with people. He added that the man who is the subject of this report was at times inappropriate with staff, and tried to call them by their first names.

101 At 4:00pm that afternoon, an ACCT case review team meeting took place, chaired by the ACCT trained SO, and attended by the man, together with another SO and a Registered Mental Health Nurse (RMN). All three members of staff had been trained to implement the ACCT procedures. They had the ACCT document, but did not have other wing records and were unaware of the interview with the police liaison officer or the allegations by the prisoners. The ACCT trained SO said that, had the information been known, and had they realised that the man was upset, it might have swayed the decision to close the ACCT document.

102 The other SO that was present is one of two Safer Custody Managers and responsible for the ACCT reviews, ensuring that they are completed at the appropriate times. My investigator asked him for his reaction to the fact that no further observations had been recorded after 8:00am. He said at

interview that he was surprised. He explained that unless the level of observation had been changed, he would expect the hourly observations to have continued. The investigator asked how many people at the prison had had ACCT training and the Safer Custody Manager said that the figure was approximately 77 per cent, including casual workers, and that the majority of permanent staff were trained. The Safer Custody Manager thought that all managers, including those working at night but excluding recent appointments, had foundation training and should be trained as case managers.

103 The Safer Custody Manager said that he was aware that the prison doctor had not been trained in ACCT, and so should not have completed the assessment. He considered repeating the assessment, but was satisfied that the man had been interviewed at length at the review meeting. He went on to say that the doctor's assessment was not given great significance by the meeting, but nevertheless confirmed it remained unchanged. In light of his answer, the investigator questioned the appropriateness of closing the document. The Safer Custody Manager repeated that the eight areas were explored and said the man was interviewed at length by the team.

104 At page ten, the team are asked to give a summary of the case review. The ACCT trained SO wrote, "[the man], by his own admission, told the above panel that this self-harm gesture was a means to try and work his ticket, he told us that he had no plans to self-harm or take his own life. Previous ACCTs have been opened at other establishments, due to him as he put it, 'trying to effect a move, working my ticket to another jail'. He did apologise for his behaviour and asked to come off the ACCT form.

105 The RMN said that his role at the review with the man was to observe the man's responses to questions, and look for any evidence of his mood being low or responses that were unreliable or inconsistent. The RMN was also aware that the prison doctor was a locum GP who had not been trained in ACCT, but thought that the doctor's medical training would equip him.

106 The review members agreed that the man's ACCT document should be closed, and arranged a post closure interview for five days later.

22 June

107 On 22 June, a probation officer visited the man at Liverpool. He told my investigator that, whenever offenders are recalled or he has had reason to recall them, he would invariably go to see them. He said it helped to clear the air and was important that people did not see the decision as personal. He said that it is important to allow the individual the opportunity to challenge or clarify the recall. The field probation officer added that the purpose of the visit was to speak to the man about the reason for the recall decision, and to explain the appeals procedure.

108 The field probation officer described the meeting with the man as flat, but not agitated and no aggression was displayed. He said the man who later died was normally more up front and lively. He said there was an air of resignation. The field probation officer said he and the man talked through the issues of the recall and the SOPO. He said that during the conversation about the SOPO, the man said "I'm not a sex case". He also questioned the condition not to consume alcohol in a public place, which the man had apparently interpreted as not being allowed to enter a public house. The field probation officer said he was able to clarify the condition for him.

109 He said the man felt that he had done nothing wrong to warrant the recall and had been "stitched up". The man asked the field probation officer what his chances were with regard to an appeal. The field probation officer explained that he was aware of the two allegations of sexual assault against prisoners. He told the man that, with the two allegations, it was not going to do his chances much good. The man agreed and said they were not important.

110 The investigator asked the field probation officer if he was aware of the man being found with a ligature around his neck. He said not and added that he was surprised, as the man had never given him the impression that he would want to end his life. He said that the thing that struck him about the visit was that the man was actively thinking about the future, talking about his release date and planning how to respond to the SOPO application. He said he had no reason to believe that the man was contemplating self harm.

111 The field probation officer was asked if, had he known about the ligature, he would have approached the interview differently. He said yes, and would have asked the man about it. He said that you could be very direct with the man.

112 One of the other prisoners on K wing knew the man well and described him as a friend. He described the man as a character who was generally bubbly and loud. However, he noticed the day before he died that he was unusually quiet. He said the man spoke to him about a letter which the prisoner believed had been sent from the Home Office. The prisoner said he mentioned that the man was quiet. The man's reply was to ask how long the prisoner thought that the man had to live. The prisoner said that he did not ask the man what he meant by the question, which he felt was a casual throwaway remark.

23 June

113 At about 8:30am on 23 June, the same prisoner saw the man again and they said good morning to each other. The prisoner saw that the man was getting a cup of tea and that he appeared to be "alright".

114 A wing officer said that he gave the man the newspaper which he had ordered. He said that he did not say much, but appeared to be in a good mood at the time. However, he recalled that during the morning exercise period he had been one of the supervising officers and overheard the man and other prisoners talking about length of sentences. He could not remember who the other prisoners were. Although he could not hear the full conversation, he heard the man say “that’s nothing” and begin to break down the years that he had been in prison into months and hours. The officer said that he thought that it was unusual and that something was not right. He confirmed that he did not speak to the man about the comment. He also heard the man say that he was looking at more jail time, and presumed he was referring to the ongoing police enquiries.

115 The officer told my investigator that he thought the man had also discussed the SOPO conditions with prisoners taking exercise that morning. He said the man thought the conditions were stringent. He said that he had spoken to the man about the conditions and explained that it was in his best interest to comply with them. He told the investigator the man was particularly focussed on one condition, not to consume alcohol in public. He said he believed the condition was unfair.

116 A female prison officer was on duty on K wing that day. She first saw the man at about 11.30am when he returned to the wing, having been outside taking exercise in the fresh air. An hour later at about 12:30pm, the wing roll was checked and confirmed as correct. She told my investigator that she knew the man quite well and said that he appeared to be cheerful. The female officer described him as a larger than life character, always pleasant, but said he would try to push the boundaries if he could get away with it. She said he would make inappropriate comments to prisoners and staff and once said to her “come on …, we are friends aren’t we” and she told him that they were acquaintances. On another occasion, he was heard to call a prisoner “sweet cheeks”, which prompted the officer to speak to him about his comments. She said, once he had been spoken to, the issue was resolved. The female officer added that the man would make himself known to every officer.

117 The female officer was asked if she had ever been concerned for the man’s safety. She said no. The female officer added that the man was anxious to speak to his probation officer, but he did not talk to her about what he wanted to talk about. The female officer explained that it was not unusual for prisoners to ask to speak to probation officers, and did not question the man’s motives. She said that she encouraged him to complete an application form to see the probation officer and believed that he did so.

118 A male officer was one of the wing patrol officers that afternoon. He confirmed that he had not had any cause to go to the man’s cell. He said the man did not work or go to the education department, and that he was in his cell. The officer said the man would normally have a sleep during the afternoon, but if he wanted anything he would either press his cell call

button or would look through the observation glass and would speak when an officer was on the landing. The investigator asked if he could recall answering any cell bell from the man that afternoon. The male officer was sure that his cell light was not activated.

119 The investigator asked why the man would be locked in his cell. The male officer said the man did not work or attend education classes and he therefore had no reason to be out of his cell. The officer said he had never known the man to be employed.

120 At about 2:30pm or 2:45pm, the prisoner who knew the man well said that the man showed him a letter which referred to a sexual offence apparently on a 17 year old boy. He said that the man was not his usual self, and he remembered the man saying that they (that is the police, courts and probation) were trying to make sure that he was sentenced to life imprisonment.

121 At about 4:00pm, the female officer began the next roll check, starting at cell K3.1 and then on to the next cell K3.2. When she looked through the observation panel, she saw the man in the corner of the cell and at first thought that he was sitting on the pipes that run through the cell. She noticed that his feet were on the floor, and then saw a green cord around his neck, secured to the window bar. She immediately shouted for assistance.

122 The male officer was on the opposite side of the landing and responded to her call, in turn shouting for additional staff. He tried to open the cell door, but it was stiff and his first thought was that it had been barricaded. He put his shoulder to the door which opened and a wedge of paper fell to the ground. Both he and the female officer entered the cell, quickly followed by another officer.

123 The male officer was carrying a fish knife, which he used to cut through the ligature, while the other officer supported the man's body. They laid the man on the floor and removed the ligature from his neck. The female officer started to remove furniture from the cell in order to make more space for those attending to the man. The other two officers began Cardio Pulmonary Resuscitation (CPR), which continued until the arrival of the healthcare staff shortly after. The female officer left the cell and went to the wing office, where she remained until the police arrived and took a statement.

124 The officer that went into the man's cell shortly after the male and female officers told the investigator that, when he entered the cell, he thought the male officer was trying to restrain a prisoner. He soon realised that the officer was cutting a ligature and trying to support the man's body at the same time. He assisted the male officer and, when the man was on the ground, he gave him one chest compression. He believed that the man was dead, but was going to continue chest compressions when the

medical staff arrived and took over. After the medical staff arrived, the officer left the area to allow the medical team to continue with their work.

125 A Registered General Nurse (RGN) was in the main accommodation area of the prison at the time. He heard loud footsteps and, realising that something was wrong, followed the staff into K wing. He said that he did not hear a radio message, or any reference to a code red or blue emergency.

126 Another was the first member of the medical team to arrive and he saw the man on the floor, lying on his back. He checked for a pulse, but did not find one, and could not detect any sign of breathing. He said that the man's body was cold to the touch, and his pupils were fixed and dilated. Even though he too believed that the man was dead, he continued to administer CPR until further medical assistance was present.

127 When other medical staff arrived, they placed an automatic external defibrillator on to the man's chest. (This is an automated piece of equipment, which instructs the user either to administer an electric shock or continue CPR.) In the man's case, the equipment instructed them to continue CPR, rather than to shock, and the instructions were followed.

128 The deputy healthcare manager heard a call on his prison radio for medical assistance on K wing, and went straight there. When he arrived at the cell he saw two members of his staff performing CPR on the man. The deputy healthcare manager said that, almost immediately after he arrived, the paramedics arrived and took responsibility for the man's medical care. They carried out their own observations, and attached an electrocardiograph machine to the man which sadly did not indicate any sign of life. The deputy healthcare manager said that they took a joint decision to stop any further attempts at resuscitation, and the man's death was confirmed at 4:26pm.

After the man's death

129 Following the man's death, the prison's Family Liaison Officer went to the man's parents' house and broke the sad news to them.

130 The prison's Care Team made themselves available to any member of staff wishing to speak to them.

131 The next day (24 June) another prisoner wrote to the Governor to say that he had spoken to the man who had referred to a letter he had received from the Home Office. He described the man as worried about the letter, and asking questions about sex offences which he was unable to answer.

132 On 28 July, the investigators met the Governor to give their initial findings and feedback. The main area of concern raised by the team was the procedures after the opening of the ACCT document. The Governor requested written confirmation, which was provided, and on 22 August

confirmed that he had commissioned his own internal disciplinary investigation.

ISSUES

Reception procedures

133 On 27 March 2006, the man was released on licence, but returned to prison less than two months later when his licence was revoked. He should have gone through the standard reception processes, but there were several omissions. First, he was not interviewed by a healthcare member of staff and so no healthcare screening was carried out. Secondly, two members of staff did not identify themselves or sign the cell sharing assessment record. Whilst neither omission was significant for the man, this might not be the case for other prisoners. At a time when prisoners are being received into custody and potentially very vulnerable, it is not acceptable for such basic procedures to be neglected.

The Governor should ensure that the healthcare screening and cell sharing risk assessment documents are completed.

All staff should be reminded that when completing official documents they should identify themselves clearly and legibly.

Response to the man's first ligature

134 In the early hours of the morning of 21 June, the OSG was alone on the wing when he discovered the man with a ligature around his neck. Although he was carrying a radio and cell key, and contrary to instructions in the ACCT document, he left in order to go and obtain assistance. The officer said that he was away from the cell for only a few minutes before returning with assistance.

135 I accept that the officer was shocked by his discovery and made a quick decision to leave the man. Nevertheless, staff working alone at night should be able to respond to emergencies, and should not leave a prisoner alone with a ligature. In the man's case, no harm was done, but medical evidence suggests that death by hanging can occur within a matter of seconds. Leaving anyone in such circumstances, even for a few minutes, is potentially life threatening.

The Governor should remind the OSG of the correct response to emergencies, and ensure that he has been properly trained.

136 The OSG told my investigator that he was unable to recall to whom in K wing he handed over the information about the man, before leaving the prison. The investigator has been unable to identify the person. There appears to be no system for recording such a basic piece of information.

The Governor should consider whether the current handover arrangements are sufficiently robust to enable him to identify which member of staff has taken over from the night patrol officer, and which officer the night patrol officer has taken over from.

Implementation of ACCT

137 On the instructions of the night SO, the OSG opened the ACCT document at 4:00am on 21 June. He ticked boxes one and four and described his concern, but did not record that the man had been found with a ligature around his neck. However he did note this information in the wing observation book. The OSG made frequent observations until the man went to sleep, and checked him more frequently than every hour until he went off duty.

138 The investigation has identified that the night SO had not received the required ACCT training. Nevertheless, he completed four of the five possible sections to show what immediate action was required, and made appropriate decisions about support for the man including requesting hourly observations until he was seen by wing management. Additionally, he wrote in the centre observation book that the man's issues needed to be dealt with by wing staff and that he should be given a telephone call to his solicitor. His expectations were that the's needs would be dealt with by the management and staff on duty during the day. Sadly, this was not the case.

139 Although they failed to sign and time the ACCT document correctly, I am satisfied that both the SO and the OSG made every effort to ensure that staff coming on duty that morning would know what had been done and what was required.

140 The day SO was the manager on duty that morning, and confirmed that he read the observation book. Other than one observation at 8:00am, the hourly observations stopped once day staff took over. A prison officer was the last person to make an observation entry into the ACCT document. His entry was a good description of his contact with the man and shows that he took the time and effort to talk to him, understand what he wanted, and offer suitable advice. The Governor should note that I regard the officer's entry as a good and informative example of his contact with the man.

141 The day SO confirmed that he was unaware that the observations had not been carried out after 8:00am. He believed that the instruction only applied when the man was locked in his cell, and not to any other times of the day. Whatever his interpretation of the night SO's instruction, the observations were not carried out even when the wing was in patrol state.

142 The day SO said that he had not been trained in either the current ACCT, or the previous F2052SH suicide and self harm monitoring procedures (my investigators found that in fact he had been trained in F2052SH procedures in1999). Neither he nor the night SO had met the Governor's requirement that all managers undertake ACCT training as required in their personal appraisals. I am concerned that, contrary to the understanding of the Safer Custody Manager, at least two front line managers appear not to be trained in ACCT, especially as they are the

ones required to deal at first hand with potentially vulnerable prisoners and identify ways to keep them safe.

The Governor should identify as a matter of urgency those managers, including night managers, who have not been trained in ACCT, prioritise their training and ensure that they are competent to carry out the task of case manager.

143 Later in the morning of 21 June, the man was taken to the healthcare department and interviewed by a locum doctor who was asked by an officer to complete the assessment section of the ACCT form. The doctor is not employed by the prison and has not been trained in ACCT, but nevertheless completed the form and returned it to the officer. The doctor's assessment did not explore in depth the reasons for the man placing a ligature around his neck. When asked to consider any relevant issues that he wished to ensure were available to the review, the doctor merely wrote that the man wanted medical attention for athlete's foot and an ear infection, and wanted to make a telephone call.

144 In addition, the doctor's assessment was factually incorrect in two significant areas. The man was not in a shared cell and he had previously attempted to take his own life. Both errors had the potential to influence the review's decisions and increase the risk to the man.

The Governor must ensure that, regardless of qualifications, only those people who have received the appropriate training in ACCT are allowed to complete the assessment section.

145 The case review took place within 24 hours, as required by the ACCT guidance, and was attended by the man. The panel had in their possession the ACCT document, but they had no knowledge of other significant information including the allegations by other prisoners and the application for a restrictive court order. Although one of the panel said that he had not accepted the doctor's assessment, there is no evidence to show that either he, or anyone else, challenged what the doctor had written.

146 Two officers at the review, employed as Safer Custody Officers and so responsible for implementing and monitoring ACCT, were aware that the doctor had not been trained in ACCT. Whilst I do not suggest in any way that they ignored their duty of care towards the man, I think they accepted the doctor's assessment in the mistaken belief that he was medically qualified to make an informed judgement. I am concerned that, as a consequence, they accepted an inaccurate and incomplete document. The man's ACCT form can at best be described as a poor assessment of his problems. The team is not required to make individual notes, but the Case Manager is required to summarise the review's findings. This has been done in this case, but without much substance as to the review process. Having accepted the assessment, the team used it as the basis

for the decision to close the man's ACCT document just over twelve hours after he put a ligature round his neck.

The Governor should satisfy himself that those staff carrying out case reviews are competent to do so.

The Governor should conduct a review of ACCT documents to satisfy himself that appropriate information has been gathered and decisions made.

147 In addition, I make the following observation on the document:

- Front Cover. Frequency of conversations and observations not recorded.
- Inside cover. No photograph. No triggers identified.
- Concerns and Keep Safe Section. More information about the problems would assist the assessor and review team.
- Assessment interview. The use of an untrained assessor reflects the poor quality of the assessment. Additionally, the top section of the assessment page has not been completed.
- Action Following Assessment. The summary makes reference to previous ACCT documents at other establishments "to effect a move". There is no evidence that the panel considered them. The summary suggests that the act of tying a ligature was manipulative and that the man did not wish to be on the ACCT document. It does not show the deliberation of the panel in considering that and other facts and how they reached the decision to close the document. The doctor did not attend the case review, and there is no evidence to show that the panel considered his presence necessary. The panel is asked to consider the likelihood of further risk behaviour and to tick one of three boxes: Low, Raised or High. This section was not completed.

Police liaison

148 As I have described earlier, the man was seen by the prison's police liaison officer, who is a serving police officer. The officer interviewed the man alone and issued him with an application for a Sex Offender Prevention Order. Wing staff were aware that the interview was taking place. Although the police officer said that the man did not appear to show any concern, it is clear that the wing manager noticed that the man was upset. The man who later died subsequently talked to prison officers and prisoners about his concerns and believed that he was going to be sentenced to life imprisonment. He was also aware that two prisoners had alleged that he had sexually assaulted them and this was also subject to police investigation. He was worried about the possible consequences.

149 The police liaison officer told my investigator that he had not been included in the prison's ACCT training. He added that, if he was concerned about a prisoner, he would pass the information to a member of staff. Considering the police liaison officer is likely to be speaking to prisoners about their offences, further charges, allegations, or as in the man's case, delivering a SOPO application, it would seem to me to be appropriate for the officer to be included in ACCT training.

The Governor should, as part of the protocol between the prison and Merseyside Police, include the police liaison officer in ACCT training.

150 The police liaison officer told my investigator that he had been alone with the man when he served him with the SOPO application. He confirmed that he had not considered including the man's solicitor, and said he had issued a number of such documents to other prisoners without the need to include a solicitor. He said from the point of identifying the prisoner to serving him with the SOPO took about thirty seconds.

151 From the evidence obtained, it seems likely the man did not understand what the SOPO was, what it meant, and asked a number of questions of staff and prisoners. Additionally, the man was upset at being given the documents.

152 We cannot know if having his solicitor or someone else present would have brought about a different outcome. However, what appeared to the police liaison officer as a routine administrative task was manifestly of much greater significance to the man. I make no formal recommendation on this matter, as I am conscious that lawyers cannot be present whenever a prisoner receives an official notice. Nevertheless, the way in which official information is shared with prisoners, especially information relating to legal matters, merits further consideration.

153 At a meeting with the Governor, the investigator discussed the aftercare arrangements for his staff. He told the Governor that he had been unable to find any evidence that a Critical Incident De-brief had taken place. The Governor's view was that it was not necessary to carry out a Critical Incident De-brief. The investigator reminded the Governor of PSO 8150, but I accept that it does not give mandatory instructions requiring governors to offer a Critical Incident De-brief.

154 On 22 September, the clinical reviewer submitted her report to my investigator. The report confirms that the man's mental health was assessed on numerous occasions, and that he was never diagnosed as having a mental illness. The report also shows that there were no obvious gaps in identifying or addressing the man's physical or mental health needs. The review makes two recommendations concerning transfer of information during previous sentences, before the period considered in this report, and which had no impact on the man's death. I have informed the prison's healthcare centre of the recommendations in a separate letter.

CONCLUSION

155 I cannot say with any certainty what impact the revocation of his licence had on the man, or that he understood what was happening with the application for the Sex Offender Prevention Order or the assault allegations. However, I am satisfied that all three issues played on his mind at the time of his death, and that he was confused and worried about his future. I also consider that Liverpool prison's management of ACCT procedures was inadequate.

RECOMMENDATIONS

1. The Governor should ensure that the healthcare screening and cell sharing risk assessment documents are completed.

2. All staff should be reminded that when completing official documents they should identify themselves clearly and legibly.

3. The Governor should remind the OSG of the correct response to emergencies, and ensure that he has been properly trained.

4. The Governor should consider whether the current handover arrangements are sufficiently robust to enable him to identify which member of staff has taken over from the night patrol officer, and which officer the night patrol officer has taken over from.

5. The Governor should identify as a matter of urgency those managers, including night managers, who have not been trained in ACCT, prioritise their training and ensure that they are competent to carry out the task of case manager.

6. The Governor must ensure that, regardless of qualifications, only those people who have received the appropriate training in ACCT are allowed to complete the assessment section.

7. The Governor should satisfy himself that those staff carrying out case reviews are competent to do so.

8. The Governor should conduct a review of ACCT documents to satisfy himself that appropriate information has been gathered and decisions made.

9. The Governor should, as part of the protocol between the prison and Merseyside Police, include the police liaison officer in ACCT training.