

**Independent investigation report by
the Prisons and Probation Ombudsman
Nigel Newcomen CBE
into the death of
a man at HMP Liverpool
in December 2014.**

Our Vision

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

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.

The man was found dead in his cell at HMP Liverpool on 23 December 2014. He was 54 years old. A post-mortem report concluded that the man died from a heroin overdose. I offer my condolences to the man's family and friends.

The investigation found that prison staff failed to act on repeated intelligence that the man was using or distributing drugs. I am concerned that, as a consequence, staff missed opportunities to refer the man for support for his substance misuse problems.

The officer who first unlocked the man's cell on the morning he was found dead, did not get a response from him as he should have done and it took too long to get ambulance staff to the man's cell after they arrived at the prison. As it was apparent that the man had been dead for some time, these issues did not affect the outcome but in other emergencies they could be crucial.

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

August 2015

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SUMMARY

Events

1. The man was remanded to HMP Liverpool on 18 January 2014. Reception staff began Prison Service suicide and self-harm prevention procedures, known as ACCT, as court staff had alerted them to his history of attempted suicide and he had recently cut his throat. The ACCT was closed three days later, when the man was no longer considered at risk. On 27 January, a psychiatrist linked the man's self-harming behaviour to problematic alcohol use, but no one referred him to substance misuse services for support.
2. On 9 August, an officer detected a smell of cannabis coming from the man's cell and submitted a security report. Security staff referred the man for a drug test, but there is no record of this happening. The next day, another officer submitted a security report because he suspected that the man was involved in drug dealing on the wing. The security department passed the intelligence to the dedicated search group, but they took no further action.
3. On 29 September, staff admitted the man to the prison's healthcare centre, for observation after he appeared to have had a seizure. He admitted that he had taken spice (a synthetic cannabinoid known as a new psychoactive substance) two days before. Healthcare staff observed him overnight, and he went back to his wing the next day. Officers warned him that they would move him to another wing if he used drugs again, but again no one referred him to the substance misuse team.
4. On 23 October, an officer reported that the man appeared to be under the influence of drugs. Security staff again referred him for a drug test, which was not carried out.
5. At 8.10am on 23 December, an officer unlocked the man's cell, but did not wait to get a response from him. At about 8.50am, officers went to check if the man was going to an education class that morning. The man was unresponsive, with no signs of life, and the officers called an emergency. A nurse examined the man and noted signs of rigor mortis, which indicated he had been dead for some time. It took ten minutes for the paramedics to reach the man's cell after they arrived at the prison.
6. The post-mortem report concluded that the man died from heroin toxicity.

Findings

7. Staff completed four security information reports, suggesting that the man was using or distributing drugs. These were not followed up by targeted searches or drug tests, as requested. Even when the man admitted to taking spice, staff did not refer him to the substance misuse team for support.
8. When the man's cell was unlocked on the morning of 23 December, the officer did not check on his wellbeing. It was more than half an hour before

officers discovered he had died during the night. Although it did not affect the outcome for the man, who was already dead, we are concerned that security procedures meant it took paramedics ten minutes to reach the man's cell after they arrived at the prison.

Recommendations

- The Governor should ensure that prisoners identified as using drugs are referred to drug treatment services and that there is an active response to security intelligence, as part of an effective drug supply reduction strategy.
- The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.
- The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

THE INVESTIGATION PROCESS

9. 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.
10. The investigator visited Liverpool on 22 December 2014. He obtained copies of relevant extracts from the man's prison and medical records.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The clinical reviewer and the investigator interviewed seven members of staff at Liverpool, some jointly. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.
12. We informed HM Coroner for Liverpool of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted a friend of the man, who was acting for his family, to explain the investigation and to ask if there were any matters his family wanted the investigation to consider. She told the family liaison officer that his family were unaware of the man's drug use, but were concerned about the availability of drugs at Liverpool. The man's friend received a copy of this report.

BACKGROUND INFORMATION

HMP Liverpool

14. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. Healthcare services are 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.

Her Majesty's Inspectorate of Prisons

15. 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 underwent a private interview in reception and there was a good focus on vulnerabilities. Security information was analysed well but not all intelligence led to searching or suspicion led drug testing. Drugs and alcohol were easily available and new psychoactive substances presented significant new challenges. The random mandatory drug test rate was relatively high, although this did not reflect true drug use as new psychoactive substances and the most diverted medication were undetectable. The prison's drug and alcohol strategy was out of date and did not address all the identified risks.

Independent Monitoring Board

16. 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 2013-2014 noted that drugs in the prison were a major concern. The IMB recommended that more resources should be allocated to tackle the problem.

Previous deaths at HMP Liverpool

17. We investigated five deaths at Liverpool in 2013 and five in 2014 before the man died. Our investigation into the death of a prisoner, who died a week before the man, found that it took too long for paramedics to reach the prisoner. At the time of writing, there have been five deaths at Liverpool so far in 2015, but there were no significant similarities with the circumstances of the man's death.

Assessment, Care in Custody and Teamwork (ACCT)

18. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

19. The man was remanded to HMP Liverpool on 18 January 2014, after police arrested him for threatening to kill his neighbour. This was not his first time in prison. Court officers completed a suicide and self-harm warning form because the man had recently cut his throat, and had a history of self-harm and attempted suicide.
20. A nurse recorded in the man's medical record that he had cut his throat three days earlier, but could not remember it because he had been drinking at the time. The nurse recorded that the man told her he had no current thoughts of suicide or self-harm. In light of his recent self-harm and the suicide and self-harm warning form, reception staff decided to start suicide and self-harm (ACCT) monitoring. He told the nurse that he had not used drugs for at least a month, and drank three units of alcohol, two to five times a week. Despite this, the man said that his self-harm and offence were caused by drinking too much. The nurse did not refer him for support for his alcohol misuse.
21. On 21 January, a Supervising Officer (SO) closed the ACCT, as he decided that the man's risk of suicide and self-harm had reduced and he no longer needed monitoring.
22. On 27 January, a psychiatrist assessed the man and concluded that his self-harm was linked to his alcohol use. She agreed that he was no longer at risk of suicide or self-harm. The psychiatrist described the man's alcohol use as problematic and was concerned that he minimised his drinking, but did not refer him for support. The man had no more contact with mental health services at Liverpool.
23. On 28 February, the man was sentenced to two years in prison. He told officers that he was okay and had no thoughts of suicide or self-harm. On 23 March, the man started work as a cleaner in the prison's education department.
24. On 10 April, the Governor issued a note to prisoners about the dangers of using spice, a new psychoactive substance. The note encouraged prisoners to speak to officers or refer themselves if they needed support from the prison's substance misuse services, Lifeline.
25. On 2 July, the man had a random drug test and the result was negative.
26. On 9 August, an officer smelled cannabis coming from the man's single cell. The officer submitted a security intelligence report, but there is no evidence that anyone spoke to the man about it. The security department noted that the man had no history of involvement in drugs, but referred him to be tested for drugs. There is no record that the drug test took place.

27. The next day, an officer submitted another security intelligence report because he suspected that the man and two other prisoners were dealing drugs on the wing. The security department recorded that all three prisoners had a history of using drugs in prison, but the information was very limited. (In the man's case, the only reported incident had happened the day before). The security department concluded that a drug test was not necessary, but informed the dedicated search group. No further action was taken.
28. The same day, the man's personal officer, recorded that the man continued to work as a cleaner in the education department and that he had no issues or concerns on the wing.
29. At 6.30pm on 29 September, the man appeared to have a seizure in his cell. The nurse recorded that he had stopped fitting when she got to the cell, but he was agitated and not in control of his movements. The doctor and nurse decided to admit the man to the prison's healthcare centre overnight for observation. The man told a healthcare assistant, that he had used spice, two days before. The man's blood pressure and pulse were normal overnight, and he was discharged the next morning.
30. No one referred the man to the prison's substance misuse service for further support, and there is no record that anyone spoke to him about getting help for drug use, but officers submitted a security intelligence report. They warned the man that they would move him to a different wing if he was involved in any more drug use. The security department did not ask for a drug test, because spice cannot be detected, but recorded that they had notified the dedicated search group of the man's use of spice. No further action was taken.
31. On 23 October, an SO recorded in the wing observation book that the man appeared to be very high on drugs. An officer submitted a security intelligence report, as the man appeared to be under the influence of drugs when he locked him in his cell, and his eyes were extremely bloodshot. The security department noted that the man had several previous reports for suspected drug taking. They notified the dedicated search group and referred the man for drug testing, but this did not take place. There was no further recorded information about the man's use of drugs.
32. At around 6.30pm on 22 December, an officer locked the man in his cell. The man did not use his cell bell that night. Neither of the prisoners in neighbouring cells knew the man well, because they had not been on the wing for very long. One of his neighbours, told the investigator that he had heard the man snoring loudly during the night, but had not been concerned when the noise stopped.

23 December 2014

33. At around 8.10am on 23 December, an officer unlocked the man's cell. The officer told the investigator that he always looked inside cells as he unlocked them and asked prisoners if they were all right, but he did not always wait for a response. He did not wait for the man to respond that morning.
34. At around 8.45am, the officer and a second officer went to check prisoners who were supposed to leave the wing to go to activities but had not yet left. When they got to the man's cell, the man's personal officer called the man's name a few times but he did not answer. The man's personal officer said that the man was lying on his side on the bottom bunk, facing the wall. The officer told the investigator that he knew that the man was a deep sleeper and when they went into the cell, at first they thought he was still asleep. When they looked more closely, they noticed that he was very pale, his skin was mottled and he had some foam on his mouth. The officers thought that the man was dead.
35. The man's personal officer asked the SO to radio a code blue emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing). The SO called the code blue at 8.52am. Control room staff called an ambulance straight away.
36. A nurse responded to the code blue, and was joined by an officer who helped her move the man onto the floor. The nurse examined the man and found blood had pooled on his right arm, he was cold and he had no pulse. She noted signs of rigor mortis and realised it would be futile to attempt resuscitation.
37. The ambulance arrived at the prison at 8.59am, and paramedics reached the man's cell at 9.09am. (Paramedics recorded that there was a delay at the gate for security checks.) Paramedics confirmed the man had died and it was apparent that he had been dead for some hours.

Contact with the man's family

38. An operational manager, was appointed as the prison's family liaison officer. At 10.30am that morning, he and a prison chaplain informed a friend of the man's, who acted for the man's sister, that he had died. They offered condolences and support. In line with Prison Service guidance, the prison contributed to the costs of the funeral, which held on 14 January 2015.

Support for prisoners and staff

39. The deputy governor, debriefed staff involved in the emergency response shortly afterwards. Those involved said they found it helpful and that the prison's care and welfare team had given them good support.

40. The prison posted notices informing other prisoners of the man's death, and offering support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case they had been affected by the man's death.

Post-mortem report

41. A post-mortem examination recorded the cause of death as heroin toxicity with early pneumonia. The pathologist concluded that heroin had depressed the man's central nervous system and caused his death.

FINDINGS

Drugs in prison

42. When he first arrived at the prison, a psychiatrist described the man's alcohol use as problematic, but did not refer him to the Lifeline service for support. From January to October 2014, officers completed four security reports about the man's suspected use of illegal drugs (9 August, 10 August, 29 September and 23 October 2014). As a result of these reports, the security department referred him for a drug test twice and notified the dedicated search group each time. However, the man's cell was never searched. Although the security department had referred him for drug test twice, this did not happen.
43. On 29 September, the man was admitted to the healthcare centre after he had a seizure and said he had taken spice. Officers warned him that if he used drugs again, he would be moved wing. The use of new psychoactive substances, (NPS) is an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests, unlike heroin which is detectable.
44. The Head of Security at Liverpool, said that access to drugs was an ongoing problem. Yet, he said that he would not have expected officers to search the man's cell, or even refer him for a drug test until there were four or five intelligence reports about suspected substance use. The head of security said that the prison did not have enough resources to search prisoners' cells who were suspected to be users, rather than suppliers. However, the man had been suspected of distributing drugs on the wing.
45. The man died of a heroin overdose. The source of his heroin and the extent of his use is not known. We are concerned that, during his time at the prison, officers and healthcare staff missed a number of opportunities to refer the man to the Lifeline substance misuse service. Although the security department referred him for drug tests and cell searches, no one referred him for support for his drug use. We note that the Independent Monitoring Board identified the use of drugs as a major concern at the prison, and recommended the prison allocate more resources to tackle the problem. At a recent inspection, HM Inspectorate of Prisons noted that intelligence about drug use did not always lead to drug tests on grounds of suspicion or cell searched.
46. We are concerned that the man was not referred for support for his drug use and no action was taken when evident security risks were identified. We make the following recommendation:

The Governor should ensure that prisoners identified as using drugs are referred to drug treatment services and that there is an active response to security intelligence, as part of an effective drug supply reduction strategy.

Unlock procedures

47. The officer unlocked the man's cell at 8.10am, but did not realise he had died until he went back to the cell at about 8.50am. As rigor mortis was present, the man was likely to have died well before his cell was unlocked. A paramedic noted that it was apparent that the man had been dead for some hours.
48. When officers unlock cells they should take active steps to check on a prisoner's wellbeing. The Prison Officer Entry Level Training (POELT) manual states:

"Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead."

49. Prison Service Instruction (PSI) 10/2011 states that:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable..."

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock. ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

50. While it would not have prevented the man's death, in other circumstances, failure to get a response from a prisoner or check their wellbeing when unlocking a cell could lead to a delay in treating a seriously ill prisoner. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

Emergency response

51. The SO radioed a code blue at 8.52am. The control room called an ambulance without delay. The nurse appropriately decided not to attempt resuscitation, as it was apparent that the man had been dead for some time. The ambulance arrived at the prison within seven minutes, at 8.59am, but paramedics did not arrive at the cell until 9.09am, 10 minutes later.

52. In the ambulance service report, paramedics described a delay getting to the patient because of security checks. In her police statement, one of the paramedics wrote that the ambulance arrived at the prison at 8.59am and they got to the man's cell at 9.09am, after clearing security checks. Paramedics told the investigator that they had had to hand in their mobile phones at the prison gate.
53. Prison Service Instruction 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol with the local ambulance service, which ensures, among other things, that there is no unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison.
54. We consider that ten minutes is too long to get paramedics from the prison gate to a cell in a medical emergency. The delay in this case would not have affected the outcome for the man, but in other emergencies, such as delay could be critical. We have identified this issue in another recent investigation into a death at Liverpool and make the same recommendation:

The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

Clinical care

55. The clinical reviewer concluded that the clinical care the man received at Liverpool was comparable to that he could have received in the community.

| Action Plan | | | | | |
|-------------|--|-----------------------|---|---|---|
| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| 1 | The Governor should ensure that prisoners identified as using drugs are referred to drug treatment services and that there is an active response to security intelligence, as part of an effective drug supply reduction strategy. | Accepted | <p>All prisoners are screened in reception for substance misuse concerns. There is a well established referral process for the drug dependency Unit (DDU) and Lifeline support from this screening. Prisoners are also able to self refer for substance misuse concerns.</p> <p>If a prisoner fails a mandatory drug test (MDT), a 'challenge meeting' is held with a Governor and a member of Lifeline in addition to the adjudication process, in order to motivate prisoners to address their substance misuse issues and begin counselling.</p> <p>We will implement an information sharing protocol between security and healthcare to advise healthcare when prisoners are suspected of, or it is confirmed that they are involved in illicit drug use. This information will prompt a review by the DDU team.</p> <p>In response to intelligence received cell searching will be authorised.</p> | 30/11/15 Security LCFT | |
| 2 | The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention. | Accepted | A governor's notice to staff (GNTS) will be republished bi annually to remind staff of this obligation. | 1/8/15 Safer Custody | |

| Action Plan | | | | | |
|-------------|---|-----------------------|---|---|---|
| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| 3 | The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency. | Accepted | It is recognised that 10 minutes was too long for the paramedics to get from the gate to the cell in this case. A protocol is in place with the North West Ambulance Service (NWAS) which includes the security measures that must be followed. The protocol has been reviewed recently to ensure that all necessary steps are taken to ensure a speedy passage through the gate and into the prison. | Completed | |