PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Liverpool in April 2014

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who was found hanged in his cell at HMP Liverpool in April 2014. He was 52 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Liverpool was conducted. The prison cooperated fully with the investigation.

On 31 March, the man was remanded to Liverpool prison on a charge of murdering his partner three days earlier. When he arrived, prison staff did not assess him as at risk of suicide or self-harm although he had been charged with killing his partner, suffered from depression and was an alcoholic. Nor was he prioritised for a mental health assessment, and one did not take place before he died. A GP prescribed medication to relieve withdrawal symptoms from alcohol, but it is not clear that he always received his medication or that his detoxification was appropriately managed. There was little evidence that wing staff actively engaged with him and supported him. On 14 April, he appeared at court by video-link from the prison. A nurse did not assess him afterwards, as should have happened. Later that day, his cellmate discovered him hanging.

I am concerned that the police did not pass important information about the man's risk of suicide to the prison. Nevertheless, even without that information, prison staff should have identified his risks. As in many cases my office investigates, staff appear to have relied too much on his personal presentation and his assurances that he did not intend to kill himself, rather than his evident risk factors. The investigation also raises concerns about the management of his detoxification, the lack of an urgent mental health assessment and, despite his vulnerabilities, a lack of apparent support from wing staff.

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 **January 2015**

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SUMMARY

1. The police arrested the man on 29 March 2014, for the murder of his partner the day before. He suggested to the arresting officer that he had tried to kill himself after his partner's death. He spent two days in police custody, and on 31 March, the courts remanded him to HMP Liverpool. His escort record included information about the crime, that he suffered from depression and that he was an alcoholic, but the police did not pass to the prison information from his family and the arresting officer about his risk of suicide.

2. The man told prison staff that he had no thoughts of suicide or self-harm and reception and first night staff at Liverpool did not assess him as at risk. There is little evidence that they fully considered his risk factors or all the information recorded about him. A reception nurse referred him for a mental health assessment, but not urgently. Healthcare staff later misdirected the referral to an external agency, and he did not meet their criteria. He never had a mental health assessment.

3. A doctor prescribed an antidepressant the man had been taking in the community and medication to relieve symptoms of withdrawal from alcohol. As part of the alcohol detoxification programme, specialist nurses should have assessed him at least twice a day for the next three days, but no checks took place after the first day and neither did a final review after ten days.

4. The man had an allocated personal officer, but he said that, because of staff shortages, he often worked on other wings and did not introduce himself to him. There is no recorded evidence of any wing staff interaction with him. On 8 April, he missed three healthcare appointments, but there is nothing to explain the reasons for this.

5. One morning in April, the man appeared at court by video-link. The court set a trial date for September. No one assessed him afterwards. His cellmate found him hanging less than six hours later. Staff responded quickly, but could not resuscitate him. After his death, the prison liaised effectively with his brother, who was his nominated next of kin. However, his sister did not consider that the prison had treated her appropriately.

6. The investigation found that, while the police did not pass to the prison all the information they held about the man's risk of suicide, prison staff should have recognised his risk when he first arrived and begun suicide and self-harm prevention procedures. The staff relied too much on his personal presentation and his assurances that he did not intend to kill himself, rather than factors known to increase the risk of suicide. These included that he was charged with an extremely violent offence against his partner, he suffered from depression, was withdrawing from alcohol, was on remand and in the early days of custody. Staff should have prioritised his mental health referral and a nurse should have assessed his risk of suicide and self-harm after his court video-link appearance. Nurses did not appropriately supervise his alcohol detoxification. The prison also needs to ensure all appropriate family members are included in liaison arrangements after a prisoner dies. We make eight recommendations.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at Liverpool informing them of the investigation and inviting anyone with relevant information to contact her. No one responded. She obtained all relevant documents from the man's time in prison. She interviewed 15 members of staff and three prisoners. After the interviews, she informed the Governor of the initial findings of the investigation.

8. NHS England commissioned a clinical reviewer to assess the clinical care the man received at Liverpool. She participated in most of the interviews.

9. We informed HM Coroner for Liverpool of the investigation and we have sent him a copy of this report.

10. One of our family liaison officers (FLO) contacted the man's brother and sister who had the following questions for the investigation to consider:

    - Was the information from their police witness statements about his risk of suicide passed onto the prison when he was remanded to Liverpool?
    - In the light of his previous suicide attempts, was he being managed under suicide and self-harm prevention measures?
    - Was he assessed by a doctor in prison and prescribed medication?
    - Why did the prison refuse to inform his sister of the details of his death?

11. The man's brother and sister family received copies of the draft report. They did not make any comments.

HMP Liverpool

12. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 prisoners. Liverpool Community Health Trust delivers healthcare at the prison. There is a primary mental health team, an in-reach team (for those with a diagnosed severe and enduring mental illness) and a clinical psychology service which delivers specialist therapy and counselling.

Her Majesty's Inspectorate of Prisons

13. The last inspection of Liverpool was in October 2013, when inspectors found that too many prisoners felt unsafe. Relationships between prisoners and staff were generally good, but the prison environment required urgent improvement. Living conditions in some cells were unacceptably poor. The quality of ACCT documents was considered reasonable, but inspectors found that some ACCT case managers had not received case management training. Mental health services were extensive and inspectors noted that discussions were underway to try to integrate the different services. Overall, inspectors identified steady, but slow, progress.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The IMB annual report for 2012-2013 was very positive about mental health services at the prison, which had been at the forefront of many initiatives. The IMB noted that prison managers had coped well in the face of difficult circumstances and outdated Victorian buildings in need of constant repair. The IMB's main concern was the difficulty associated with mentally disordered prisoners.

Previous deaths at HMP Liverpool

15. Since April 2010, there have been seven apparently self-inflicted deaths at Liverpool including that of the man. As with him, three of the previous deaths occurred shortly after the prisoners' arrival at the prison: all within two weeks. In addition, four of the previous deaths had been charged with or convicted of serious sexual offences or violence against a partner. Most were not being managed under self-harm and suicide prevention procedures at the time of their deaths. We have previously made recommendations that all known risk factors are taken into consideration when assessing a prisoner's risk of self-harm or suicide. We make another recommendation about this in this report.

Assessment Care in Custody and Teamwork

16. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multi-disciplinary reviews and

should not close the ACCT plan until all the actions of the caremap are complete. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

17. On 29 March, the police arrested the man and charged him with the murder of his partner, the day before. During their enquiries, his brother had told the police that he was worried about his brother's state of mind, as he had had suicidal tendencies in the past. When he was arrested, he said to the police officer "tried to commit suicide but that didn't work".

18. The man told police that he misused alcohol and a doctor saw him three times due to the risks associated with withdrawing from alcohol. He told the doctor on each occasion that he had no thoughts of suicide or self-harm. He was checked every 15 minutes due to his withdrawal from alcohol. He was not assessed to be a risk of suicide or self-harm.

19. On Monday 31 March, around midday, the man appeared at Magistrates Court. A police officer wrote on the person escort record (PER – which accompanies all prisoners when they move between police stations, courts and prisons) that he had been charged with murder and was violent (he had stabbed the victim eighteen times). They noted that he was an alcoholic, but had only mild withdrawal symptoms, and in the health section of the form, that he had depression. The risk of suicide and self-harm section was blank and the PER did not include the information from his brother and the arresting officer about his risk of suicide.

20. Shortly after 1.15pm, the court remanded the man to prison to appear at Crown Court on 14 April. He arrived at HMP Liverpool at 3.45pm. He had previous experience of prison for short periods, but had not been to prison since 2009. A Supervising Officer (SO) checked his details, including the PER, at the reception desk

21. A nurse saw the man for an initial health screen around 4.30pm. He told the investigator that he did not recall him, but said that the only information he would have had about him was his medical record from his previous time in prison, which he had not had time to look at. He said he did not see his escort record.

22. The records show that the man told the nurse that he had been charged with murder. The nurse did not ask him any further questions about this, and told the investigator that he was unsure why it was one of four offences highlighted on the health screen. He said he suffered from depression for which he took mirtazapine. He said that his GP had recently referred him to community mental health services and he was waiting for an appointment. The nurse did not ask him the reason for the referral. He told the nurse he had no history or current thoughts of suicide or self-harm. He reported that he had a six month stay in a psychiatric hospital, after a breakdown in 2002. He said that he misused alcohol and drank around eight cans of lager daily. The nurse noted that he was alert and oriented.

23. The nurse referred the man for a mental health assessment, but said that he had not regarded this as urgent. In his referral, the nurse noted that the man's daughter had committed suicide one year before, and that his GP had recently referred him to community mental health services. He noted that he suffered from depression, anxiety, mood swings, anger management

problems and paranoia and that he was on remand. Mental health referrals are discussed at a single point referral meeting each week on a Monday. The next meeting, on 7 April, would consider his referral. The nurse did not assess him as at risk of suicide or self-harm.

24. At 5.18pm, a nurse from the prison's drug dependency unit (DDU) assessed the man for alcohol dependency using the Alcohol Use Disorders Identification Test (AUDIT). (She used another nurse's medical record login as hers was not working, but made it clear that she had completed the assessment.) He told the nurse that he had been drinking 12 cans of lager daily and scored 12 on the test, indicating mild to moderate withdrawal symptoms. She noted that he would have a librium detoxification to ease withdrawal symptoms. She referred him to the reception doctor and put him on the list for the drug dependency unit doctor's clinic the next day. She said that he had seemed quite quiet and a bit shaky and nervous about being in prison, but she had not been too concerned about this, considering his situation.

25. At around 7.00pm, a doctor assessed the man. They discussed his alcohol consumption and he said he had last had a drink three days before. He said that his GP had prescribed him mirtazapine for a couple of years. The doctor phoned his community GP to check this, and prescribed mirtazapine, librium and vitamin B.

26. An officer completed the man's first night assessment. He did not have any information about him so relied on his answers to his questions. He told him that he had been charged with murder, but the officer did not ask any further questions about the circumstances. He told the investigator that this was because he had not seemed distressed.

27. The officer recorded that the man had said that he had been expecting to come to prison and did not feel vulnerable. He said he had no thoughts of suicide and self-harm and reported misusing alcohol and some short-term memory loss. He advised him to talk to a nurse, wing staff or a Listener if this got worse. (Listeners are prisoners trained by the Samaritans to offer confidential support to other prisoners in distress.) Because of his alleged offence, the officer did not offer him a telephone call as security staff would need to clear all numbers first. (They later approved his brother's number, but he never made any telephone calls at the prison.) The officer told the investigator that he had no concerns about his risk of suicide and self-harm, so he did not open an ACCT.

28. Staff assessed the man as suitable to share a cell and allocated him a shared cell in the prison's first night centre. He had no personal possessions when he arrived at Liverpool and was wearing clothes provided by the police. He had 28 days to get any clothes sent in, after which he would have had to buy them from the prison catalogue or wear prison-issue clothing.

29. On 1 April, a doctor assessed the man at the morning substance misuse clinic. The doctor said he could not remember whether he had reviewed the previous day's medical notes before assessing him. He noted that he had a history of alcohol dependence and had suffered fits as a result ten years previously. He observed that he was anxious and suffering from slight

tremors due to alcohol withdrawal. The doctor noted he had a history of depression and prescribed diazepam to lessen the likelihood of fits. The doctor did not assess him as at risk of suicide and self-harm and did not consider that he needed to refer him to mental health services.

30. The doctor could not recall whether he knew that the man was charged with murdering his partner. He said he would not normally ask prisoners about their offence as they sometimes felt he was prying into their personal details. The doctor acknowledged that there was information about his charges on SystmOne, the electronic prison record.

31. As part of his alcohol detoxification programme, drug dependency unit staff should have assessed the man twice a day for the first three days. The checks involve taking blood pressure, completing a Clinical Institute Withdrawal Assessment (CIWA) and assessing whether the level of medication appears correct. It is an opportunity for staff to consider further referrals to the doctor or other services.

32. At 2.37pm, an entry on the man's medical record said that the drug dependency unit staff had not assessed him "due to prison regime lockdown". At 4.00pm, he moved to I wing, a general residential wing, rather than H wing, the detoxification wing. Staff were unable to explain this, but suggested that either H wing was full at the time, or that the staff who moved him did not know that he was on an alcohol detoxification programme.

33. An officer was allocated as the man's personal officer. Personal officers are expected to get to know the prisoners they are responsible for, act as a first point of contact for any problems and make regular entries in their records about their time at the prison. The officer said that he worked on I wing for only four of the 14 days he was there. Some of the days he was not working, but said that more often he had been sent to work on other wings, because of staff shortages. He had never introduced himself to him as his personal officer and could only remember speaking to him, very briefly, twice. He made no entries in his records.

34. On 2 April, at around 10.00am, a nurse from the drug dependency unit noted in the man's medical record that she had been unable to take his observations as he was not in his cell. There is no record that anyone from the drug dependency unit went to check him that afternoon.

35. The equalities officer assessed the man as he had said that he had short-term memory problems. He told her that he used a notebook to help him remember things. She gave him a notebook and pens and informed wing staff. She booked him an optician's appointment as he did not have his glasses with him in prison, which he needed to read and write.

36. Drug dependency unit staff did not check the man on 3 April, either in the morning or the afternoon. Staff wrote in his record that they had not been able to see him because he was not in his cell and because of the prison regime. A nurse completed the afternoon entry in his medical record using another nurse's login. She said that her colleague was new and did not yet have a personal login so she had logged in for him. She recognised that this was not good practice.

37. A Lifeline worker, an agency that offers psychosocial support to prisoners with drug or alcohol problems at Liverpool, saw the man on the afternoon of 4 April. He told him that he was okay but suffered from memory loss. They completed part of an initial alcohol misuse assessment. He told the Lifeline worker that he had no previous or current thoughts of suicide or self-harm or suicide. The Lifeline worker said that he had had no concerns about him, who had engaged positively.

38. On 7 April 2014, a prisoner moved into the man's cell. There is no record of whether he had shared a cell before this. They knew each other and the cellmate said they got on well. He knew, from local press and television reports, that the man was facing a charge of murder. He said he never heard anyone talking to him about this and he did not talk to him about the circumstances, except to say that he intended to plead guilty. He said the man kept himself to himself and seemed fine. He did not consider that he gave any indication that he intended to kill himself and he did not notice any change in his mood or behaviour, over the week they shared a cell. He said that if he had been worried about him, he would have spoken to staff.

39. The single point referral meeting discussed the man that afternoon and agreed his case should be allocated to the Criminal Justice Liaison Team (CJLT). The CJLT is court based, but visits prisoners on remand.

40. The man had three healthcare appointments on the morning of 8 April, which he did not attend. One was with the optician, one was for a secondary health screen and the other was for a routine blood test. Staff said that prisoners are informed of medical appointments by a slip of paper from the healthcare centre which officers put under their cell door. We do not know whether he received this and there is no record why he did not attend the appointments, which would require an officer to unlock and escort him to the healthcare centre.

41. On 9 April, the man's brother, nephew, niece and a friend visited him. This was his only visit. His brother later told police that he thought he had seemed nervous and on edge. When they left, the man shook his brother's hand, which his brother considered to be strange as he had never done so before. After the visit, his brother said he had been worried that he might harm himself. He did not talk to prison staff about his concern.

42. On the tenth day of an alcohol detoxification, staff from the drug dependency unit should review the prisoner to determine whether they are still experiencing any withdrawal symptoms and to assess their risk of suicide and self-harm. A nurse recorded that she had tried to assess the man at around 9.00am on 10 April, but had been unable to see him due to a prison lockdown. She said it was unlikely that she had reviewed the previous entries her colleagues had completed, recording their unsuccessful attempts to assess him. She said if she had realised that no one from the drug dependency unit had assessed him since his first day at the prison, she would have tried to assess him later or asked the primary healthcare team to help.

43. The GP had prescribed librium for the man three times a day. On five occasions during his ten-day detoxification, it is not possible to tell from the

prescription chart whether he received his librium, as there is no entry in the chart.

44. Prisoner A on I wing knew the man from outside prison. He knew from his family and from reports in the local press, that he had allegedly killed his partner. He told the investigator that he had never heard other prisoners talking about this. He said although he spoke to him a number of times, he never asked him about how he felt and he did not disclose any concerns to him.

45. However, the prisoner told the investigator that he thought that the man would kill himself as his "head was gone". He said that he walked around the wing looking down at the ground and that when other prisoners put their dirty bed linen outside their cells to be washed, he would take it. He did not know if staff had observed this. The prisoner had assumed that he was collecting sheets to hang himself. He said the man's personal hygiene was poor. The prisoner said that he never told wing staff about the risk he thought the man presented to himself. In retrospect, he wished he had done so.

46. The prisoner told the investigator that the man often came to his cell asking for tobacco. Staff and prisoners said that they often saw him picking up cigarette butts from the floor. He said that he gave him some clothes and razors, as he understood that he was waiting for money to be transferred into his account.

47. The prisoner was released on 10 April. He left his cellmate, Prisoner B, a bag of belongings, including clothes, razors and shower gel, to give to the man. Prisoner B said the man had seemed pleased when he received them. He said other prisoners had told him that the man had stabbed his wife 14 times, after she had taken all his money. He did not think that he seemed depressed or concerned when he saw him.

48. A few days later, at around 9.45am, an officer collected the man for a video-link appearance at Crown Court. He had been told the evening before of the video-link appearance by a written notice put under his door.

49. At 9.55am, an officer set up the video-link in a private room and the man spoke to his solicitor. No officers were present. After five minutes, she took him to the video-link court room and they connected to Crown Court immediately. She stayed for the hearing. The judge asked him to confirm that he understood the court proceedings, and he showed no signs of being distressed. She said that she did not know that he had been charged with murder until she attended the court video-link proceedings.

50. The officer said the man did not seem upset and she had no concerns about him being at risk of suicide or self-harm. She recorded the key dates listed by the court including his trial in September. The hearing concluded at 10.32am and one of her colleagues took him straight back to his cell. (It has not been possible to identify who this officer was.) When he returned from the video-link hearing, his cellmate asked him how it had gone and he told him that they were putting the murder charge and a previous fraud charge together. The cellmate did not detect any change in his mood.

51. At 10.58am, a nurse again recorded that she had not been able to assess the man after he had completed his alcohol detoxification, as he was not available. She relisted him for a nurse assessment the next day.

52. After lunch, at around 1.45pm, an officer unlocked the man and his cellmate. He went to the education department for his induction. A member of education staff told the investigator that they had delayed his education induction, until he finished his alcohol detoxification programme. This was routine. She saw him at around 2.30pm, and told him that he would have to complete an English and maths assessment. He explained he did not have any glasses. She said that he seemed frustrated about this and said that he had asked his brother to send them to him. He said he would like to read a newspaper and she thought he felt a bit held back by not having his glasses. She said that she usually had spare glasses or a magnifier, but other prisoners were using them. She asked him to come back the next day, and said that he seemed fine about this.

53. A SO said that she had spoken to the man at some point during the day when he asked for, and she had given him, some razors. She said this was a routine request and razors were freely available to prisoners unless the prison had assessed them as at risk of suicide or self-harm. She said that she had also seen him outside the wing office that afternoon and he had said that he was all right. She saw nothing in his demeanour to concern her.

54. CCTV footage shows that an officer locked the man in his cell at 3.13pm. (The officer does not remember him.) He came back from a healthcare appointment at 3.49pm and waited for an officer to unlock his cell. At 4.17pm, an officer unlocked the door for the man's cellmate, who went in to get his hot water flask and came straight back out. The cellmate said that he believed the man was asleep on the bottom bunk as he could see the shape of a person under the sheets. He went to get some hot water.

55. A minute later, the cellmate went back to his cell and tried to open the toilet door but it would not open. He could see through the gap that the man was hanging on the back of the door. He immediately told Officer A, who was on the landing nearby. He did not go back into the cell and stayed in a cell with a Listener that evening.

56. Officer A immediately went into the cell and could see the man through a crack in the toilet door. He was hanging by a bed sheet from the door handle in a seated position, just above the floor. It was 4.20pm. He did not have a radio so shouted for staff assistance and forced the toilet door open. He supported the man's weight and used an anti-ligature knife to cut the sheet from his neck. As he did so, he said that he slipped from his grip and fell backwards onto the floor and banged his head.

57. Officer A pulled the man into the main area of the cell. He heard a rasping noise from his throat and thought he was still breathing. He called his name, but there was no response. His eyes were fixed and he could not find a pulse. The officer went back to the cell door to call for help again.

58. The SO had been on another landing when she heard the officer shout for help. She started running towards him and radioed the control room to ask for

staff assistance, although she did not know the nature of the emergency at the time. The SO said that there were normally only two radios on the wing, so she did this to avoid any delay. When she got to the landing, an officer shouted that it was a code blue (indicating a life-threatening situation such as when a prisoner is not breathing, is unconscious or is hanging) and they needed a nurse. She then immediately radioed a code blue emergency.

59. A nurse was in the centre surgery when he heard the officer's call for help and he was the healthcare first responder that day. Another nurse was with him and they immediately went to the cell. On their way there, the nurse heard the SO radio the code blue emergency and he asked his colleague to get the emergency bag, including a defibrillator. (A defibrillator is a life-saving device that gives the heart an electric shock in some cases of cardiac arrest.)

60. CCTV records show that the nurse got to the cell within a minute of the officer finding the man and the SO arrived seconds later. The nurse examined him but could not find a pulse. He noted that he had unresponsive pupils, was floppy, looked grey and was not breathing. He asked the officer to hold his head straight and he began chest compressions. According to the incident log, the control room called an ambulance at 4.24pm. The timings do not match with the CCTV, but it appears that there was no delay calling an ambulance once the code blue was called and he received prompt emergency treatment.

61. Two more nurses arrived seconds later and assisted with chest compressions, while the first nurse inserted an airway. Two more nurses arrived shortly afterwards, with the emergency bag. They attached the defibrillator but this did not detect a shockable heart rhythm. The nurses administered oxygen and attached an Ambu bag mask to assist resuscitation, while continuing chest compressions. One nurse told the investigator that the man was cold to the touch.

62. According to the log completed by an officer at the cell, paramedics arrived at the cell at 4.37pm. The resuscitation efforts continued but, at 4.59pm, a paramedic pronounced the man dead.

63. The Governor held a debrief to review the incident and offer support to the staff involved in the emergency response.

64. The prison family liaison officer and an operational manager left the prison just after 6.00pm and went to inform the man's brother, who he had nominated as his next of kin, of his death. On 16 April, the Governor wrote to express his condolences and to offer his, and the family liaison officer's, support and help. The prison helped organise and pay for the funeral, in line with national policy.

65. The man's sister said that she had been upset by the way the prison treated her after her brother's death. She told the investigator that she had telephoned the prison after her brother died and a manager had said that he would ask the police family liaison officer to speak to her. This was because she was not listed as her brother's next of kin and they needed to verify her identity. The manager could not recall whether he had asked the police family liaison officer to contact her, or had asked her to contact them. There was no

record of this in the prison's family liaison log and she had no further contact from the prison.

66. The man's sister had given the police a statement on 1 April, which she said included information about her brother's risk of suicide at the time. After he died, his sister telephoned the officer who took her statement, as she was concerned that the police had not passed this information to the prison. She said that the officer had told her that the information had been passed to the prison and it was up to the prison what action they took. The investigation found that the police did not pass any information to the prison about the man's risk of suicide.

67. The prison recovered a letter dated 14 April, from the wing post box, which the man had written to his brother. In the letter he asked his brother to bring him some belongings urgently, including a watch, glasses and clothes. He asked for his brother and niece's phone number and said he wanted to talk to him about their mother.

68. A prisoner told the investigator that he had overheard two prisoners talking in the showers after the man had died. He believed it was either the evening of 14 April or the next morning, but was not sure which. He said that one of the prisoners had told the other that he had repeatedly teased him about stabbing someone for money. He said he would not be able to identify the two prisoners and he did not witness anyone talking to him in this way. Other than this account, no other prisoners or staff, said that they witnessed or heard about such behaviour. There were no relevant security information reports no other evidence of bullying.

69. On 15 April, unaware that the man had died, the Criminal Justice Liaison Team (CJLT) emailed the administrator for the single point referral meeting. They indicated that the man did not fit the criteria for their service as he had not attended appointments in the community. They suggested that he should be referred to the prison's psychological services.

ISSUES

Assessment of the man's risk of suicide or self-harm

70. The man's brother and sister were concerned that information they had given to the police about his risk of suicide was not passed onto the prison. His brother had told police that he was worried about his brother's state of mind as he had attempted suicide in the past. He had told the officer who arrested him "tried to commit suicide but that didn't work". His sister said that she had told police, on 1 April, that she was concerned he would commit suicide. She said that she had telephoned an officer after his death, who told her all the information she had given him had been passed to the prison.

71. The Detective Sergeant investigating the man's death confirmed that none of the information from the man's family or the arresting officer about his risk of suicide was passed to the prison. This matter is outside the remit of the Prison and Probation Ombudsman and is currently subject to an internal investigation by the Merseyside Police Professional Standards Department.

72. Prison Service Instruction (PSI) 64/2011, which covers safer custody procedures and PSI 74/2011, about early days in custody, both list a number of risk factors and potential triggers for suicide and self-harm. The man had a number of the listed factors that are significant indicators of risk of suicide, including early days in custody; substance misuse and detoxification; previous self-harm; a family history of suicide, a mental illness diagnosis such as depression; court appearances and violent offences, especially against family members or partners. There is little evidence that staff took these factors into account when assessing his risk

73. It is concerning that the police had not flagged up to the prison the information they had about the man's risk of suicide. However, even without that information, the prison knew enough about his circumstances to suggest that they should have begun ACCT suicide and self-harm prevention procedures. He had been charged with the murder of his partner; he had a history of alcohol misuse and was undergoing an alcohol detoxification; his daughter had committed suicide a year earlier; he suffered from depression and his GP had recently referred him to community mental health services. He told a nurse in reception that he suffered from anxiety, mood swings, paranoia and anger management issues. All these factors were significant indicators of risk of suicide and self-harm, and should have alerted staff. Although he told prison staff that he had no thoughts of suicide and self-harm, with this range of risk factors, it is difficult to understand how they concluded that he was not at risk of suicide.

74. We are concerned that staff did not consider all the available information when assessing the man's risk and that they did not share information with each other to make a holistic assessment. Few of the staff questioned him about the circumstances of his arrest and his murder charge. It is worrying that some of the staff said that they preferred not to know the reasons why someone was in prison – although this is a crucial factor when assessing risk of suicide or self-harm. The first night officer had no information about him and relied entirely on what he told him. The doctor who assessed him the day after he arrived in prison, was unsure whether he had reviewed his medical

record from the day before. We consider that the investigation has identified an incoherent and uncoordinated approach to assessing risk of suicide and self-harm at the prison and all staff need to be clear about their responsibilities.

75. Staff judgement is fundamental to the suicide and self-harm prevention system, which relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. However, we are concerned that the staff relied so heavily on the man's assurances that he had no thoughts of killing himself rather than making an assessment taking into account all his risk factors. There is no evidence that they gave any consideration to opening an ACCT. A prisoner's presentation is obviously important and reveals something of their level of risk. But, it is only a reflection of their state of mind at the time they are seen by the member of staff and should be considered as a single piece of evidence used to make a judgement of risk. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.**

76. In April, the man made a court appearance by video-link, when key legal dates were set including his trial date. Later that day he hanged himself in his cell. Prison Service Order 3050, on continuity of healthcare, specifies a court appearance by video-link as a significant event that can affect the health of a prisoner and that prisoners might need to be assessed for risk of suicide and self-harm afterwards.

77. The Head of Healthcare at Liverpool told the investigator that after his appearance, the man should have gone to reception for a nurse to assess him or officers in the video-link facility should have called healthcare staff to allocate a nurse to come to see him. She said that the prison had sent these instructions to all prison staff. The officer who works in the video-link facility appeared unaware of this instruction and told the investigator that she would only contact healthcare staff if she had particular concerns about a prisoner. A court appearance by video-link can have a significant impact on a prisoner and we agree with the Head of Healthcare that nurses should assess prisoners after a video-link hearing, just as they would if they had returned through reception after attending court in person. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff assess prisoners for risk of suicide and self-harm and other

potential health issues after a court appearance by video-link, and notify wing staff of any concerns.

Mental Health Assessment

78. A nurse made a standard mental health referral to the single point meeting on the day the man arrived at Liverpool. The meeting of 7 April discussed the referral and allocated his case to the Criminal Justice Liaison Team based at the courts. They referred it back to the prison on 15 April, the day after he died, as he did not meet their eligibility criteria. This meant that no one assessed his mental health during his time at Liverpool.

79. It is concerning that the mental health referral team did not appear to understand the referral criteria for the Criminal Justice Liaison Team. In another recent investigation into a death at Liverpool, we noted that there was a good range of mental health services at the prison, but there was no clear line of accountability and confusion about the model for service delivery. In that investigation, we found that this led to a mental health assessment being missed. The Governor agreed that mental health services need streamlining and said that this was planned.

80. We agree with the clinical reviewer that the nurse should have made an urgent referral for the man to have a mental health assessment the day he arrived at Liverpool. He had a diagnosis of depression, his daughter had died by suicide, and he said that he suffered from paranoia, anxiety, mood swings and anger management problems. He reported that his GP had referred him to community mental health services. Doctors who saw him later that day and the next morning, also missed opportunities to refer him. We consider that the murder charge alone, particularly as his partner was the victim, should have resulted in an urgent mental health assessment.

81. The Head of Healthcare said that when a prisoner arrives on a charge such as murder they will now receive a mini mental state assessment in reception before the single point referral is actioned. We make the following recommendation:

The Head of Healthcare should ensure that mental health referrals for newly arrived prisoners charged with serious offences are prioritised and the prisoner is seen within two days of a referral being made.

Obtaining GP records

82. On 31 March, a doctor telephoned the man's community GP to confirm his prescription of anti-depressants. This was good practice. However, we consider that healthcare staff should have obtained further details from his GP, particularly as he said his GP had recently referred him to the community mental health team. This could have provided further insight into his risk of suicide and self-harm, alcohol misuse and history of depression. Prison Service Instruction (PSI) 74/2011, Early Days in Custody, requires efforts to be made to retrieve any information required from the prisoner's GP, or other relevant service the prisoner has recently been in contact with. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison

Managing alcohol detoxification

83. As part of his alcohol detoxification programme, nurses from the drug dependency unit should have assessed the man twice daily for the first three days. It appears that staff tried to see him to carry out the required observations, but they did not assess him after the first day. The staff did not escalate this issue to anyone or attempt to see him at another time or elsewhere in the prison. After he had completed his detoxification, drug dependency unit staff should have assessed him on day ten. A nurse attempted to do this but the records show that she was unable to see him because the prison was in lockdown. She went back to complete the assessment again four days later, on the morning of 14 April, but he was not in his cell at the time. (It is possible that he was at the video-link.)

84. We are concerned that none of the drug dependency unit staff checked previous entries on the man's observation sheets. Had they done so, they would have noted that no one had assessed him, since the morning of 1 April. The Head of Healthcare said that after his death, she had reviewed his medical record and realised that the staff had not raised the problem of getting access to him with anyone. She discussed this with the Governor and they instructed drug dependency unit staff to escalate the matter to the duty governor if necessary when they cannot get to see a prisoner for observations.

85. Part of the difficulty in assessing the man was caused by location in the prison. After spending one night on A wing, he should have moved to H wing, usually used for prisoners withdrawing from drugs or alcohol. Drug dependency unit staff said it was helpful to have prisoners on detoxification programmes on H wing as this meant they did not have to go to different prison wings to observe them. Officers on H wing were also more familiar with their practice and routines. We understand that prisoners withdrawing from drugs or alcohol are still held on other wings, but there is now a process for drug unit staff to request a move to H wing. This is escalated to the duty governor if a move cannot take place. We make the following recommendation:

The Governor and Head of Healthcare should ensure that, so far as possible, prisoners withdrawing from alcohol are held on H wing after their induction and that drug dependency unit staff assess and support them in line with the local policy.

Medicines administration

86. The GP prescribed librium for the man to take three times a day for the first nine days he was in prison. There are five missing entries on his prescription chart for this medication. A nurse told the investigator it was common practice for nurses to issue medication by taking instructions over the telephone, without seeing the prescription chart. This meant that they dispensed the medication without recording it on the prescription chart. She understood that this contravened the Nursing and Midwifery Council (NMC) standards. It

is possible that he chose not to collect his medication but without a record we cannot know. If he did decide not to take it, it should have been recorded.

87. The Head of Healthcare did not accept that nurses issued medication on the basis of advice over the telephone. She said it was not possible for nurses to annotate the prescription chart when a prisoner had not attended to collect it, as it would be too time consuming. However, she was aware that this contravened NMC standards. She said that she was in the process of reviewing with the pharmacy the arrangements for prescribing medication.

88. Subsequently a memo was issued to the drug dependency unit staff indicating that the prescription charts for librium must be completed for every dose and a monthly audit would take place. The monthly audit for August 2014 indicated that there were some problems; some entries were left blank, prescription cards were not always on the same wing as the prisoner and sometimes the cards were filled in before the prisoner had received his medication. They were trying to resolve these problems. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff administer medication in line with Nursing and Midwifery Council standards.

Wing staff's knowledge of the man

89. An officer was assigned as the man's personal officer, but had not introduced himself to him. The officer said that he had worked on the wing for only four of the fourteen days the man was there. Wing officers told the investigator that staff reductions had caused difficulties, that staff were often reassigned at short notice to other wings and that there were fewer officers on each wing. A SO said there has also been an increase in the number of staff on sick leave, often with stress.

90. The man was an older prisoner with short-term memory problems. It is possible this was part of the reason he missed his healthcare appointments. He did not have his glasses so found it difficult to read. He had no money to buy items such as tobacco. We acknowledge the difficulties of running a successful personal officer scheme in a large local prison such as Liverpool with a high turnover of prisoners. However, there were no entries in his record to evidence any interaction or support from wing officers. This is unacceptable, particularly in the light of his evident vulnerabilities. We make the following recommendation:

The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

Family Liaison

91. The man's sister said she had been upset by the way the prison treated her after his death. She said a manager had told her that he would ask a police family liaison officer to visit her, but this never happened. He could not

remember this and the conversation is not covered in the prison's family liaison log. No one from the prison contacted her again. The manager said that he was mindful that there had been a family estrangement and at one point the man's brother had not wanted his sister involved in organising the funeral, and did not want her to attend. There were also victim issues involved. He said he had dealt with multiple family members in the past, and they had done so after his death. We recognise that some commendable family liaison work took place after his death. However, it is important for prisons to include all members of the family where possible and to log all decisions made about contact with a deceased prisoner's family. We make the following recommendation:

The Governor should ensure that family liaison after a death at the prison follows national guidance and, where possible, includes all appropriate family members.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of newly-arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors.

2. The Governor and Head of Healthcare should ensure that healthcare staff assess prisoners for risk of suicide and self-harm and other potential health issues after a court appearance by video-link, and notify wing staff of any concerns.

3. The Head of Healthcare should ensure that mental health referrals for newly arrived prisoners charged with serious offences are prioritised and the prisoner is seen within two days of a referral being made.

4. The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison.

5. The Governor and Head of Healthcare should ensure that, so far as possible, prisoners withdrawing from alcohol are held on H wing after their induction and that drug dependency unit staff assess and support them in line with the local policy.

6. The Head of Healthcare should ensure that all healthcare staff administer medication in line with Nursing and Midwifery Council standards.

7. The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes.

8. The Governor should ensure that family liaison after a death at the prison follows national guidance and, where possible, includes all appropriate family members.

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
1	The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception and first night staff: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. • Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors	Accepted	Training will be delivered to Reception, First Night and Healthcare staff concerning Risk and Triggers. GNTS 139/14 and 106/13 will be supported by an Individual letter to all staff carrying out First Night, Reception screening advising them about Risk and Triggers and ACCT opening where a concern exists. In addition, staff will be reminded not to base judgements solely on Prisoner self-reporting of risk. Work to adapt the System One reception screen to ensure an Assessment of Risk factors are made when carrying out.	1st April 2015 Head of Safer Custody	
2	The Governor and Head of Healthcare should ensure that healthcare staff assess prisoners for risk of suicide and self-harm and other potential health	Accepted	All prisoners appearing in court by video link who have a change of circumstance, or who video link staff have any concerns	31st March 2015 Healthcare	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	issues after a court appearance by video-link, and notify wing staff of any concerns		about, will be seen by healthcare. Video link staff will be reminded of the fact that a court appearance that does not result in a change of circumstances can also have the effect of increasing the risk of self-harm or suicide, and that it is their responsibility to be vigilant in their interactions with prisoners. They will be reminded that: - where they identify a clear risk of self-harm or suicide they must open an ACCT; - where they have some concerns or have received information that there may be an issue, but are not sure that an ACCT is warranted, they should refer the prisoner to healthcare staff for a more detailed assessment of risk.		
3	The Head of Healthcare should ensure that mental health referrals for newly arrived prisoners charged with serious offences are prioritised and the prisoner is seen within two days of a referral	Accepted	All registered general nurses (RGNs) will be given Mental Health awareness training. A new reception model that concentrates on immediate risk is	1st April 2015 Healthcare 1st June 2015 Healthcare	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
	being made		currently being developed. This will be followed by a comprehensive secondary screening within 48 hours on the Induction wing.		
4	The Head of Healthcare should ensure that healthcare staff request community GP records when a prisoner first arrives at the prison	Accepted	GP consent is now sought for all prisoners entering HMP Liverpool where confirmation of Medication and a summary of health is made.	Healthcare Complete	
5	The Governor and Head of Healthcare should ensure that, so far as possible, prisoners withdrawing from alcohol are held on H wing after their induction and that drug dependency unit staff assess and support them in line with the local policy	Accepted	All prisoners subject to detox are located onto H wing after Induction. The only exception is for Vulnerable Prisoners.	Head Of Residence complete	
6	The Head of Healthcare should ensure that all healthcare staff administer medication in line with Nursing and Midwifery Council standards.	Accepted	All NHS staff have been written to by the Director of nursing reminding them of their requirement to adhere to NMC guidance. A Pharmacy medication management action plan has been introduced which covers the storing and dispensing of medication in with NMC. This is being monitored by the prison and commissioners.	Head of Healthcare Complete	

Action Plan					
No	**Recommendation**	**Accepted/Not Accepted**	**Response**	**Target date for completion and function responsible**	**Progress (to be updated after 6 months)**
7	The Governor should ensure that officers have meaningful contact with every prisoner, through an effective personal officer scheme, which ensures that officers get to know prisoners and identify their needs backed up by regular case history notes	Accepted	A personal officer scheme is in place. A system of management checks of PNOMIS case notes entries to monitor interaction has been implemented.	Head of Residence Complete	
8	The Governor should ensure that family liaison after a death at the prison follows national guidance and, where possible, includes all appropriate family members	Accepted	All Family Liaison officers have been reminded that family members where relationships are fractured should also be identified and supported	Head of Safer Custody Complete	