PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man at HMP Liverpool in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

March 2013

This is a report of an investigation into the death of a man in December 2011, who was found hanging in his cell at HMP Liverpool. He was 36 years old. I offer my condolences to his family and friends.

An investigator carried out the investigation. The local Primary Care Trust (PCT) appointed a clinical reviewer to carry out a review of the man's clinical care while in custody. I am sorry for the delay in issuing this report.

The man was remanded into custody at Liverpool on 6 December 2011, charged with an offence of domestic violence. This was the first time he had been in prison. His cellmate said that he was upset and worried about the charges he was facing, but neither he nor his cellmate appear to have mentioned his state of mind to prison staff.

On the morning of 11 December an officer carried out a routine security roll check, on the wing at about 5.30am. He returned to the man's cell and looked in at least three times but has been unable to explain why. Inexplicably, he maintained that he did not see anything which concerned him nor could he recall making return visits. A second roll check was conducted by a different officer shortly after 6.00am. Although he signed that he had completed the check, the CCTV footage shows that he did not check the cell. The man's cellmate found him suspended from bed sheets in the separate toilet area of the cell just after 8.00am in December. Healthcare staff were called but sadly they were unable to resuscitate him.

While I think it would have been difficult for staff at Liverpool to have anticipated the man's actions, it is not clear that the circumstances of his alleged offence and the fact that this was his first time in custody – both known risk factors - were taken into account when assessing his risk. The investigation found that the emergency response was swift but it does not appear that emergency codes were used. While it did not affect the outcome in this case, on another occasion this could be important I am also concerned by the sequence of roll checks carried out by wing staff on the morning he was found, specifically that one officer did not complete his roll check as required. We cannot know whether this would have made a difference in his case, but I understand that this is to be the subject of a disciplinary enquiry.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2013**

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SUMMARY

1. The man was remanded into custody at HMP Liverpool on 6 December 2011, charged with offences against his partner.

2. In a statement made to the police, the man's cellmate said that, following his remand into custody, he was very anxious about the charges he was facing. The night before his death, they talked about his forthcoming court case. His cell mate said that he spent most of the evening smoking and pacing around the cell until he went to sleep around 1.30am. This was the last time that his cellmate saw him alive.

3. Around 5.30am, an officer carried out a roll check on the wing. When the officer got to the man's cell, he checked the main cell through the observation hatch and then he checked the separate toilet area through an observation panel. CCTV recordings show that he checked both observation panels a number of times and then returned again after he had completed the other checks. He reported nothing untoward.

4. A second officer came on duty around 6.05am. In his statement to the police, he said that he received a handover from the other officer and was told that there had not been any incidents of note overnight. He was then required to conduct another roll check. The officer said that he then checked all the cells, but the CCTV footage does not show him checking the man's cell. He can be seen checking cells on the other side of the landing.

5. At 8.06am, after being unlocked, the man's cellmate left his cell and shouted for help. Two officers were close by and immediately went into the cell where they found him hanging in the toilet area. Healthcare staff and an ambulance were called. Sadly, attempts to resuscitate him were unsuccessful and paramedics pronounced his death at 8.37am.

6. This report makes five recommendations relating to: the use of emergency calls, improved documenting of risk factors, more expeditious notification of families and the actions of staff in carrying out roll checks.

THE INVESTIGATION PROCESS

7. On 19 December, the investigator issued notices to staff and prisoners at Liverpool informing them of the investigation and asking anyone who had relevant information to contact her. She visited the prison and met the Governor and the deputy governor. She also spoke to a member of the Independent Monitoring Board and the prison family liaison officer. She obtained the man's prison and clinical records and visited the cell where he died.

8. The investigator attended a meeting at the Coroner's Office on 19 December 2011 and met the man's family. She gave them information about the scope of the investigation and explained that the PPO family liaison officer (FLO) would contact them. One of the Ombudsman's FLOs spoke to the next of kin on 25 January 2012. The family had the following concerns:

    - They said that he did not know how to get clean clothes or arrange visits. When they brought clothes to a visit, they were told that he could not have them.

    - They wanted to know if he had asked for any help.

    - They wanted to know if he had spoken to his solicitor.

    - The local press had reported his death and they wanted to know if the prison had spoken to them.

9. The local Primary Care Trust (PCT) was asked to conduct a review of the medical care provided to the man while he was in custody. The review and subsequent report was completed by a clinical reviewer and the report was received on 2 October 2012. The investigator has asked the clinical reviewer for clarification of some issues. A revised report has not yet been received.

10. The investigator returned to Liverpool on 5 April to carry out interviews with prison staff. Another investigator conducted further interviews on 8 May. She met a Detective Sergeant from Merseyside CID on 18 May to discuss police interviews with two prison officers.

11. An Assistant Ombudsman conducted a further interview with a prison officer on 24 July 2012. He also contacted the Coroner's officer on 25 July to explain that he was unable to interview another officer because he declined to be interviewed until an impending disciplinary investigation was completed.

12. We regret the delay in the issue of the draft report caused by some unavoidable staff absence.

13. The man’s family have had the opportunity to respond to the draft report. They remain concerned about the induction process at Liverpool and the actions of an officer. Other concerns that they raised have been responded to in separate correspondence.

HMP LIVERPOOL

14. HMP Liverpool is a local prison which serves courts from the Merseyside area and holds up to 1477 remanded, unsentenced and convicted adult male prisoners. There are eight residential wings, some of which have different functions and offer specific services to prisoners such as drugs support, detoxification and resettlement.

Healthcare at HMP Liverpool

15. Healthcare services at Liverpool are provided by the Primary Care Trust (PCT). A purpose built healthcare centre which opened in 2007, provides outpatient and inpatient facilities. A doctor is on duty every day during normal working hours and nursing staff remain on duty throughout the night.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prisons carried out an unannounced full follow up inspection of Liverpool in December 2011. Inspectors found that there was reasonable support for those at risk of suicide or self-harm, although some procedures needed to be strengthened. The reception of prisoners into Liverpool was described as busy but efficient. There was no first night strategy in place to ensure that newly-arrived prisoners were consistently supported. Induction was well presented, but did not cover issues such as self-harm or diversity in sufficient depth.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who help to ensure that proper standards of care and decency are maintained. The IMB at Liverpool published their latest report in 2011. Commenting on the prison's management of self-harm and suicide prevention, the IMB noted that "the prison takes this part of its work very seriously and the management, officers and staff work in a vigilant and professional manner".

KEY EVENTS

18. The man was remanded into custody on 6 December 2011, charged with offences against his partner. This was his first time in prison. He was due back in court on 13 December. His Person Escort Record (PER) does not identify any concerns about self-harm or suicide. (The PER is a record used to record movements and information about a prisoner such as from court to prison.)

19. During his first health screen on reception to the prison, the man told prison staff that he had no previous mental health problems, did not drink alcohol and had never tried to harm himself. A nurse commented in the clinical record that he appeared calm and rational and said he had no thoughts of self-harm or suicide. The record indicates that he had no concerns about his physical health and was not taking any medication.

20. The Governor of A and H wing told the investigator that all new prisoners are given information about the prison regime when they arrive. He said they should be interviewed by an officer who goes through a check sheet to make sure that the prisoner is told about how to arrange visits, how to make telephone calls and what to do if they have any questions. There is also information about education, housing, drug problems and other general prison guidance. They are also given a hygiene pack containing soap, shaving equipment and toothbrush and other necessities.

21. The officer on duty in reception when the man arrived said that her job was to carry out a first night interview with prisoners. She said that she tells prisoners what will happen in the next 24 hours. She also discusses any family concerns, substance misuse issues or anything that might be worrying the prisoner. In her statement to the police, she said that she could not specifically remember his first night interview but that if she had been concerned about him, she would have begun suicide and self-harm monitoring procedures and passed the information to healthcare staff. He signed a number of papers, including the record of the first night interview, indicating that he had been given this information. He was not allowed to make telephone calls at that time in case he contacted the victim of his alleged offence.

22. The Governor of A and H wing told the investigator that new prisoners were expected to attend induction the day after they arrived. Although the man was put on the list to attend induction on 7 December, he did not attend. He was put on the list for the following day but again he did not attend. The Governor said while prisoners were expected to attend, they were not obliged to. (In a survey of prisoners for the last HMIP inspection, 79% of non-vulnerable prisoners said that they attended induction.) As the man did not attend an induction session, prison staff visited him in his cell on 9 December and gave him further information about the prison regime.

23. The man’s cellmate made a statement to the police after the man’s death. In his statement, he said that when the man came to share his cell on 7 December he was “very stressed out and worried about his future”. He said that he told him that he had not committed the offences for which he had been remanded and was worried about his children and his family. He also asked the cellmate to write down his mother’s address and contact details and to make sure his mother knew the truth “if anything happened”. The cellmate put the details with his own personal belongings.

24. The cellmate said that the day before his death, the man had a visit from his brother. He said that he was quite upbeat after the visit but as the evening wore on he became agitated and walked about the cell, rolling and smoking cigarettes. Around midnight, he told his cellmate that “he didn’t have a leg to stand on” when talking about his court case.

25. The cellmate said he went to sleep between 1.30 to 2.00am. He remembered the man was sitting on the chair by the window, smoking and watching television. He said that he did not look as “down” as he had previously been.

26. At around 5.00am, Officer A completed a roll check (which is a security check to ensure that the correct number of prisoners are in the prison). CCTV footage covering the area of the wing of the man’s cell shows the officer looking into his cell through the observation panel on the main cell door. He then checked the observation panel in the separate toilet area to the right of the main cell. He then looked through both panels again before walking round the landing and checking the other cells. When he had done this, he returned again to check the cell and toilet area and then leant over the landing railing for a moment.

27. During his interview with the Assistant Ombudsman, the officer said that he could not explain why he returned to the cell. He said that when he had seen the CCTV footage he was surprised by his actions and could only speculate that he might have left the flap to the observation panel open and had returned to close it. He could not give any further explanation and said the same to the police during his interview with them.

28. Officer B came on duty at approximately 6.05am. In his police statement, he said he received a handover from his night duty colleague and there were no incidents of note. He said that he started a roll check around 6.20 am and signed the wing roll book to say that he had completed it and it was correct. The CCTV footage shows that he checked only two cells on the landing. He can be clearly seen walking past the man’s cell without looking into either the cell door or the toilet observation hatch. (The officer was subsequently suspended from duty pending an investigation.)

29. In his statement to the police, the cellmate said that around 8.25am he was woken by the cell door being unlocked and pushed slightly open. As he wanted to go to the toilet, he opened the toilet door and saw the man to his left, with his back to him hanging by his neck from a noose made of bed sheets. He immediately ran out of the cell and shouted for officers to come quickly.

30. The CCTV shows that two officers went immediately to the cell. The cellmate said he saw Officer C lift the man up and the other officer use his anti ligature knife to cut the sheet form around his neck. They then placed him on the floor.

31. Officer C used his whistle to alert other staff that he needed assistance as neither officer had a radio. Other officers came to the cell and prisoners who were on the wing were moved back to their cells. The cellmate went into the cell next door.

32. A nurse told the investigator that she was the designated person to respond to healthcare emergencies that day and held a radio with a designated call sign for that purpose. She said that at what she thought was around 8.15am, she saw officers running towards G wing. At the time, she was giving out medication on K wing, but thought there must be an emergency and decided to follow. She said that she arrived at the top of G wing on landing 3 when she heard an emergency code blue call over the radio system. (An emergency code blue call indicates a serious breathing problem.) She had not taken the emergency bag with her when she had set off as she was not aware of the nature of the incident. However, as she was only a few feet from the man's cell, where the radio call had asked her to go, she decided she would go straight there. The duty governor that day said that he did not hear an emergency call.

33. The nurse immediately asked for an ambulance to be called, for the emergency bag to be collected and for further healthcare assistance. She said that it had taken her just seconds to get to the cell. When she went in she saw the man lying in the toilet area on his back. She checked his femoral, carotid and wrist pulses and whether he was breathing but there were no signs of life. She immediately started cardiopulmonary resuscitation.

34. Seconds later, Nurse B and an officer arrived at the cell with a defibrillator and the emergency bag. Nurse B saw Nurse A performing CPR and took over chest compressions while Nurse A set up the defibrillator and attached it to the man. (A defibrillator is a life-saving machine that gives the heart an electric shock in some cases of cardiac arrest.)

35. Nurse C was giving out treatments at the G wing surgery when he noticed the staff response. He could not recall if he had a radio or

whether he heard an emergency call, but said he went to the incident. When he arrived at the cell, he saw the other nurses carrying out CPR. He asked the Nurse B to get the man's information from the surgery and then went to assist Nurse A by giving oxygen while she continued chest compressions. He said there were no apparent signs of life. Paramedics arrived at 8.36am. They also found no signs of life and the man was pronounced dead at 8.37am.

36. Officer D said that he noticed a letter that the man had left and he read the front part of it. He said that it was a long letter and seemed to indicate that he had decided to take his own life. The letter was given to the police.

37. The Governor held a hot debrief to allow the staff involved to identify any issues and receive mutual support and from the duty care team. Prisoners on G wing were informed of the man's death and those who were at risk of self-harm or suicide were reviewed in case his death had affected them. A Listener stayed with the cellmate to support him. Listeners are prisoners who have been trained by the Samaritans to provide a listening service to other prisoners.) Other prisoners were also offered the services of Listeners.

38. A Governor, who had been given the role as the prison's family liaison officer (FLO), and a chaplain went to inform the man's family of his death at 11.30am. He explained that it took some time because there were only two governors on duty at the weekend. He said after they had informed senior staff, police and the coroner of the death and completed risk assessments; this was the fastest they could get there.

39. The FLO said that the man's family were already aware of his death when he arrived at the house. He said that there had been a number of telephone calls to the prison asking about what had happened to him, which started about half an hour after he had been found in his cell. He did not know how news of his death had been passed on, but suspected that a prisoner might have used an illegal mobile phone to contact the family. It is also possible that another prisoner alerted his family or acquaintances of his family using the prison telephone system before they were locked in their cells.

40. In line with national guidance, the prison offered a contribution towards the funeral. Representatives of the prison attended the funeral with the agreement of the family.

ISSUES

Health

41. The man attended his health screen on 6 December, when he arrived at Liverpool. No concerns were raised about his physical or mental health. He did not have any further contact with healthcare services.

Assessment of risk of suicide and self-harm

42. When the man arrived at Liverpool he was seen by a nurse, who completed a reception health screen, and by an officer, who completed a first night interview. It appears that he did not give either of them cause for concern that he might be at risk of self-harm.

43. We note that this was the man's first time in prison and that his alleged offence was violence against a partner - both of which are known triggers for self-harm. He also did not attend two scheduled induction appointments indicating a lack of engagement with the prison regime which might also have led to concerns about his state of mind.

44. It is possible that staff at Liverpool were aware of the triggers and took these into account when making their assessment. While they have recorded that they had no concerns about the risk of self-harm or suicide, they did not indicate that they had considered these known risk factors and discounted them. It is therefore not possible to be sure what factors, if any they took into account other than the man's personal presentation. We do not suggest that staff reached the wrong conclusion when they assessed his risk when he arrived at Liverpool, but we believe that noting on the record the known risk factors helps in the risk assessment process. The information might also help other staff identify whether any subsequent concerns are significant. We make the following recommendation:

    The Governor should ensure that staff document any known risk factors when assessing whether a prisoner is at risk of suicide or self-harm

Emergency response

45. Officers C and D went to the man's cell as soon as they were alerted by his cellmate. They used a whistle to alert other staff and get assistance. One member of healthcare staff said she heard a code blue emergency call over the radio but no other staff could recall hearing one. On arrival at the cell, the officers immediately lifted him up and cut the sheet from his neck. Nurse A arrived at the cell very quickly and began CPR. Other healthcare staff arrived shortly afterwards. He was given oxygen and a defibrillator was used. The defibrillator advised not to shock, so CPR was continued until paramedics arrived.

46. The staff interviewed as part of this investigation said that it appeared as if the man had been dead for some time when he was found. Although an emergency code was not used at the outset, the response to the emergency was very quick and the lack of code is unlikely to have had any bearing on the outcome for him. However, we are concerned that on other occasions the failure to use an emergency radio code might mean that appropriate staff and equipment do not get to the scene of a serious incident quickly enough. We therefore make the following recommendation

    The Governor and Head of Healthcare should ensure that all staff are aware of and use appropriate radio codes in medical emergencies.

Roll checks

47. Officer A carried out a roll check on G wing at around 5.00 am before he went off duty. It is clear from the CCTV footage that he returned to the cell three times to check something. However, when interviewed he said he could not remember seeing anything untoward or explain why he had gone back to look at the cell again.

48. He handed over to Officer B, who said that he also carried out a full roll check which he started around 6.20am. He said that he usually checked all the cells on the wing but varied his starting and finishing points. The CCTV footage shows that he checked two cells but walked past the man's cell. He signed the roll to say that he had checked all the cells and that the count was correct.

49. Merseyside Police carried out an investigation into the management of the roll checks, but the Crown Prosecution Service decided that there was not enough evidence to obtain a conviction. No charges were brought against either officer.

50. We have not been able to interview Officer B. Initially this was because of the police investigation, and then because of his subsequent ill health and an internal disciplinary investigation. On 24 July, we were told that he was willing to be interviewed but not until after the prison's disciplinary investigation, which was due to start the following week. On 8 October the investigator contacted the prison to find out the outcome of the disciplinary investigation and was then told that it had not yet started because the PPO investigation was still ongoing.

51. It is apparent from the evidence we have seen that Officer A did complete the required checks, although he seemingly did not notice whether the man was hanging in the toilet area of his cell at that time. Officer B did not undertake the checks that he was supposed to do. We do not know at what time the man hanged himself and whether

either check would have made a difference to the outcome. It is of some concern that Officer A was unable to explain why he went back to the cell several times, yet maintains he saw nothing of concern. We cannot explain this behaviour, nor discount the possibility that he saw something that, for whatever reason, did not fully register with him. We do not suggest that there is any blame to be attached to him, but it does indicate a need for managers to debrief him fully about the matter in case the lack of recollection of his actions is a result of some form of trauma or other reason affecting fitness for duty.

The Governor should ensure that Officer A's actions are reviewed and explored with him in the interests of staff and prisoner safety.

52. The apparent failure of Officer B to check the cell means that another possible opportunity to save the man was missed. In the circumstances, we believe that a disciplinary investigation should be held to establish whether any disciplinary action is merited. We understand such action is intended and he was aware of this. However, we make the following recommendation:

The Governor should ensure that a disciplinary investigation into the actions of Officer B is carried out, and the outcome shared with this office, the Coroner and the man's family.

Informing the man's family of his death

53. The man's death was pronounced by paramedics at 8.37am. However, his family were not officially told until after 11.30am, by which time they had found out about his death.

54. The FLO told the investigator that the prison received several telephone calls from the man's family before he left the prison. No information was given out over the telephone. When he arrived at the mother's address he said it was clear that they already knew as many family members had arrived there. After the family had been informed the only information given to the press was that a death had occurred at the prison and that an officer had been suspended. This was in line with standard Prison Service practice.

55. PSI 64/2011 Safer Custody states in Chapter 13:

> "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

56. We believe that prison staff should have gone to see the man's family sooner than they did. The FLO told us that there were only two operational managers on duty, which meant that they had to complete the death in custody contingency plans between them. He acted as

family liaison officer, but his other duties meant he could not focus exclusively on this role. Although there are fewer staff available at weekends, it is important that families are told about a death and given as much information as possible from an official source and arrangements at weekends should take this into account. We make the following recommendation:

The Governor should ensure that following a death in custody the news is broken to a prisoner's family as soon as possible.

Family concerns

57. The man's family asked a number of questions. While these are not directly related to the circumstances of his death, the prison has provided the following information.

58. They also asked whether he knew how to get clean clothes and arrange visits. Liverpool told the investigator that information about arranging visits and bringing property into the prison is given at induction. The man did not attend induction but staff visited him in his cell on 9 December and gave him the information which included visits and clothing. He signed a document to confirm that he had been given this information.

59. The family visited him three times during the five days he was at the prison which suggests he was aware of the visits process. They have told us that on one of these occasions, they were not allowed to give him clothes. It is possible that this was at the weekend, when one of the visits took place. The prison says that for logistical reasons visits staff are not able to accept clothes at the weekend.

60. There is no record of the man's solicitor visiting him during his time at Liverpool or of him telephoning his solicitor.

CONCLUSION

61. The man was remanded into Liverpool on 6 December 2011, for alleged offences against his girlfriend. He was not initially assessed as at risk of suicide or self-harm, although it is not clear what factors were considered. He did not tell healthcare staff or prison officers how affected he was by the charges against him but he told his cell mate that he was very worried. We consider, even with the known risk factors, it would have been difficult for the prison to have predicted and thus prevented his actions.

62. During the early hours of 11 December, the man left a note to his family in his cell. A roll check in the early morning apparently did not notice anything untoward and a subsequent check did not take place as required. He was found hanging in the toilet area of his cell by his cell mate at round 8.00am. Although the formal code system was not used, the emergency response was swift, but attempts to resuscitate him were unsuccessful.

RECOMMENDATIONS

1. The Governor should ensure that staff document any existing risk factors when assessing whether a prisoner is at risk of suicide or self-harm.

   This recommendation has been accepted by the prison. They said, "A list of all known triggers will be published as part of a weekly briefing to all staff. This will be repeated quarterly. Staff will be reminded to document that these increased factors have been considered".

2. The Governor and Head of Healthcare should ensure that all staff are aware of the appropriate radio codes to be used in emergencies.

   This recommendation has been accepted by the prison. The prison said, "A Governor's Notice to Staff will be published reminding staff on use of emergency codes and using 'urgent message' in a prefix. In addition staff responsibility to summon an ambulance following discovery of a life threatening emergency. This action will be monitored through the Safer Liverpool meeting and the NTS will be republished annually".

3. The Governor should ensure that Officer A's actions are reviewed and explored with him in the interests of staff and prisoner safety.

   This recommendation has been accepted. The prison said, "A terms of reference to review Officer A's actions has been commissioned. A Governor has been commissioned to undertake this review".

4. The Governor should ensure that a disciplinary investigation into the actions of Officer B is carried out, and the outcome shared with the PPO, the Coroner and the man's family.

   This recommendation has been accepted. The prison said, "A Governor has been commissioned to investigate the actions of Officer B. The outcome will be shared as requested".

5. The Governor should ensure that following a death in custody the news is broken to a prisoner's family as soon as possible.

   This recommendation has been accepted. The prison said, "A FLO will be deployed at the earliest opportunity following standard risk assessments. This will be monitored and reviewed via the Safer Liverpool monthly meeting".