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 the man in June 2011 at HMP Liverpool

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 the man, who was found hanging in his cell in HMP Liverpool in the early hours of June 2011. I offer my condolences to the man's family and friends.

The investigation was carried out by my investigator. A clinical reviewer was appointed to review the man's clinical care in custody. I am sorry for the delay in issuing this report, which was suspended during a criminal investigation into the circumstances of the man's death. HMP Liverpool cooperated with the investigation.

The man was arrested on 10 June 2011. During his remand at the police station and in court cells, he was constantly supervised after he threatened to harm himself. When he was remanded to prison, court staff sent a suicide and self-harm warning form to HMP Liverpool and verbally forewarned reception staff at the prison of his arrival and risks. The court issued a further warning about the man's risk of suicide after a hearing on 21 June.

I am concerned that staff at Liverpool failed to address explicit warnings and indicators relating to the man's risk of self-harm. Reception staff took no action on initial receipt of the warning form and then mislaid it, so it was not passed to the nurse who carried out his initial health screen. However, this form was not the only source of information about the man's risks and insufficient consideration was given to a number of other known risk factors. Had suicide and self-harm prevention procedures been started at the outset, more structured support would have been provided to the man, who had already requested counselling to help him deal with the unfamiliar environment and the allegations against him.

The officer who found the man did not follow the expected emergency procedures set out in national guidance, an issue that has been raised in previous investigation reports from this office. I recognise that Liverpool has since implemented appropriate guidance for staff.

The 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 2014**

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SUMMARY

1. The man was arrested by Merseyside police in June 2011. Shortly after his detention at a police station, he told staff that he would harm himself. A doctor and a psychiatric nurse assessed him and recommended constant supervision. Just before he was due to attend court on 15 June, staff who opened his cell found him with a blanket tied around his neck. He was taken to hospital, then on to court, where custody staff opened a suicide and self-harm warning form. After a further court appearance on 17 June, he was remanded to HMP Liverpool. Court staff telephoned to alert the prison to the man's impending arrival and his background. It was his first time in prison.

2. When the man arrived at Liverpool, the escort staff handed the warning form to a senior officer in reception who acknowledged receipt, but did not act on its contents or pass it to the reception nurse. (The form was then mislaid and found after the man's death.) The man was calm during his reception and general health assessments and denied any thoughts of self-harm. However, he asked for help to deal with being in prison and the nature of the allegations against him and the reception nurse referred him for counselling.

3. The man's request to be held in the vulnerable prisoners' wing was approved. He initially shared a cell with another prisoner who he found to be supportive and helpful. However, on 21 June, his suitability to share a cell was reassessed. His level of risk was raised as he was potentially facing further charges of sexual offences against an adult male and he was moved to a single cell. The man had appeared before court that day, via a video link. Court papers sent to the prison about his next appearance contained a warning that one of the reasons he had been refused bail was that he was a suicide risk. A prison administrator noted the warning on 22 June and brought it to the attention of the operational manager responsible for safer custody. However, no formal action was taken to assess the man's risk. There is little recorded about staff interaction with the man during his eight days at Liverpool.

4. At around 5.15am in June, an officer discovered the man suspended by a ligature in his cell. The officer radioed for the night manager and nurse and then waited for them to arrive before entering the cell. Resuscitation attempts were unsuccessful and paramedics pronounced the man dead at 5.39am.

5. The investigation found that officers in reception did not actively consider how to address the suicide and self-harm warning form and then mislaid it. The reception nurse who then conducted a health assessment did not take account of the man's many risk factors when assessing his risk of suicide and self-harm. Prison staff missed a further opportunity to investigate and appropriately manage his risk when the court sent a remand warrant, indicating that one of the reasons bail had been refused was his high risk of suicide. The prison has since introduced a protocol for staff to take action on concerns about prisoners' safety after court hearings.

6. While the delays in the emergency response do not appear to have impacted on the outcome for the man, we are concerned that the officer who found him was reluctant to go into a cell in an emergency and did not use an emergency code when he radioed for help. We are satisfied that the prison now has appropriate guidance clarifying staff responsibilities in medical emergencies.

THE INVESTIGATION PROCESS

7. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and inviting anyone with relevant information to contact him. The man's former cellmate responded and was interviewed.

8. The investigator went to the prison on 1 July 2011. He spoke to the Governor and other prison staff and saw the man's cell. He obtained the man's prison and medical records, documents relating to his time in police custody between 10-17 June, as well as those held by G4S escort services. He also visited the cell area at South Sefton Magistrates' Court. He subsequently interviewed several prison and healthcare staff, four escort staff, a community psychiatric nurse who had seen the man in police custody and a prisoner. After the interviews, the investigator gave the Governor written feedback on the initial findings.

9. Liverpool Primary Care Trust, the healthcare commissioning body at that time, appointed a clinical reviewer to review the man's care and treatment in custody. The clinical reviewer and the investigator jointly interviewed healthcare staff at the prison.

10. In accordance with the Ombudsman's terms of reference, the investigation was suspended while Merseyside Police conducted a criminal investigation into the circumstances of the man's death and during the subsequent criminal proceedings. We remained in contact with the police and, after the conclusion of the criminal investigation; they shared a number of documents, including witness statements and transcripts of interviews.

11. We informed HM Coroner of the investigation and he provided the post-mortem report. We have sent a copy of this report to the Coroner.

12. Solicitors representing the man's family wrote to us listing a number of issues they wished the investigation to cover.

13. The investigator and one of our family liaison officers subsequently visited the man's family to discuss the investigation. His family raised additional questions and concerns, including:

- Why no action had been taken on a suicide warning form and why the prison's family liaison officer had said that prison staff might not have acted differently if they had seen the form.
- The man had not been able to telephone his wife for seven days, although her telephone number had been verified after five days. His family believe he would have benefitted from earlier contact.
- Had the man received a postal order they had sent?
- Had prison staff noticed recent cuts to the man's wrists?
- They were concerned about the number of ligature points in his cell.
- Why are prisoners used to help settle new arrivals into the prison?

HMP LIVERPOOL

14. HMP Liverpool is a local prison which serves the courts in Merseyside and holds approximately 1,400 men. The prison has eight residential wings and a purpose-built healthcare unit which opened in 2007. K wing holds prisoners regarded as vulnerable to intimidation or attack from other prisoners, usually because of the nature of their offence.

15. Liverpool Community Health Trust is commissioned to provide healthcare. The prison healthcare centre provides outpatient services, as well as 24-hour inpatient care. A doctor is on duty during normal working hours.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons carried out a full announced inspection of HMP Liverpool in October 2013. Inspectors found good leadership and considered that managers and staff were striving to improve conditions. However, there had been problems with risk assessments in the early days of custody and prisoners, particularly those who were vulnerable, felt unsafe. At reception, vulnerable prisoners were prioritised for initial health screens. They were then normally housed on K wing, but due to population pressures they had to spend at least their first night in an overspill unit in A1 wing, where provision for them was poor. As vulnerable prisoners were spread in several areas throughout the prison, it was difficult to manage them and provide for their needs. The induction programme was well structured, but vulnerable prisoners sometimes had to wait for a week before taking part.

17. Inspectors found that prisoners' living conditions were generally poor, the applications system was inconsistent and disorganised and the personal officer scheme was not effective. Some operational support staff who worked at night were inadequately trained and did not know the emergency procedures. The video link was used for over a third of court appearances and there was a protocol to ensure that concerns about safety were reported after the hearings.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB report for Liverpool for 2012-2013, noted that the prison operated a positive suicide prevention policy and staff were vigilant and professional.

Previous deaths at Liverpool

19. Since 2011, there have been six self-inflicted deaths at Liverpool, including that of the man. Two have yet to be investigated. In previous investigations, we made recommendations about assessing prisoners' risk of self-harm and the emergency response and similar concerns are identified in this report.

Assessment, care in custody and teamwork (ACCT) procedures

20. Assessment, Care in Custody and Teamwork (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 might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. If a prisoner is considered to be at very high risk of suicide, staff can implement constant supervision, which means the prisoner must be watched at all times. 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. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

21. The man was arrested in June 2011 and taken to Copy Lane Police Station in Liverpool, where he was charged. This was his first time in custody. Several years earlier, he had been diagnosed with depression and suicidal thoughts as a reaction to family and work problems, but he had not attempted to harm himself.

22. After suffering a panic attack at the police station, the man was taken to hospital. While there, he put a piece of cotton gauze in his mouth in an apparent attempt to make himself sick. After examination, he was discharged and returned to the police station in the early hours of 11 June. Later that day, the duty doctor assessed the man, who denied any thoughts of self-harm. Nevertheless, the doctor assessed him as a standard to moderate risk and recommended that he should be constantly supervised. The police remained concerned about the man's mental state and his risk of suicide in view of the seriousness of the charges he was facing and because of a comment he had made to an officer that he wanted to kill himself. The police requested a mental health assessment.

23. A community psychiatric nurse (CPN) assessed the man at 2.00pm on 12 June. He strongly denied making the comments about suicide attributed to him and said he had no such thoughts. The nurse told the investigator that she had concluded that the man did not have a mental illness or depression, but he was perplexed and shocked at his situation and unsure of what was happening. The nurse noticed some minor redness to the man's wrists which she attributed to handcuffs. She considered the man was at high risk of suicide and shared her assessment with colleagues at the court the man was due to attend. She asked them to inform the magistrates that he was a high risk of suicide whether he was bailed or remained in custody. Constant supervision continued.

24. When escort staff took the man to South Sefton (Bootle) Magistrates' Court the next morning (13 June), the Senior Custody Officer, A, completed a suicide/self-harm warning form to ensure that constant supervision continued while he was held in the court cells. The magistrates granted the man bail on the condition that he lived at his mother's home in South Wales. However, when he arrived, the local police re-arrested him at the request of Merseyside Police, who were investigating additional allegations against him.

25. Police officers recorded that during the journey back to Liverpool, the man was handcuffed but became violent towards the officers escorting him and was forcibly restrained. He had an open wound to his left wrist which was bandaged and they noted, "due to the gravity of his offence, DP [detained person] has tried to harm himself, cause injuries to self, swallow objects and thrown down stairs". He was described as suicidal and officers put in place a care plan specifying constant supervision, as he was considered to be a high risk of suicide. Later that evening, they reduced the level of observations to "intermittent", with checks at 15-minute intervals.

26. The man was due to appear in court during the afternoon of 15 June. When the police opened his cell before the journey, he was standing with a blanket tied around his neck. They took him to hospital and, after he was discharged, they went on to court. Magistrates remanded him for two days and when he returned to the police cells, he was constantly supervised.

27. The man went to court again on 17 June. His Person Escort Record (PER - which accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors) indicated that he had attempted to self-harm at the police station and was subject to constant supervision. A Prison Custody Officer at the court completed a suicide/self-harm warning form noting his actions and he remained constantly supervised in the court cells.

28. At court, the man became agitated and hysterical after a meeting with his solicitor. Court escort staff were concerned that he might hurt himself so they restrained him and called an ambulance. The paramedics took him to hospital, where he was sedated and a hospital discharge letter indicated that his vital signs should be monitored. The man returned to court and was remanded to prison until 21 June. One of the reasons given for refusing him bail was his risk of suicide. When he was leaving the court, the man appeared to faint and had to be physically supported by escort officers.

29. Senior Custody Officer, at the court told the investigator that, at 2.17pm, he telephoned reception staff at HMP Liverpool to tell them that the man was on his way to the prison and that he had been identified as a risk of suicide and self-harm. When interviewed, one of the escort officers, said that when they arrived at the prison, he had briefed prison staff about the man's background and circumstances and given the court documents, including his PER and the suicide and self-harm warning form.

30. Senior Officer (SO), A, was responsible for managing reception staff and reviewing the documents for newly-arrived prisoners. He signed to acknowledge receipt of the suicide and self-harm warning form. At Liverpool, prisoners who arrive with a suicide and self-harm warning form or whose alleged offences are related to public protection issues are listed on a daily log sheet divided into two sections. The SO added the man's name to the list of prisoners subject to public protection arrangements, but did not include him in the section listing those at risk of suicide and self-harm and whether they were being managed under ACCT procedures.

31. SO, A, explained to the investigator that officers conduct reception interviews and cell sharing risk assessments, but suicide and self-harm warning forms are passed to reception healthcare staff who carry out "medical and well-being" interviews and then decide whether ACCT monitoring is necessary. The SO added that healthcare staff were responsible for acting on the warning form and, if they considered that the man was at risk of self-harm, he would expect them to initiate the suicide and self-harm prevention procedures by opening an ACCT plan and submitting the document to him. If an ACCT plan is opened, one copy of the warning form is filed in the ACCT document

and another in the prisoner's medical record. If ACCT monitoring is not started, copies are held in the prisoner's core and medical records.

32. SO, A, could not recall whether he had received a call from Senior Custody Officer at the court to warn him of the man's imminent arrival. He did not remember anything specific about the man and thought this suggested that he had not been upset or distressed. In discussion with the investigator, the SO said he would have no particular concerns about a mature man in prison for the first time who had been charged with a number of sexual offences.

33. After the initial reception process, Nurse, A, conducted a health screen, including questions about mental health. She noted that the man had denied thoughts of self-harm and had disclosed treatment for depression some twenty years earlier. He had maintained good eye contact during the screen, answered her questions and was at times humorous. She saw no evidence of low mood or psychosis. The nurse told the investigator that she had not received the suicide and self-harm warning form and would have signed for receipt if she had. (The section of the healthcare document to acknowledge receipt was blank.) The man had not volunteered any information about recent self-harm or disclosed that he had been to hospital since his arrest. She saw no injuries to his wrist or elsewhere and said this would have prompted further questions if she had noticed them as they might have been an indicator of self-harm. The same day, a member of healthcare staff faxed a request to his GP, asking the surgery to fax or send information to the prison about his current medication.

34. Nurse, A, said that the man had no concerns about his physical health but he requested counselling to help him cope with his situation and the allegations he was facing. She therefore completed a single point of referral form for a routine mental health assessment. She explained that healthcare staff discuss such referrals at a weekly meeting and prisoners are then directed to specialist services. (They discussed the man at the meeting held on 20 June and referred him to the Primary Care Psychological Service at the prison to further assess his needs. The referral was accepted and he was placed on the waiting list, but he died before the service could see him.)

35. The investigator spoke to the, Consultant Clinical Psychologist at Liverpool, who said at that time the waiting list for non-urgent counselling was between two to three weeks. He added that it is possible for a prisoner to be seen within hours of an urgent referral, but the man had been placed on the waiting list as there was no indication on the referral form that he was in crisis.

36. Officer, A, and Nurse A completed a cell sharing risk assessment and assessed the man as standard risk. An unsigned entry on the assessment noted that, although the man did not meet the criteria for high risk, he would be further assessed after two days as they had no information from police national computer about his charges.

37. During the reception process, the man applied to be allocated to K wing, for vulnerable prisoners. Staff completed a prisoner security information form.

The section of the application form entitled “Information of Special Importance” noted “yes” to the question of “suicide possibilities” and it was also recorded, “charged sex offence against children, self-harm, suicide risk”. An operational manager interviewed the man about his application. He said that the man seemed fine but wanted to be safe from other prisoner who might wish to harm him as there had been significant media reporting of his alleged offences. He added that the nature of the offences made the application a foregone conclusion. He did not know about the suicide and self-harm warning form and none of the other staff had mentioned it. However, he said that information about suicide or self-harm would not have influenced the outcome of his application to live in K wing.

38. Officer B carried out the next stage of the reception process, searching and X-raying the man’s clothes. He countersigned section three of the cell sharing risk assessment to indicate that he was standard risk. The officer said he did not notice any marks or injuries on the man’s body as staff try to allow some privacy when prisoners are undressed.

39. Officer B recalled that the man appeared to be all right and unconcerned about his predicament, but he wanted to telephone his family. However, the nature of his alleged offences meant that he was subject to public protection measures and telephone numbers he wished to call had to be checked. He was therefore not allowed to make telephone calls until he had received clearance. The officer offered to telephone the man’s wife. His son answered the call and the officer gave the man’s prison number, and details of the visiting procedures. He also advised how to send money and clothing into the prison, the process for telephone calls from the man and told them about websites where they could get more information about prison procedures. The officer spoke briefly to the man’s wife and mentioned that he had been allocated to the vulnerable prisoner’s wing. She asked the officer to pass on the family’s love and that they were thinking of him.

40. There was little recorded interaction between the man and wing staff during his eight days in prison. His family were concerned that prisoners are used to help settle newly-arrived prisoners. Prison staff explained that wing staff try to ensure that prisoners who might be nervous or shocked by their first experience of custody share a cell with an experienced prisoner who can help them by explaining prison life and who offer friendship at what can be a traumatic time. The man initially shared a cell with another prisoner. The man’s cell mate told the investigator that the man had told him that he had been on ‘suicide watch’ at the police station and wanted to kill himself. He responded by asking how his family would feel about this. They got on well and when the man moved cells, the cell mate had visited him during association time to give him tobacco.

41. On 19 June, the man wrote a letter to his family, explaining that he had been unable to telephone them as he had no money to buy phone credit and it would also take some time for the prison to process his permitted telephone numbers. He said that he was “worried beyond human understanding” about them and had had, “a very very hard time”. He asked them to book a visit and

send clothes and other items. He also described his cell mate as a "remarkably kind and understanding person who has helped me to cope enormously … he has helped and advised me. Without him – I would be hopelessly lost". We received a copy of this letter, but it does not appear that the man ever posted the original.

42. On 21 June, Nurse B, a registered mental nurse and specialist primary care practitioner, conducted a further more detailed health screen. The man told the nurse that he was worried and wanted to discuss being in prison and the charges he was facing. However, she was aware that Nurse A had already referred him to the single point of referral meeting which would consider his request for counselling. She explained the role of Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners in distress) and how he could contact the Samaritans. The man's biggest concern at that time was that he had not brought his digital hearing aids which he needed for both ears and she advised him how his family could send them in. He also told her that he had not smoked before but had started four days earlier when he arrived at the prison.

43. At interview, Nurse B said that reception healthcare staff would not routinely see a prisoner's PER, but officers should notify them of any relevant information on the PER and other documents. At the health screen, she was unaware of the suicide and self-harm warning form. However, she had assessed the man's mental health and he had denied any suicidal thoughts when she asked specific questions about this. She added that had she known he had attempted to harm himself two days earlier, she would have initiated ACCT monitoring, regardless of what he had said about his thoughts or intentions. She described him as calm, relaxed and lucid.

44. On 21 June, a locum GP, reviewed the man's medical notes and recorded, "Attended AED [Accident Emergency Department] on 17 of June acting strangely. He was prescribed Haloperidol 5mg IM (intra muscular). No follow up planned." (The doctor was unavailable for interview.)

45. The same day, Operational Manager, B, told SO B, one of the wing managers, that the man's CSRA had been reassessed as high risk for cell sharing and he had to be moved to a single cell. As there were no single cells available on K wing at that time, he was relocated to B wing. The SO said that the man was initially concerned about the reasons for the move. The SO had not been told the reasons why his level of risk had been raised, he reassured the man that it was not because he had broken the rules and that he would return to K wing as soon as a single cell became available. He said that when the man had first arrived, he had ensured that he shared a cell with another prisoner as it was his first time in prison. He commented that the man had been quite dependant on his cell mate, who had been very supportive.

46. At interview, Operational Manager B, who had reassessed the man's risk, explained that the raised level of risk had been based on information about two possible further charges of sexual assault against an adult male. He had

therefore allocated the man to a single cell because of his perceived risk to other prisoners.

47. The man's family was concerned that there had been a delay in him accessing the telephone system. Operational Manager B explained that the man had arrived at the prison on a Friday and telephone accounts were not processed over the weekend. SO B said that regime and resource issues had led to delays in dealing with the administration of some matters and facilitating telephone calls was regarded as a non-essential task. The security department confirmed that the man's telephone account had been created on 20 June. He then declared the telephone numbers he wished to call and his preferred numbers were cleared from 23 June. He was authorised to use the telephone from that date but, at first, he had no money to buy telephone credit. His wife had sent him a postal order, but it did not clear until the day before his death. (According to prison records, the man first called his family on 24 June.)

48. The man appeared before magistrates on 21 June, by video link. He was remanded until 19 July. The court sent a remand warrant to the prison stating "SUICIDE RISK" as one of the reasons bail had been refused.

49. The next morning, the man returned to K wing, where he was allocated a single cell. Most prisons have safer cells with a reduced number of ligature points but as he was not subject to special suicide and self-harm measures, he was in a standard cell. Later, as prisoners collected their evening meal, SO B had a conversation with the man and told him about help he could get from the prisoner support system, the chaplaincy and the Listener scheme. The man thanked him and said he was okay. The SO noticed that a group of prisoners, including the man's cell mate, were talking to the man. The senior officer said that had not shown any signs of anxiety or stress, but seemed "in awe of the whole process" (meaning his experience of prison up to that point) and none of the other prisoners had mentioned any concerns about him.

50. The same day, 22 June, a safer custody administrative officer, A, transferred the information from the court's suicide and self-harm warning to the man's electronic records. She entered on the record that there was an active alert of self-harm in custody and, "Information received from Bootle MC [Magistrates Court] that the man is a suicide risk - SO C informed". In her police statement, the safer custody administrative officer, A, stated that as the man's remand warrant had identified him as a suicide risk, she had emailed and spoken to SO C, the safer custody team suicide prevention coordinator, to inform him.

51. At interview, SO C remembered that he had picked up the message from the safer custody administrative officer at about 5.00pm. He said that a little later that evening, he had asked SO B to have a chat with the man to see if he was all right. (Although SO B had spoken to the man that evening, in his statement to the police he denied that this was at the request of SO C and said that no such discussion took place.)

52. Just after 10.00am on Friday 24 June, the man went to the healthcare unit for a hepatitis B injection which is routinely offered to prisoners. An hour later, he telephoned his wife, who said she would visit on Sunday. (An officer listened to a recording of the telephone call after the man's death and described him as sounding low in mood.)

53. The first officer on the scene had started night duty on K wing at 7.30pm on the evening of 24 June. At 5.05am, the next morning, a diabetic prisoner reported feeling unwell, so the officer radioed Nurse A and asked him to attend the wing to examine the prisoner. Around five to 10 minutes later, the officer decided to carry out the roll check (count) of the prisoners on the wing. When he reached the man's cell, he looked through the cell observation window, turned on the cell light and saw the man hanging from the bed frame, by a ligature made from strips of a torn bed sheet.

54. The first officer on the scene said that the radio system was on 'talk through', so all staff with radios could hear what was said. He immediately radioed Oscar 1 (the radio code for the manager in charge of the operation of the prison and Hotel 1 (the radio code for healthcare first responder) requesting assistance. He received a response from both staff and waited for them to arrive (which he estimated took 30 seconds). The officer said that although he had a cell key in a sealed pouch he would not enter a cell alone. He said he had been taken aback by what he saw through the hatch and preferred to wait for colleagues to arrive.

55. By this time, Nurse A had arrived at the wing healthcare office to prepare medication for the diabetic prisoner and on his way to his cell, he met the senior officer on duty that night, SO D and the second officer on the scene. He then heard the first officer on the scene shouting to them to go to level 5 on K wing. When the first nurse on the scene arrived at the cell, the officer told him that the man was hanging.

56. SO D told the investigator that after he heard the first officer on the scene's radio call asking for the nurse, he immediately went to K wing. He had not heard an emergency code. When he reached the cell, he looked through the glass observation panel and saw the man hanging from the top bunk. He opened the cell door and the nurse went in first, followed by the second officer on the scene and then the first officer on the scene**.** SO D remained outside and radioed for an ambulance. Staff in the control room replied and asked him to call back on a landline to provide further details about the man before they called the ambulance. He therefore went to the office to get the information from the computer.

57. The first nurse on the scene cut the ligature, which was wrapped around the top bunk, assisted by the first officer on the scene. He found no signs of life and the man's pupils were fixed and dilated. He asked for an ambulance to be called and shouted to the second officer on the scene to collect the emergency bag from the office, which contained resuscitation equipment, including a defibrillator. (A defibrillator is a life-saving device that analyses heart rhythm and automatically delivers electric shocks to victims of cardiac

arrest when it determines there is a rhythm that is likely to respond.) The second officer on the scene said that it took around three minutes to fetch the bag. The nurse then conducted cardiopulmonary resuscitation (CPR). He used the defibrillator, which administered one shock. CPR continued until paramedics arrived and took over. Resuscitation attempts were unsuccessful and the paramedics pronounced the man dead at 5.39 am.

58. A note the man had written to say goodbye to his wife and children was found in his cell. His family questioned why they had not received a letter he had written on 19 June. The prison gave the investigator a copy of this letter, which contained a prison stamp, but we have been unable to establish why the original had not been posted.

Debrief

59. Operational Manager C, held a debrief with the staff involved in the emergency response to discuss any issues arising and offer support. Staff also wrote statements detailing their involvement.

Liaison with the man's family

60. Operation Manager B was appointed as the prison's family liaison officer. At around 10.00am that morning, he visited the man's wife with the prison's chaplain to break the news of his death to her and their son. The prison contributed to the cost of the man's funeral, in line with national guidance. He and a colleague attended the funeral as representatives of the prison.

Informing staff and prisoners

61. Notices were issued to prisoners and staff informing them of the man's death. Staff also reviewed all prisoners subject to suicide and self-harm prevention measures (in case they had been affected by the man's death) and alerted the Listeners on K wing.

Recovery of the man's suicide and self-harm warning form

62. On 27 June, a member of staff in the prison's healthcare department found the man's suicide warning form in the outpatients' department in-tray. Staff said that they had no knowledge of where the form had been since 17 June.

Post-mortem

63. A post-mortem examination showed that the man died as a result of compression of the neck due to hanging. The pathologist noted a healing injury to the man's left wrist.

Police investigation

64. Merseyside police carried out an investigation into the circumstances of the man's death and his care in custody. A member of prison staff was subsequently charged with offences, but was cleared of all charges in December 2013.

ISSUES

Escort services' management of the man

65. The Ombudsman's remit includes the transfer of detained persons between police stations, courts and prisons. We are satisfied that The man was appropriately managed by escort staff and we recognise the care and attention displayed by the staff involved in his detention at court and transfers between the police station, court, hospital and prison.

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

Reception procedures

66. Before the man was taken to Liverpool on 17 June, the court's senior custody officer, telephoned reception staff at the prison to alert them to his high risk of suicide and self-harm. When he arrived, one of the escort officers, reiterated the man's background and circumstances and gave his PER and suicide and self-harm warning forms to reception staff. Both documents highlighted his risk of suicide.

67. Prison Service Instruction 52/2010 *Early days in custody*, the guidance which was in force at the time of the man's death, listed a number of risk factors for suicide and self-harm. It stated that all staff should be alert to the increased risk of suicide and self-harm posed by prisoners during their early days in custody and act appropriately to address any concerns. The instruction also stipulated that PERs and any other available documents, including suicide and self-harm warning forms, must be examined and the prisoner interviewed in reception, to assess the risk of self-harm. Governors were expected to have effective local systems to obtain, analyse, record, forward and act on the information gathered. The man had a number of factors that were significant indicators of risk, including first time in prison; early days in custody; a recent history of deliberate self-harm; remand prisoner; and he was subject to child protection measures.

68. SO A, who received the documents, added the man's name to the daily list of public protection prisoners, but not to the section for those at risk of suicide and self-harm. He took no action on the warnings and passed the documents to Nurse A, who conducted the initial health screen. The SO believed it as the responsibility of reception healthcare staff to take appropriate action on such documents during their assessment. The nurse did not receive the suicide and self-harm warning form. It was subsequently mislaid and found in the outpatient department in-tray on 27 June, two days after the man's death. The investigation has been unable to establish its whereabouts between 17 June and when it was found.

69. The reception manager gave no reasonable explanation as to why officers had not acted on the police and court documents flagging the man's risk of suicide and why the papers were not passed to healthcare reception staff. It is also of concern that they went missing. However, given the man's

background and circumstances, the information from these documents should not have been the only prompt for considering whether he merited being managed under suicide and self-harm prevention procedures. We consider that staff took insufficient account of all the man's known risk factors and that they should have considered initiating ACCT procedures when he first arrived at Liverpool on 17 June irrespective of receiving a warning form. They missed a further opportunity to do so a few days later when they received the remand warrant from the court which had highlighted his high risk of suicide. The man's request for counselling during both his health screens indicated that he might not have been as robust as he had appeared to prison staff. The failure to recognise his risk also meant that it was not taken into account in the decision-making about his cell allocation.

70. It seems that in assessing his risk of self-harm, staff relied heavily on the man's statements that he had no such thoughts. Staff judgement is fundamental to assessing risk and relies on them using their experience and skills, as well as local and national assessment tools, to determine risk. All risk factors must be recorded, collated and considered to ensure that a prisoner's level of risk is holistically judged. A prisoner's presentation is obviously important and reveals something of their level of risk. However, 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.

71. Too often prison staff place too much reliance on what the prisoner tells them and ignore the weight of other risk-related information. The man had a number of serious risk factors, which should have been considered carefully in the context of suicide and self-harm and it is a concern that staff who assessed him gave insufficient weight to them and did not consider whether he needed additional support. We are also concerned at the lack of clear procedures and understanding of responsibilities in reception at Liverpool. 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 a newly-arrived prisoner 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 or expressed suicidal intent.**

Welfare checks after court appearances

72. On 21 June, the man appeared before the court by video link and was further remanded. The remand warrant received by the prison that day indicated that one of the reasons he had been refused bail was his high risk of suicide. Although the man had had a secondary health screen that morning, there is no evidence of any further checks by either healthcare or prison staff after his court appearance to see whether this had affected his state of mind. The next day, the safer custody administrative officer entered the details of the warning on the man's electronic records and notified SO C verbally and in writing. The SO said that he had asked SO B to speak to the man. SO B denied this but said that he had in any event spoken to the man that evening as a matter of course about the circumstances of his cell change. The man told him he was okay and SO B said he did not seem anxious.

73. Chapter 6 of Prison Service Order (PSO) 3050, *Continuity of healthcare for prisoners*, gives guidance on significant life events that might affect a prisoner's health such as court appearances by video link. It notes that prisons must have protocols in place for screening such prisoners for any potential healthcare, or suicide/self-harm issues. We note, from HM Inspectorate of Prisons' recent inspection report, that Liverpool has now implemented such a protocol, therefore we make no further comment on this issue.

74. The locum GP reviewed the man on 21 June. He read the hospital discharge letter, but decided to take no further action. There was no explanation for this judgement and the GP could not be contacted for interview. The clinical reviewer believes this was a further missed opportunity to assess the man's risk of suicide and self-harm again and to consider managing the man under ACCT procedures.

Referral for counselling

75. At his reception health screen on Friday 17 June, The man asked to be referred for counselling to discuss the alleged offences, (a request he repeated at the secondary health screen). Nurse A made a routine referral to the mental health services and, on Monday 20 June, staff at the Primary Care Psychological Services meeting placed him on the waiting list. There was no indication of acute crisis and on the information available to her we consider it was reasonable for Nurse A to have treated the man's referral as routine.

Emergency response

76. In a letter to Prison Governors in January 2010, the Chief Executive of the National Offender Management Service, circulated guidance on the minimum actions required of staff. It stated that under normal circumstances, the night manager must give permission to unlock a cell and a minimum of two/three staff should be present. However, where there appeared to be immediate danger to life, subject to a risk assessment, a member of staff could enter alone. It also contained a reminder that:

"Staff have a duty to of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or other in unnecessary danger."

77. The first officer on scene had a cell key in a sealed pouch to open cells at night in an emergency but said that he would not enter a cell alone. Operational Manager B explained that the local policy was that at least two officers had to be present to open a cell. A staff member could open the sealed the pouch and enter alone but the night manager would have to give permission for them to do so and the usual scenario would be that the cell would not be opened until the manager and other assistance arrived.

78. We are concerned that the first officer on the scene said that he would never enter a cell alone and would always wait for his colleagues and that this approach was endorsed by an operational manager. In an emergency, time is of the essence and it is important that all staff who work in prison at night are prepared to enter a cell in order to preserve life subject to their own safety. Staff can and should alert the night orderly officer when they are doing so, which helps to ensure safety. We therefore make the following recommendation:

The Governor should ensure that all staff are aware that, subject to a personal risk assessment and providing there is no obvious danger to themselves or others, they should enter a cell on their own at night in an apparent life-threatening situation.

79. Staff accounts of how the emergency was raised when the man was discovered are contradictory. The first officer on the scene said that he called for the night manager and nurse over his radio. However, the first nurse on the scene said he was already on one of the lower floors of the wing on his way to see another prisoner and the first officer on the scene had shouted down to him. The first nurse on the scene could not remember what was shouted. SO D recalled hearing the first officer on the scene ask for the nurse to attend immediately.

80. Staff in prisons use specific radio codes in medical emergencies. A 'code red' message indicates severe loss of blood and 'code blue' means breathing difficulties or that the prisoner is unconscious. Use of such a code enables staff to easily communicate the nature of an emergency incident to those responding and enables them to better prepare, including taking the correct emergency equipment. The first officer on the scene did not use a code. This meant that the other staff who responded were not immediately alerted to the nature of the emergency. However, he estimates that after his request for help, the nurse and officers arrived at the man's cell around 30 seconds later. It took a further two minutes for the second officer on the scene to leave the cell and collect the resuscitation bag. The night manager radioed to request an ambulance but control room staff then asked him to ring back with further

personal details about the man before they made the call.

81. The Chief Executive of National Offender Management Service and the former Director of Offender Health jointly wrote to prison governors about emergency access to establishments on 17 February 2011 to repeat and reinforce earlier guidance in 2007. (This was later formalised in Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes*, issued in February 2013.) The letter emphasised the need for "rapid access" to emergency services in clinical crises. Prisons were instructed that an ambulance should be called in all cases where there are grave concerns about the immediate health of a prisoner and that it should not be a requirement for a member of the healthcare team to attend before an ambulance is called.

82. In addition to the first officer on the scene's failure to use a code when he called the night manager and nurse, an ambulance was not called until the night manager arrived at the cell and requested one. A further delay was incurred when the control room sought further information before making the call. Although on this occasion, there was no evidence that the failure to enter the cell immediately or use a code had any bearing on the outcome for the man, we are concerned that in future emergency incidents even a short delay might impact adversely on a prisoner's chances of survival.

83. PSI 03/2013, which was issued after the man's death, now contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that in the event of a prisoner being unconscious, the control room must call an ambulance immediately. Liverpool's current guidance reinforces that staff should not wait for the night manager or healthcare staff to attend before confirming such an emergency. We are satisfied that Liverpool's current local protocol is in line with PSI 3/2013.

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 a newly-arrived prisoner 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 or expressed suicidal intent.

2. The Governor should ensure that all staff are aware that, subject to a personal risk assessment and providing there is no obvious danger to themselves or others, they should enter a cell on their own at night in an apparent life-threatening situation.

Death in Custody Action Plan for: the man HMP Liverpool 25th June 2011

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	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 a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and	Accepted	Notices to Staff and Briefings have been issued Bi Annually, to alert staff to Risk and Triggers that raise the risk of self harm/suicide. A pro forma was introduced immediately following the man's death to ensure suicide warnings are logged on receipt by the reception SO and then signed for on handover to Healthcare staff. At the end of the shift the SO and Healthcare staff conduct a final cross reference check of warnings to confirm what actions were taken in each case.	**Immediate**	

	self-harm warning forms and PERs. Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.				
2	The Governor should ensure that all staff are aware that, subject to a personal risk assessment and providing there is no obvious danger to themselves or others, they should enter a cell on their own at night in an apparent life-threatening situation.	Accepted	Staff will be reminded of this requirement annually via a Governors notice and via briefings. This requirement will form part of a briefing/training pack that is being developed which will be delivered to nights staff.	**1/10/14**	