

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of a man, a prisoner at HMP Liverpool in January 2015

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit [nationalarchives.gov.uk/doc/open-government-licence/version/3](http://nationalarchives.gov.uk/doc/open-government-licence/version/3) or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: [psi@nationalarchives.gsi.gov.uk](mailto:psi@nationalarchives.gsi.gov.uk).

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future. This is the investigation report into the death of a man, who was found hanged in his cell at HMP Liverpool in January 2015. He was 24 years old. I offer my condolences to his family and friends.

Although the man was identified as at risk of suicide and self-harm when he arrived at Liverpool, I am not satisfied that the subsequent procedures were managed effectively enough to give him the support he needed. There were also some delays in him receiving treatment for benzodiazepine withdrawal and I am concerned that, although he was identified as at risk of suicide and self-harm and referred twice to specialist staff, he never had a full mental health assessment while he was at Liverpool.

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**

**November 2015**

## Contents

Summary .....	
The Investigation Process .....	
Background Information .....	
Key Events .....	
Findings.....	

# Summary

## Events

1. On 22 January 2015, the man was charged with harassment and remanded to HMP Liverpool. This was his first time in prison. He had a history of self-harm, drug abuse, anxiety and depression. A reception nurse began Prison Service suicide and self-harm prevention procedures, known as ACCT, and referred him to the mental health team. A doctor prescribed medication to alleviate symptoms of drug withdrawal and to help him sleep.
2. The man spent his first night in the induction wing. He was not allowed to telephone anyone because of public protection concerns. The next day, he moved to the drug treatment wing and began a methadone programme. He was later prescribed medication for withdrawal from benzodiazepines.
3. That day, 23 January, at an ACCT assessment, the man was distressed that he had not been allowed to contact his family to let them know where he was. He said he might harm himself. His mental health and contact with his parents were identified as his main issues. A subsequent ACCT case review noted that both concerns had been addressed, although nothing substantive had been done.
4. Later that evening, another prisoner attacked the man, causing minor injuries. The next morning, 24 January, staff moved him to a shared cell on I Wing, a standard prison wing. That afternoon, a prison officer noted he was confused, unsteady on his feet and his speech was slurred. He denied taking any illicit substance. In the evening, he asked if he could phone his mother and his son. An officer told him he would have to wait until the next day.
5. On 25 January, the man had a mental health triage assessment. The nurse recorded that his main concerns were to receive methadone and diazepam and to let his family know that he was in prison. He said he heard voices every day but had no thoughts of suicide or self-harm. The nurse noted he would be discussed at a mental health team meeting and should have a further review to assess his auditory hallucinations. He had no further contact with the mental health team.
6. The man asked to make a phone call, but was told he was not allowed to phone anyone for public protection reasons. A nurse saw him shortly afterwards and noted that he appeared to have taken an illicit substance.
7. Around 10.30pm on Tuesday 27 January, the man's cellmate told the night officer that he was concerned about him, who was aggressive and said he was hearing voices and would kill himself. The night manager moved his cellmate to another cell but did not review his risk.
8. The night officer noted in the ACCT record that the man had pressed his cell bell throughout the night to ask for tobacco. He continued to ask for tobacco the next morning and was aggressive when staff challenged his behaviour. A member of staff from the public protection unit and drug support worker spoke to him during

the morning. He continued to be abusive and aggressive. An officer noted he appeared to be talking to himself.

9. The following afternoon an officer went to collect the man for a video link court hearing. When she unlocked the door, she found him had hanged himself. Resuscitation efforts were unsuccessful and, at 2.17pm, the prison doctor and paramedics pronounced him dead.

## Findings

10. Although the man was appropriately identified as at risk of suicide and self-harm when he arrived at Liverpool, we are not satisfied that officers managed the procedures effectively enough to give him the support he needed. Two caremap actions, for a mental health assessment and for someone to telephone his parents to let them know he was in prison, were marked as completed at his ACCT case review, but he had not had a mental assessment and no one had contacted his parents.
11. The day after he arrived at the prison, the man was assaulted by another prisoner. This was not properly investigated and no one considered whether this affected his risk. Despite further concerns about his safety, including the possibility he was using illegal drugs, no one reassessed his risk of suicide and self-harm. Some staff, who had key interactions with him, did not know he was being managed under ACCT procedures.
12. There were some delays in the man being prescribed diazepam and we are concerned that, although he was identified as at risk of suicide and self-harm and referred twice, he never had a full mental health assessment.

## Recommendations

- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
  - setting levels of observations that reflect the assessed risk;
  - reviewing the prisoner's risk and level of support as circumstances change, with ACCT case reviews where appropriate;
  - setting ACCT caremap actions are specific, meaningful, and not marked as completed until the identified issues have been resolved
  - recording all significant events which might indicate a raised risk of suicide or self-harm in the ACCT document.
- The Head of Healthcare should ensure that prisoners receive medication as prescribed and that there are no unnecessary breaks in treatment.
- The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator visited Liverpool on 4 February 2015. He obtained copies of the man's prison and medical records.
15. The investigator interviewed 22 members of staff and one prisoner at Liverpool in March.
16. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
17. We informed HM Coroner for Liverpool and Wirral of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. The investigator and one of the Ombudsman's family liaison officers met the man's parents to explain the investigation. They had the following questions they wanted the investigation to consider:
  - Why were their son's family or his girlfriend not told that he was in prison?
  - How long had their son been in the prison?
  - Did their son have any marks on him?
  - Had the prison been in 'lockdown' during while their son was there?
  - Had their son been the victim or perpetrator of any bullying?
19. The man's mother gave the investigator the names of two prisoners she believed might have information that her son was being bullied at Liverpool. The two prisoners were released from prison soon after his death. We wrote to them to invite them to talk to us, but we were told that they did not live at the addresses we had for them.
20. The man's family received a copy of the draft report and indicated that there were no factual inaccuracies in the report.

# Background Information

## HMP Liverpool

21. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. Healthcare is delivered by Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust. The Lifeline team provides interventions and services for prisoners with drug and alcohol problems. Prisoners can access mental health services through one of three pathways: either a weekly single point of referral meeting, through secondary mental health screening or through crisis intervention services.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Liverpool in May 2015 has yet to be published. In preliminary inspection feedback, inspectors reported that all new prisoners had a private interview in reception and there was a good focus on vulnerabilities. Levels of self-harm and the subsequent use of suicide and self-harm prevention procedures (ACCT) were lower than in comparator prisons. The quality of ACCT documents varied and too many lacked consistent case management, were insufficiently multidisciplinary and had inadequately completed caremaps.

## Independent Monitoring Board

23. 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 2014 noted that the healthcare providers had changed, which had led to some improvements, including better healthcare involvement in ACCT procedures. The Board reported that the prison had a positive suicide prevention policy. Overall, the Board concluded that staff at Liverpool provided a high standard of professional care, despite difficult circumstances.

## Previous deaths at HMP Liverpool

24. Since April 2010, there have been nine apparently self-inflicted deaths at Liverpool, including that of the man. Four of the deaths occurred within two weeks of the prisoners' arrival. We made recommendations about the need to improve ACCT procedures in each of these investigations.

## Assessment, Care in Custody and Teamwork

25. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
26. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in

place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

27. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

## Key Events

28. On Thursday 22 January 2015, the man was arrested and charged with breaking the conditions of a restraining order to prevent him harassing his parents. He appeared in court and was remanded to HMP Liverpool. His next hearing was scheduled for Wednesday 28 January, by video link.
29. The man arrived at Liverpool around 5.50pm. His escort record noted that he had previous convictions for affray, possession of drugs and possession of a kitchen knife in a public place. Court officers did not record any risk of suicide or self-harm.
30. Reception officers recorded the man's personal details and he named his girlfriend as his next of kin. An officer interviewed him and noted that he was on remand charged with breaching a restraining order. It was his first time in prison. He said that he had no thoughts of suicide or self-harm. He said that he had a heart condition. The officer referred him to the Drug Dependency Unit (DDU) for treatment because he reported use of illegal drugs.
31. The officer explained the prison rules to the man. He said that he had not expected to be sent to prison, but otherwise did not raise any concerns. The officer noted that he had explained the support available. He was assessed as suitable to share a cell.
32. At 7.26pm, a nurse assessed the man, who told her that it was his first time in prison. He said that he did not drink alcohol but used heroin and crack cocaine daily. He said that he had previously spent two days in a psychiatric hospital and had self-harmed all his life by cutting his arms; the last time had been in November 2014. He said he did not have any current thoughts of suicide or self-harm. She noted he had symptoms of anxiety and depression and he asked to be referred to the mental health team.
33. The nurse decided to open an ACCT because the man had a history of self-harm, was withdrawing from drugs, was low in mood and she considered him a vulnerable adult because of his unusual behaviour. (At interview, she was unable to recall what was unusual about his behaviour.) She referred him to the substance misuse doctor and the mental health team by completing a Single Point of Referral (SPoR) form, noting that he suffered from anxiety and depression. (The SPoR is part of the multi-disciplinary referral process. Allocation for assessment by specialist mental health services takes place every Monday, so the nurse anticipated that he would be discussed on Monday 26 January.)
34. An officer completed an ACCT immediate action plan and noted that the man would benefit from sharing a cell. He set the level of observations as six times during the day and six times at night until his first ACCT review. The officer noted that the man was waiting to see the drug dependency team and was subject to Public Protection Unit (PPU) restrictions. The officer noted in the ACCT document that the man had given his girlfriend's name and address as his next of kin but not her phone number. The officer told him about the support available to him, including Listeners (prisoners trained by the Samaritans to support other prisoners who are distressed).

35. A drug test showed that the man was positive for opiates, cannabinoids and benzodiazepines. He told a nurse that he used two bags of heroin, two rocks of crack cocaine daily and 25 10mg tablets of benzodiazepines each day. He showed some signs of withdrawal symptoms and she referred him to the reception doctor that evening and to the drug dependency unit doctor the next day.
36. A locum GP saw the man and prescribed paracetamol and ibuprofen, to help relieve his withdrawal symptoms, and zopiclone to help him sleep. The GP noted his history of self-harm and that a nurse had opened an ACCT. He told the GP that he had some thoughts of suicide and self-harm. (We were not able to interview the GP as he was out of the country during the investigation.)
37. The man arrived on A Wing, the induction wing, around 9.10pm. An operational support grade recorded in the ACCT document that the man wanted to make a phone call but was not allowed one. Staff did not record any concerns during his first night at the prison.

### **Friday 23 January 2015**

38. The next morning the substance misuse doctor saw the man and recorded on SystmOne (the prison medical record) that he was feeling suicidal. The doctor told the investigator that he believed this was because he was withdrawing from opiates. He prescribed a methadone reduction programme, with 30mls on the first day, 40mls for 14 days and then a reduction of 5mls each week after that.
39. The doctor told the investigator that he was not aware that the man had been using benzodiazepines, as he did not mention them during the assessment. He had not noticed that a nurse Murray and the locum GP had recorded this on SystmOne during his reception screening.
40. That morning, a member of staff in the public protection team completed the man's case details form and noted that he was subject to harassment procedures involving his parents. Until further notice, he was not permitted to contact them by mail or phone while he was in prison. The member of staff did not see him to explain this.
41. The man completed his first day induction that morning. An officer recorded in the ACCT record at 12.10pm that she had spoken to him several times during the morning. She noted that he had appeared a little confused and wanted the nurse to increase his methadone.
42. Around 1.40pm, an officer assessed the man as part of ACCT procedures. He said his main concern was not being able to contact his parents or his girlfriend and their child. The officer explained that because of the restraining order, the public protection unit had to authorise any phone calls. He said that he suffered from short-term memory loss but was not taking the medication he had been prescribed for it. He said he misused drugs but did not drink alcohol. He said that he had a history of self-harm but gave no other details, except that he last harmed himself when he was in police custody. (The investigator found no evidence to support that he had harmed himself in police custody.) He said he might harm himself if he was not allowed to contact his family to tell them where

he was. The officer told the investigator that the assessment was difficult as the man was slurring his words and she was not sure what was causing this.

43. At 2.43pm, officers found the man lying on his cell floor. He was conscious but said he felt light headed. A nurse examined him and his blood pressure and pulse were within the normal range. He told her that he used benzodiazepines as well as opiates, but had not been prescribed a detoxification programme for that. She recorded on SystmOne that he had not previously admitted to using benzodiazepines, although this had been recorded on SystmOne the previous day. She referred him to the reception doctor.
44. At 3.30pm, a Supervising Officer (SO) held the man's first ACCT case review with a nurse from the drug dependency unit. An officer was not present but spoke to the SO before the review. (The officer told the investigator that she had not been invited to attend the review.) The SO told the investigator that the man had been upset and tearful during the review. He appeared confused and did not seem to understand the public protection restrictions against him, which she had to repeat several times. He was concerned that his mother would not know where he was.
45. The nurse told the investigator that she worked as an agency nurse solely to attend ACCT case reviews and to do secondary mental health screens. She recorded on SystmOne that the man was low in mood, it was his first time in prison, and he had a history of substance misuse which had led to restricted access to his family through restraining orders. He said that he had cut himself in the past as a coping mechanism but he had no current thoughts of suicide or self-harm. She said he did not appear to have any suicidal intentions or any concerns about being on the wing.
46. The SO knew that the man would soon move to the detoxification wing (H Wing), and decided that his level of observations should remain the same, six during the day and six at night, until he was settled on his new wing. She recorded that his risk of suicide and self-harm was raised and scheduled his next ACCT review for Friday 30 January. He told the SO that he felt better now that he had spoken to her.
47. The SO entered two actions on the man's caremap: for drug dependency unit staff to complete a secondary mental health screen, and that she would ask a chaplain to tell his family where he was. She signed and dated the caremap and noted that the actions had been completed. She told us that this meant she had asked the chaplaincy to contact his family. The nurse said that the mental health referral had been made, but the assessment had not been done.
48. The SO said that after the ACCT case review, she phoned one of the prison chaplains and asked him to let the man's mother know that he was in prison, but she did not know whether he had done this. The chaplain told the investigator that he could not recall the SO speaking to him about the man and he had not recorded this in the chaplaincy journal, which he would normally do. The man's family told us that no one from the prison contacted them until after his death.
49. Another SO said the man arrived on H Wing around 3.30pm on 23 January and shortly afterwards he told her that his belongings, including his prison-issue

cutlery and utensils, were missing. As she was supervising prisoners in the medication queue, she told him to speak to another officer. At around 5.00pm, she saw him with blood on his face and he told her he had been assaulted. She took him to the healthcare clinic and a nurse dressed and cleaned several wounds on his face. She noted that he appeared slightly disorientated and referred him to the doctor.

50. While they were in the clinic, the man told the SO that other prisoners had directed him to another prisoner's cell on the second landing where utensils were held, as he needed a plate and cutlery to replace his missing items. Four prisoners had followed him into the cell and one prisoner assaulted him before another prisoner intervened. He said he was scared to go back to the landing. She arranged for him to move to B Wing, a standard residential wing, the next day. She did not know that he was being monitored under ACCT procedures.
51. Around 5.45pm, the SO took the man back to his cell on H Wing. He was unsteady on his feet and a locum GP saw him in his cell at about 6.30pm. (The GP was not available for interview.) The GP recorded the injuries and noted that no further intervention was required. The GP prescribed a diazepam detoxification programme, including carbamazepine, an anticonvulsant, and diazepam. A nurse gave him diazepam.
52. The night officer recorded in the ACCT log at 8.00pm that the man said he had no thoughts of suicide or self-harm but was unhappy because he had no tobacco, which had been stolen on A Wing.

### **Saturday 24 January 2015**

53. At about 3.00am on 24 January, the man pressed his cell bell and asked the night officer for some tobacco but he did not have any. The officer gave him additional blankets, as he said he was cold.
54. At around 9.00am, the man moved to I Wing, a standard residential wing, where he shared a cell with another prisoner. (It is not clear why he moved to I Wing instead of B Wing.) The cellmate told the investigator that the man initially seemed disorientated, dazed, and possibly concussed but seemed okay after a brief sleep.
55. An officer told the investigator that he had answered the man's cell bell several times that morning. Once, the cellmate told him that the man had had a fit; he said that he kept looking as if he had gone to sleep and then would suddenly come round. The officer did not witness the alleged fit but he thought it looked as if he had taken drugs and asked a member of healthcare staff to attend. He told a nurse that he was okay and just wanted his methadone. There was no entry in his medical record about this incident, although the officer recorded in the ACCT that a nurse had attended. He denied taking any illicit substances.
56. During afternoon association, the cellmate told the officer that the man had been acting bizarrely. The officer found him on the landing. He was unsteady on his feet and appeared confused. His speech was slurred and he said he was lost. The officer recorded that he had taken him to his cell, told him to lie down and

locked the cell door so that he did not go onto the landing. He suspected that he might have taken an illicit substance and asked a nurse to see him.

57. At 2.15pm, a nurse examined the man and noted his blood pressure and pulse were within normal range. His pupil reaction was sluggish. He was incoherent and complained of nausea and a headache. He denied taking any illicit substances. A nurse referred him to the doctor.
58. At 3.19pm, a GP saw the man and recorded that he was difficult to understand because his speech was slurred and he was drowsy. His pulse was now higher. The doctor thought that he might have taken an illicit substance and arranged to review him again later. A GP saw him again at 4.46pm, and noted that he did not have any symptoms of a head injury. The GP asked staff to monitor him for the next six hours, in case he had taken an illicit substance.
59. At 5.00pm, an officer recorded in the ACCT log that the man had asked to phone his family. All prisoners were locked up for the evening and the officer told him that he would have to wait until the next day.
60. An officer noted in the ACCT log at 7.20pm that the man said he was okay but wanted to know when he would receive his prescribed medication. The officer told him to speak to a nurse. (He had received methadone in the early afternoon, but had not received diazepam.)

### **Sunday 25 January 2015**

61. Around 10.50am, a nurse completed an initial mental health triage assessment. (He recorded this on SystmOne using another nurse's log-in, as he was new and not yet on the system.) He noted the man's main concerns were getting his methadone and diazepam and ensuring that his family knew that he was in prison. The man told a nurse that he heard voices of dead members of his family every day, but the nurse noted that he did not have any other psychotic symptoms. He said that he did not have any thought of suicide and that he would not harm himself because of his son.
62. The nurse did not use a standard screening tool when he assessed the man. He recorded the following actions:
  - Discuss [the man] at SPoR meeting
  - Discuss with DDU staff possible use of illicit drugs on the wing
  - Further review regarding the auditory hallucinations
  - Bereavement counseling
63. The nurse completed another single point of referral form and a screening assessment form. The man did not have any further contact with the mental health team before he died.
64. At 10.15am, an officer noted in the ACCT log that the man had asked him if he could make a phone call. The officer said he could not, because of public protection restrictions.

65. At 11.42am, a nurse saw the man in the substance misuse clinic and noted that he might have taken an illicit substance. He appeared sedated so staff did not give him his methadone. He was adamant that he had not taken anything and complained that he had not received the diazepam he had been prescribed on 23 January. She found that the prescription chart had been misplaced and received diazepam that evening.
66. Around 4.30pm, a prisoner on another wing seriously assaulted a prison officer. As a result, the prison was 'locked down' until 28 January while staff searched for a weapon. This meant that prisoners were allowed out their cells only to attend visits, collect food, have a shower or make telephone calls. An officer recorded in the ACCT log that the man collected his evening meal around 5.00pm. No one noted any concerns about him.

### **Monday 26 January 2015**

67. At 9.30am on 26 January, a violence reduction officer saw the man briefly to discuss the assault on H Wing. He said he did not know where the cell was in which the assault happened, or who the assailant was. He said his only concern was to be kept away from the prisoner who had assaulted him. The officer told him that he would review CCTV footage and try to find out who this was and take action to ensure that they were kept apart. He said he felt safe on I Wing.
68. The officer reviewed the CCTV footage and in his investigation report. He noted that the CCTV footage showed a SO finding him, but the entrance to the cell could not be seen clearly. It did not show who had attacked him. Information from other prisoners suggested that some prisoners had directed him to collect a plate from cell H2-3. The prisoner whose cell it was returned and apparently found him taking other items from the cell and then attacked him.
69. The officer concluded that there was no evidence to indicate who had attacked the man, but that the prisoner from cell H2-3 should be confronted about the incident. However, no one interviewed the other prisoners who gave the information and no further action was taken either before or after the man's death.
70. At around 11.30am, a GP saw the man to follow up the reports that he had appeared sedated on Saturday afternoon. He suspected that the man had been sedated because he had taken an illicit substance or because of his methadone dose. He was alert, fully co-operative and displayed no evidence of any significant drug withdrawal symptoms. He told the GP that he wanted his methadone and said that in the community he took 50 to 100 diazepam tablets. The GP recorded that he had no thoughts of suicide or self-harm. He reinstated a revised methadone prescription (20mls day one, 25mls day two and 30mls thereafter) and noted that he should continue to receive his prescriptions of diazepam and carbamazepine.
71. The mental health team did not discuss the man at the single point of referral meeting on Monday 26 January, as should have happened, after the referrals from two nurses. (The administrator for the meeting said that a nurse submitted another referral, which he received on Tuesday 27 January, for the meeting on Monday 2 February 2015. It is not clear why the nurse made another referral.)

## Tuesday 27 January 2015

72. In a statement for the police, an officer said that he went to the medication hatch at 12.30pm. The man was collecting his medication, but was shouting and swearing at the nurse. He took him back to his cell and he continued to shout and swear.
73. The man had a video link court hearing on 28 January, and a member from the Lifeline drug and alcohol service went to see him at 3.00pm on 27 January to give him information about how to get further help if he was released. As the prison was still in lock down, she spoke to him through the cell observation panel. She said he seemed confused when she mentioned his court appearance the next day, but she had no concerns about him.
74. At 4.15pm, an officer unlocked the man to collect his methadone and to have a shower. She recorded in the ACCT log that he said he was okay. Later, he collected his dinner around 6.30pm. At 8.00pm, another officer recorded that he was lying in bed watching television.
75. The man's cellmate told the investigator that most days the man slammed the cupboard a lot, threw things about the cell, emptied the cupboard contents on the floor and then repacked them. He appeared forgetful and was always looking for something that he thought he had misplaced. He said that his behaviour got worse over time.
76. The cellmate told the investigator that at about 10.30pm on 27 January, while they were watching television, the man jumped up and turned the volume of the television to full. He started acting aggressively by slamming doors and throwing clothes onto the floor. He said he had not been given his medication and was hearing voices in his head.
77. The cellmate said he could not calm the man, who kept saying that the voices were telling him to do things, but he would not say what. He put a piece of plastic cutlery into his pocket and the cellmate was concerned that he might hurt him with it when he was asleep. The cellmate pressed the cell bell and told the night officer that he thought something was wrong with the man.
78. The night officer told the investigator that he answered the cell bell at 10.30pm and the cellmate appeared agitated. The man was at the back of the cell pacing backwards and forwards. He said that the cellmate told him that the man had threatened to "do himself in" and that he feared for his own safety. He asked the man how he was feeling and what was on his mind. The man denied having any problems with his cellmate. He said that he had no thoughts of suicide or self-harm or any intention to harm his cellmate. The man and his cellmate then argued briefly.
79. The officer thought the man and his cellmate should be moved apart and he phoned the night manager. The night manager told the investigator that he went to the wing at 11.10pm and spoke to both prisoners individually. He was not concerned about them, but decided to move the cellmate, at his request, to another cell. He said the man became agitated, but seemed to calm down after the night officer made him some tea.

80. The night manager and officer went back to the man's cell around 11.30pm collect some bedding for the cellmate. The night manager said that he had no concerns about him. The officer checked him shortly afterwards and again at midnight. Both times, he said he was okay.
81. Officers are required to patrol the wing landings approximately every 30 minutes throughout the night, until about 5.00am. As the man was on an ACCT, the officer checked him each time. At first, he was watching television, but began to get agitated and paced up and down the cell.
82. The officer said that at around 1.30am the man was throwing his cell furniture around and shouting that his cellmate had taken his tobacco. He threatened to hurt any one that came into his cell. The officer gave him a cigarette and he calmed down. (The officer did not note this in the ACCT record.) He stayed in bed sleeping for the next few hours.
83. The officer started a morning roll check of prisoners at around 5.00am. Shortly afterwards, he answered the man's cell bell and found him irate and throwing his furniture around. He said he wanted a cigarette. The officer suspected that he had taken an illicit substance. He tried to calm him down and told him that the day staff arrived about 7.00am and might arrange some tobacco for him. He calmed down. At 5.00am, the officer wrote in the ACCT record that the man had used his cell bell during the night because he wanted tobacco.
84. The officer observed the man at 5.30am and 6.00am sitting on his bed watching television. Around 6.30am, the day officer came on duty for the day and the night officer briefed him about the man.
85. The day officer said that the man was one of the first prisoners he checked after the handover. He asked for hot water for tea but the officer said he could get some later in the morning. Before he reached the end of the landing, the man pressed his cell bell again and he went back and warned him not to use the cell bell inappropriately. He swore at the officer. The officer said he had to go back to his cell three more times because he had pressed his bell. The third time, he started to bang and kick the door. The officer noted this in the ACCT record at the time.
86. At 9.02am, an officer noted in the man's record that she had given him a written warning for continued misuse of his cell bell and being aggressive to staff. Shortly afterwards, a member of the public protection unit went to his cell with the officer to explain the restrictions about him contacting his parents and to ask him to sign a form to confirm that he understood this.
87. The public protection worker told the investigator that when the officer unlocked the cell it was obvious that the man was not happy. He was pacing around the cell and appeared to be under the influence of either drugs or alcohol. She tried to explain why she was there but said he would not listen. The officer asked him to calm down but he pushed his way onto the landing and started shouting at the public protection worker that she should tell his parents that they were not allowed to see his son. The officer ordered him to go back into the cell. He then started kicking the cell door and swearing.

88. At about 9.40am, a substance misuse worker went to the man's cell to tell him that she had made an appointment for him in Wigan so he could continue with his methadone prescription if he was released from court later that day. He responded aggressively and said he did not want to engage with the substance misuse service. She gave him some information about the risk of overdose and tolerance levels to read and left him a document about confidentiality and sharing information for him to sign. When she went back about ten minutes later, he asked her to wait a minute, went into the toilet area and then appeared to have a heated argument. At first she thought he was speaking to his cellmate, but then realised he was the only occupant. She told an officer that she was concerned about him.
89. The officer went to the cell but could not see the man and presumed he was in the toilet area. He asked the man to return the paperwork to the member of the public protection unit, but he refused and would not come out of the toilet area. The officer said that he was not aggressive.
90. The public protection worker told the investigator that she thought that the man was hallucinating and was concerned about his mental health. She spoke to a dual diagnosis mental health worker, who told her to refer him to the mental health team. When interviewed, she said she had not known that he was on an ACCT or that he had mental health issues. (Lifeline staff do not have access to the SystmOne medical record.)
91. At approximately 11.45am, the man went to the medication hatch to collect his medication. A nurse said she had no concerns about him. An officer said he saw him collect his lunch and he looked calm. On his way back to his cell, he told an officer that he had had problems using the prison phone system. He said he had tried to enter his phone account number and it had not worked. The officer told him to put an application in to resolve the problem, but did not make an entry in the ACCT record about this conversation. The officer told us that he did not have any concerns about him when he locked him in his cell.
92. At 12.55pm (according to the CCTV) an officer responded to the man's cell bell and he asked her what time his visit was. She clarified that he meant the video link court hearing, and told him that an officer would collect him at the required time. He asked when he would get his methadone, and she again said an officer would collect him at the right time. She reminded him not to use his cell bell for non-emergency matters. (She did not write this in the ACCT record until after his death and later amended the time on the record to match the time on the CCTV footage. She did not note the reasons why she had amended the time on the ACCT document.)
93. At 1.41pm, an officer went to collect the man from his cell for the video link hearing. When she looked through the door observation panel, she saw him hanging from a ligature made from a blanket tied to the top bunk bed. She unlocked the door and shouted to staff on the landing below for help. Several officers arrived in less than 30 seconds.
94. A SO radioed a code blue emergency, which was recorded on the control room log at 1.42pm. At the same time, the control room called an ambulance. A GP who was in the wing treatment room and had heard the officer's shout for help,

took a bag with emergency equipment (including oxygen and defibrillator) to the cell.

95. An officer said they supported the man's body and removed the ligature from around his neck before placing him on the floor. Another officer started cardiopulmonary resuscitation using chest compressions. The GP said that he showed no signs of life when she arrived. She gave rescue breaths until the nurses arrived.
96. A nurse took over chest compressions from an officer and another nurse assisted the doctor. A nurse attached a defibrillator, which found no shockable heart rhythm. At 1.45pm, paramedics arrived at the cell and examined the man. He showed no signs of life. The paramedics continued cardiopulmonary resuscitation and administered oxygen and adrenalin. At 2.17pm, they confirmed that he had died.

### **Contact with the man's family**

97. The Head of Safety and Equalities acted as the prison's family liaison officer. At 4.00pm, he and the Governor visited the man's girlfriend, who he had named as his next of kin, to break the news of his death. While they were at her home, the family liaison officer contacted the man's parents, who came to meet them. He met with them the next day, on 29 January 2015, to give them more information.
98. The family liaison officer remained in contact with the man's parents and gave them information, including about the post-mortem and inquest process. The funeral was held on 23 February. In line with Prison Service instructions, the prison contributed towards the costs.

### **Support for prisoners and staff**

99. After the man's death, a governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
100. The prison posted notices informing prisoners of the man's death and outlining the support available to them. Officers spoke to all prisoners on I Wing and offered them support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by the death.

### **Post-mortem report**

101. The post-mortem examination concluded that the cause of the man's death was hanging. The toxicology results showed that he had previously used cocaine, cannabis, methadone, paracetamol, ibuprofen and carbamazepine and benzodiazepines.

# Findings

## Management of the man's risk of suicide and self-harm

102. When he arrived at Liverpool, the man had a number of factors which increased his risk of suicide and self-harm which included a restraining order to prevent him harassing his parents, a history of self-harm and depression and he was dependent on and withdrawing from drugs. We are concerned that reception officers did not spot his level of risk when he first arrived. However, the reception nurse identified him as at risk of suicide and self-harm and opened an ACCT.
103. In the short period the man was at Liverpool, we consider that staff did not manage the ACCT procedures effectively in order to address his risk of suicide and self-harm and give him the support he needed. A SO identified two issues for the caremap at his ACCT case review. The first issue was for him to have a secondary mental health screen, which had already been requested at his initial reception screening. The caremap indicated that the action had been completed that day, although he was still waiting for an appointment. He had told the ACCT assessor that he would harm himself if he was not allowed to contact his parents to tell them he was in prison. As he was not allowed to contact them directly, the second issue was for a prison chaplain to phone his family on his behalf and tell them that he was in prison. This action was also marked as completed on 23 January, but no one from the prison had contacted his family.
104. Although the man had been assessed as at raised risk of suicide and self-harm, staff were required to observe him, at most, only once every two hours, which we consider too infrequent for someone at raised risk. This level of observation was never changed. A prisoner assaulted him on his second day at the prison and because he said he did not feel safe on the wing where the attack took place, staff moved him to a different wing. No one considered whether this incident had increased his risk of suicide and self-harm. Prison Service Instruction 64/2011 states that if a prisoner is on an ACCT and an event occurs that raises concerns about their well-being, this should trigger an ACCT case review. No ACCT case review took place.
105. Prison Service Instruction (PSI) 74/2011 – Early Days in Custody, lists a number of risk factors and triggers for suicide and self-harm. It states that all staff should be alert to the increased risk of suicide or self-harm posed by prisoners during their early days in custody and act appropriately to address any concerns. This was the man's first time in prison and it was likely to have been a difficult time for him. He was described as a vulnerable adult, was withdrawing from drugs and had a history of self-harm. A number of staff were concerned about his presentation and behaviour. He had said he would harm himself if he was not able to contact his parents and had been assaulted two days after he arrived. Overnight on 27/28 January, his cellmate reported that he had said that he would "do himself in" and officers noted that he became agitated and threw furniture around. On 28 January, a worker from the Lifeline Service thought that he was hallucinating as he was involved in a heated argument even though he was the only person in his cell. Despite this, during his seven days at Liverpool, there were no further ACCT case reviews to review his risk, after the first case review

on Friday 23 January. Staff did also not record several notable incidents in the ACCT document, as they should have done.

106. Although a nurse correctly identified that the man was at risk of suicide and self-harm and opened an ACCT when he arrived at the prison, there was a lack of active support and review subsequently. No one considered whether his apparent poor behaviour was evidence of deteriorating mental health and increased risk. It is important that multidisciplinary case reviews are held after significant events that might affect a prisoner's well-being, that effective caremap actions are set and monitored to ensure prisoners receive active and continued support, and that the level of observations reflect the assessed level of risk. We make the following recommendation:

**The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:**

- **setting levels of observations that reflect the assessed risk;**
- **reviewing the prisoner's risk and level of support as circumstances change, with ACCT case reviews where appropriate;**
- **setting ACCT caremap actions are specific, meaningful, and not marked as completed until the identified issues have been resolved**
- **recording all significant events which might indicate a raised risk of suicide or self-harm in the ACCT document.**

### **Clinical care**

107. The clinical reviewer, made a number of detailed recommendations in his review, which the Head of Healthcare will need to address. We do not repeat them all in this report. Overall, the clinical reviewer concluded that the clinical care the man received was comparable to that which he could have expected in the community, but there were some concerns.

### ***Substance misuse treatment***

108. The man's substance misuse problems were identified by the nurse during his reception health screening on 22 January. The nurse recorded that he was dependent on opiates, cocaine, cannabis and benzodiazepines. The substance misuse doctor did not identify his benzodiazepine dependence when he saw him on 23 January and could not explain this oversight. He does not appear to have checked the SystemOne record. A GP prescribed diazepam the next day, as part of a detoxification programme, but his prescription chart was not transferred with him when he moved from H Wing to I Wing on 24 January. This meant that he did not receive diazepam until 25 January, which caused him further anxiety. A GP told the investigator that the planned introduction of electronic prescribing would reduce the risk of such errors, but that staffing issues meant that the new system had not yet been implemented. It is important that prisoners, especially when they are at risk of suicide and self-harm, receive appropriate medication when they are detoxifying. We make the following recommendation:

**The Head of Healthcare should ensure that prisoners receive medication as prescribed and that there are no unnecessary breaks in treatment.**

109. On 25 January, several members of staff thought that the man might have taken an illicit substance. (The clinical reviewer noted that Liverpool has recognized that there has been an increase in the use of New Psychoactive Substances, such as spice, which can cause bizarre or aggressive behavior and hallucinations.) Healthcare staff stopped his methadone prescription for a day as a precaution, but he received methadone again the next day after a doctor assessed him. We are satisfied that this approach was appropriate.
110. A worker from the Lifeline Service told the investigator that, when she went to see the man on 27 and 28 January, she had limited knowledge of his substance misuse and mental health history. This information is usually recorded on SystemOne, which Lifeline staff do not have access to. She did not know that he was on an ACCT. The clinical reviewer considered that Lifeline workers need access to all relevant information and appeared to operate in isolation. Use of SystemOne by Lifeline staff would ensure that more joined up, integrated approach to substance misuse treatment. We have recently made a recommendation about this issue following the death of a prisoner at Liverpool in December 2014. As the prison has only recently received that recommendation, we do not repeat it here.

### ***Mental health***

111. The nurse at reception identified that the man had a history of mental health problems and had been to hospital for a psychiatric assessment for two days in November 2014, after cutting himself. She referred him to the single point of referral meeting and for a mental health assessment on 22 January. On 25 January, a nurse referred him to the single point of referral for an assessment after an initial mental health triage.
112. Liverpool's local arrangements are that all potential cases for the mental health teams should be discussed and allocated for assessment at the single point of referral meeting, which takes place every Monday. The man's case should have been discussed at the meeting on Monday 26 January, but this was not done. This was a missed opportunity for the mental health team to review his mental health history and the evidence from the nurse's assessment the day before, in which he noted that the man might have used illicit drugs on the wing and had reported experiencing auditory hallucinations.
113. Although the man was assessed twice and referred to the mental health teams in the short time that he was at Liverpool, this did not result in any effective interventions being put in place for him. The referral meeting was the most likely forum for this to have happened, but the referral system did not work for him. It is not clear why. The clinical reviewer noted that at the time of his death there were transitional arrangements for mental health provision, which appeared to be causing some confusion.
114. We do not consider that the man's mental health was given sufficient priority for someone who had been identified as at risk of suicide and self-harm, with a history of self-harm, depression and anxiety and who had recently had a psychiatric admission. The clinical reviewer noted that a weekly referral meeting led to an inherent delay in the system. Even on 28 January, when he was behaving erratically and staff considered he might have been hallucinating, no

one referred him for an urgent mental health assessment through the Crisis Service. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations