

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sam Molyneux, a prisoner at HMP Liverpool, on 1 April 2016

**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*



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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.

Mr Molyneux was found hanged in his cell at HMP Liverpool on 1 April 2016. Mr Molyneux was 21 years old. I offer my condolences to Mr Molyneux's family and friends.

Mr Molyneux was a challenging individual with a long history of illicit drug use and unpredictable behaviour. The investigation found a number of deficiencies in the operation of suicide and self-harm prevention procedures which were not conducted correctly. I am concerned that this is not the first time that I have found suicide and self harm prevention to be insufficient at Liverpool. The governor must take steps now to address these failings.

I am also concerned that Liverpool failed to support Mr Molyneux appropriately after he was assaulted, only five days prior to his death. More generally, I am concerned at the evident availability of illicit drugs at Liverpool, particularly New Psychoactive Substances (NPS), known as 'Spice'. Mr Molyneux readily and repeatedly admitted to being a user of Spice to prison staff but this was never properly addressed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

December 2016

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Summary

Events

1. Mr Molyneux was aged 21 and single. He had a history of mental illness, of self-harm and attempted suicide, and abuse of drugs, including Spice. Mr Molyneux had convictions dating back to 2006, and had served custodial sentences from 2011. His last custodial sentence ended on 12 February 2015.
2. On 25 August 2015, Mr Molyneux was remanded into custody at HMP Liverpool charged with breach of a restraining order and burglary. As he had told court staff that he would hang himself if he was sent to prison, on his arrival at Liverpool, staff monitored Mr Molyneux under Prison Service suicide and self-harm prevention procedures (known as ACCT).
3. Staff monitored Mr Molyneux under ACCT procedures on two further occasions at Liverpool after Mr Molyneux said he had thoughts of self-harm and suicide.
4. On 27 March 2016, Mr Molyneux was assaulted by fellow prisoners and received treatment for a superficial injury to his left hand. No action was taken by staff to support Mr Molyneux.
5. On 1 April, at 10.16pm, an officer found Mr Molyneux hanged in his cell. Staff began resuscitation until paramedics arrived. The paramedics pronounced Mr Molyneux dead at 10.52pm.

Findings

6. We found that ACCT procedures at Liverpool were not conducted correctly. At some case reviews the assessment of Mr Molyneux's risk failed to include consideration of all his risk factors and reduced the frequency of checks without any evidence that his risk of suicide and self-harm had reduced. Assessment of his risk was continuously raised and lowered but it is not always clear from the record what was discussed or considered or why these decisions were arrived at. No first case review was carried out on 20 February 2016, as required, nor were post-closure interviews held.
7. Other than medical attention and the initiation of procedures to move him to another wing, Mr Molyneux did not receive the support from staff he could have expected following his assault.
8. Mr Molyneux had a long history of daily use of Spice, which he shared with staff. He made further admissions of use within Liverpool several times but these were seemingly not taken seriously or appropriately addressed by staff members.
9. We are concerned that as some medical practitioners record a prisoner's medical notes on different case management systems, there is little opportunity for comprehensive oversight of a prisoner's clinical history and therefore no coordinated approach to his care at Liverpool.
10. On the day of his death, prison staff did not correctly follow emergency procedures.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - Understanding their responsibilities and the need to share all relevant information about risk;
 - Considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;
 - Assessing the level of risk and recording the reasons for decisions;
 - Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;
 - Setting ACCT caremap actions which are specific and meaningful and should review progress against caremaps at each review;
 - Conducting ACCT reviews as specified in the national instructions;
 - Conducting ACCT post-closure interviews as specified in the national instructions.
- The Governor should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence which:
 - Ensures staff efficiently and effectively communicate the nature of the act of violence;
 - Ensures staff support and protect victims;
 - Ensures staff take appropriate measures against perpetrators to address violent or anti-social behaviour.
- The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances
- The Head of Healthcare should ensure all health care providers record all interventions in a prisoner's primary medical records so all information is documented, enabling appropriate continuity of care for each prisoner.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:
 - Ensures staff efficiently and effectively communicate the nature of a medical emergency;
 - Ensures staff call for an ambulance immediately after an emergency code message is radioed.

The Investigation Process

11. 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.
12. The investigator visited Liverpool on 7 April. He obtained copies of relevant extracts from Mr Molyneux's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Molyneux's clinical care at the prison.
14. The investigator interviewed 17 members of staff and three prisoners at Liverpool in May and June.
15. We informed HM Coroner for Liverpool of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr Molyneux's mother to explain the investigation and to ask if there were any matters the family wanted the investigation to consider. Mr Molyneux's mother asked whether her son had been on suicide watch, whether he had received prescribed medication, and whether he had been bullied. She also requested details of the assault. Mr Molyneux's mother received a copy of the draft report. She did not make any comments.

Background Information

HMP Liverpool

17. HMP Liverpool is a local prison, holding over 1200 men and serves the Merseyside, Wigan and Blackburn courts catchment area. Lancashire Care NHS Foundation Trust provides health services at the prison. Lifeline Project provides the substance misuse services.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Liverpool was carried out in May 2015. Inspectors found that the quality of suicide and self-harm prevention procedures was variable. Some were very good but too many lacked consistency of case management, had inadequately-completed care plans and too many reviews that were neither timely nor multidisciplinary. Support for victims of violence and antisocial behaviour was underdeveloped. There were no management plans to address issues of vulnerability, to promote a prisoner's return to normal location (a general population wing) or ensure progression to other prisons. Staff were not sufficiently proactive in dealing with prisoners' issues. Relationships were further undermined by a lack of continuity of staff on the wings. Health provision had deteriorated sharply. Prisoners waited too long for routine GP appointments and they did not always have timely access to the full range of primary care services such as chronic disease management, clinics and screening programmes, which put their health at risk. Inspectors commented that three prisoners had taken their lives in the previous 14 months.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its annual report to December 2014, the IMB noted its concern about the level of bullying, use of mobile phones, and the use of drugs at Liverpool. The IMB was also concerned about the lack of sufficient staff to safely run the prison. It reported an increase in incidents of self-harm and bullying, with increased numbers of prisoners being supported because of a risk of suicide and self-harm.

Previous deaths at HMP Liverpool

20. Mr Molyneux's was the sixth self-inflicted death at Liverpool since 2014. It is very disappointing to find so many of the same issues repeated in a number of our investigations. We have raised concerns about the prison's assessment of the risk of suicide and self-harm among its prisoners and made recommendations about the quality of the relevant procedures. We have also raised concerns about the emergency procedures at the prison which were not consistent with national instructions.

Assessment, Care in Custody and Teamwork (ACCT)

21. 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. 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 carried out at irregular intervals to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary 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. 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 (Management of prisons at risk of harm to self, to others and from others (Safer Custody)).

New Psychoactive Substances

22. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
23. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence, and intimidation.
24. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

25. On 25 August 2015, Mr Molyneux was remanded into custody at HMP Liverpool charged with burglary and breach of a restraining order. Mr Molyneux had a conviction history dating back to 2006, and had served custodial sentences from 2011. His offences included those against the person, fraud, theft, drugs, firearms and possession of offensive weapons. His last custodial sentence ended on 12 February 2015. Mr Molyneux had a history of depression and illicit drug abuse, in particular Spice, a New Psychoactive Substance.
26. Before he left court for Liverpool, a court custody officer completed a Person Escort Report (PER) and a Suicide and Self-Harm Warning (SSHW) form. These documents are intended to alert staff in all criminal justice agencies who come into contact with a prisoner, about his or her risk of suicide and self-harm. Mr Molyneux told the officer that he would hang himself in prison and stab the first person he saw. The officer noted this on the forms. The escort record and the SSHW form accompanied Mr Molyneux to Liverpool.
27. A Supervising Officer (SO) and a nurse saw Mr Molyneux in reception. The nurse conducted the initial health screen, opened an ACCT document and completed the 'concern and keep safe' form. She recorded that Mr Molyneux had a history of self-harm and attempted suicide and had threatened to hang himself. A cell-sharing risk assessment (CSRA) was completed and Mr Molyneux was assessed as being at high risk due to a history of violence, bullying and setting a fire during previous custodial sentences.
28. The nurse recorded in Mr Molyneux's medical records that he had a history of anxiety and depression and his community doctor had prescribed citalopram (an anti-depressant). She recorded Mr Molyneux's history of self-harm and suicide, and a history of NPS (Spice) use. She referred Mr Molyneux to the mental health team and requested his records from his doctor in the community.
29. The SO completed an ACCT immediate action plan and explained to Mr Molyneux how to access help both from the Samaritans and Listeners (prisoners trained by the Samaritans to support other prisoners), if he needed it. He assessed Mr Molyneux as being at a raised risk of suicide and self-harm, and asked staff to check him at least once an hour.
30. On 26 August, at 10.10am, a member of the mental health team saw Mr Molyneux. Mr Molyneux said he felt very low as he did not have access to his son. He said he planned to work with social services so he could have supervised access. He said he used seven grams of Spice a day. She advised Mr Molyneux on the dangers and effects of using NPS but Mr Molyneux said would probably use it in prison, despite any consequences. She recorded that Mr Molyneux had no thoughts of self-harm.
31. At 10.40am, an officer assessed Mr Molyneux as part of ACCT procedures. Mr Molyneux said he had not seen his young son for eight months. He said he used seven grams of Spice a day. He had first self-harmed at the age of 12, and attempted to hang himself in 2013. He had been placed on an ACCT during earlier prison sentences, as he had swallowed glass and cut his arms. He said

he did this because he was depressed. He said he had no current thoughts of self-harm or suicide.

32. At 3.00pm, a SO held the first ACCT case review with an officer, a member of the mental health team and Mr Molyneux present. Mr Molyneux said he felt low but reiterated that he had no current thoughts of self-harm or suicide. She nevertheless assessed that Mr Molyneux was at a raised risk of suicide and self-harm, and reduced the level of observations from one per hour to four over the course of the day and four over the course of the night. She completed the ACCT caremap which contained four actions: to engage with mental health, to review the CSRA as Mr Molyneux wanted to share a cell, to engage with substance misuse services, and to receive confirmation of his medication from his doctor in the community.
33. On 27 August, Liverpool received Mr Molyneux's community medical records, which confirmed that he had been diagnosed with anxiety and depression and was prescribed citalopram at a single dose of 40mg a day. A prison GP repeated the prescription of citalopram.
34. On 2 September, a custodial manager and a nurse held an ACCT case review with Mr Molyneux. The manager recorded that Mr Molyneux was relaxed and engaged with the review. Mr Molyneux said that he felt much better than when he had arrived at Liverpool. They agreed that his risk of suicide and self-harm was low and they agreed to close the ACCT. The manager updated the caremap as all the actions had been completed. They set a post-closure review for 9 September. No post-closure interview was held.
35. On 11 September, Mr Molyneux was transferred to HMP/YOI Hindley. A nurse saw Mr Molyneux on arrival. He informed her of his history of self-harm, although he had no such thoughts currently, and was referred to the mental health team. Mr Molyneux was seen again by mental health staff on 12 September and 25 September. On both occasions, he said he had no thoughts of self-harm or suicide. He said he had used Spice daily in the community for four to six years. He had used Spice while at Liverpool and would do so at Hindley if he could obtain it. He said that when he did not use Spice he was anxious, had palpitations, his sleep and appetite were affected and he felt angry. He told the prison doctor he felt depressed, was not sleeping and was irritable. The doctor suggested a reduction in citalopram, then a prescription of mirtazapine (an anti-depressant), to be reviewed. He also prescribed zopiclone (for insomnia) for three nights only.
36. On 2 October 2015, Mr Molyneux was transferred back to Liverpool. On arrival, a prison GP only repeated the prescription of mirtazapine. On 7 October, Mr Molyneux appeared at court but his case was adjourned.
37. In October, Mr Molyneux saw members of the mental health team on three occasions. At a review on 12 October, he asked for his medication to be reviewed and admitted using Spice. He was referred to the prison GP and substance misuse team and, on 14 October, a GP reviewed Mr Molyneux's records, requesting a doctor's appointment. On 29 October, a prison GP saw Mr Molyneux for a medication review. He recorded that Mr Molyneux denied any

thoughts of self-harm or suicide and he prescribed an increase in mirtazapine from 15mg to 30mg.

38. On 26 November, an operational support grade (OSG) opened an ACCT document after Mr Molyneux said he had swallowed a razor blade. A nurse examined Mr Molyneux and recorded that she found no injuries. When she asked Mr Molyneux what had happened he just laughed. A custodial manager completed an ACCT immediate action plan. He recorded that Mr Molyneux was at a raised risk of suicide and self-harm. He noted that officers should check Mr Molyneux five times over the course of the day and five times over the course of the night.
39. The following morning, an officer assessed Mr Molyneux under ACCT procedures. Mr Molyneux said he had not swallowed any razor blades but had claimed to have done so because he did not have a job. He said he used Spice and suffered from depression. He said he had the support of his mother and sister but they were unable to visit as they lived in Wigan. Mr Molyneux said he expected to be sentenced to four years when he next appeared at court and wanted to transfer back to Hindley.
40. At an ACCT case review held that afternoon, Mr Molyneux told a Supervising Officer (SO), a member of the mental health team and a member of the chaplaincy team that he had not swallowed any razor blades and had no intention of harming himself; he just wanted a job. On the basis of what they had been told, the SO and the nurse agreed that the risk of suicide and self-harm was low and closed the ACCT. They set a post-closure review for 4 December.
41. On 30 November, an OSG re-opened the ACCT after Mr Molyneux gave him a letter that said he had heard voices that told him to harm himself, that he wanted to move to healthcare and speak to a member of the mental health team and if he was not moved he would hang himself. Later that evening, a custodial manager told Mr Molyneux that, as the mental health team only worked during the day, he could not facilitate a move to healthcare. He offered Mr Molyneux the opportunity of speaking to a Listener but he declined. He recorded that officers should check Mr Molyneux five times over the course of the day and five times over the course of the night.
42. Over December, ACCT case reviews were held with Mr Molyneux on three occasions. On 1 December, a SO, a nurse and a member of the mental health team were told by Mr Molyneux that he had thoughts of killing himself because he could not see his son. He said he could not cope without having a job and had a serious Spice habit. The SO assessed that Mr Molyneux was at a raised risk of suicide and self-harm, and reduced the level of observations to four times over the course of the day and four times over the course of the night. The ACCT caremap had two actions: for Mr Molyneux to get a job, and to engage with the psychology team.
43. At the next case review held on 8 December, a custodial manager, a SO and a nurse were present. The SO recorded that Mr Molyneux was unable to work as he had been assessed as being a security high risk prisoner on his arrival at Liverpool on 25 August. Mr Molyneux's level of security risk was to be reviewed in January, and the ACCT would remain open to support Mr Molyneux until then.

Mr Molyneux was now assessed as being at a low risk of suicide and self-harm, and the level of observations was reduced to three times over the course of the day and three times over the course of the night. The caremap was reviewed but not updated.

44. At the third ACCT case review held on 24 December, a custodial manager, a SO, a nurse and a member of the mental health team were present. The manager recorded that Mr Molyneux had the same issues as considered at the previous review and that he said he was concerned about his medication. Those present assessed that Mr Molyneux was again at a low risk of suicide and self-harm, and the level of observations remained unchanged. He updated the caremap and added a note that a doctor should review Mr Molyneux's medication. The next case review was set for 7 January. He did not sign the case review, or enter the time it took place.
45. In December, Mr Molyneux also saw a member of the substance misuse team. On 2 December, he reiterated his history of drug abuse. He agreed to undertake work in his cell to help him think about his triggers and his craving for drugs and the impact this had on his health. She recorded that Mr Molyneux was on ACCT procedures and prescribed mirtazapine. When she saw him again on 22 December, for a substance misuse review, she recorded that Mr Molyneux had not completed his in-cell work although he said he would complete and return it to her as soon as possible. Mr Molyneux said he did not leave the wing due to security issues. She told Mr Molyneux she would hold another review in early February.
46. On 23 December, a nurse saw Mr Molyneux after staff requested medical assistance because Mr Molyneux said he had cut himself. He recorded that Mr Molyneux refused to show where he had cut himself and refused any treatment. The nurse told Mr Molyneux to tell staff if he changed his mind about receiving treatment.
47. On 2 January, a nurse responded to a call for medical assistance as Mr Molyneux had cut himself. She recorded that Mr Molyneux had made superficial scratches to his right arm, and she dressed the wound. Mr Molyneux then said he had taken 13 mirtazapine tablets in the last 30 minutes. At 4.30pm, another nurse contacted the toxicity help line to establish what course of action was required. She referred the details to a prison GP and recorded that Mr Molyneux was no longer to be permitted to have any medication in his possession. At 5.22pm, Mr Molyneux saw the GP and told him he had taken an overdose of medication because he was unable to have a job. The GP recorded that Mr Molyneux refused to have a blood test and admitted Mr Molyneux to healthcare for health observation checks to be conducted every 30 minutes for the first four hours, hourly for two hours, every two hours thereafter. He noted that he anticipated Mr Molyneux would return to the wing the next morning.
48. That afternoon, two nurses held an ACCT case review with Mr Molyneux, who denied he felt suicidal or had taken an overdose of medication. He said he was prevented from seeing his son. The nurses assessed that Mr Molyneux was at a raised risk of suicide and self-harm, and increased the level of observations to hourly. At 11.10pm, Mr Molyneux refused to have his health observations

checked by a nurse. He was discharged from healthcare back to the wing. The level of ACCT observations remained at hourly.

49. Over the rest of January and early February ACCT case reviews were held on five occasions until the ACCT was closed on 5 February. On 7 January, Mr Molyneux told staff that he had no current thoughts of suicide. Those present nevertheless assessed that Mr Molyneux was at a raised risk of suicide and self-harm, but reduced the level of observations to four times over the course of the day and four times over the course of the night.
50. At an ACCT case review held on 14 January, Mr Molyneux told staff that he had not had his activity risk review which had been scheduled for January, and he had been worried about his son who had been ill. The SO recorded that the ACCT should remain open until Mr Molyneux was engaged in purposeful activity. The case manager and the SO assessed that Mr Molyneux remained at a raised risk of suicide and self-harm, and the level of observations remained unchanged. The caremap was updated and the action to have his medication reviewed was closed. At 7.18pm on 14 January, a member of the mental health team saw Mr Molyneux after he told staff he had thoughts of harming himself. He also said that he heard voices and saw shadows. The nurse recorded that Mr Molyneux was calm in mood and demeanour and referred him to be seen by a doctor.
51. At a further ACCT case review held on 28 January. Mr Molyneux said he had no thoughts of self-harm or suicide and asked for the ACCT to be closed. The SO recorded his assessment that Mr Molyneux was at a low risk of suicide and self-harm, and reduced the level of observations to three during the day and three at night. Although the next case review was set for 4 February, on 29 January, the SO and nurse held an ACCT case review with Mr Molyneux because he had been in a distressed state. Mr Molyneux nevertheless asked for the ACCT to be closed. They assessed that Mr Molyneux remained at a low risk of suicide and self-harm, and maintained the level of observations.
52. On 5 February, a SO and two nurses held an ACCT case review with Mr Molyneux, at which the SO recorded that Mr Molyneux understood he had to change his behaviour and stop using Spice if he wanted a job. Those present agreed that Mr Molyneux's risk of suicide and self-harm was low and they agreed to close the ACCT. They set a post-closure interview for 12 February. No post-closure interview took place.
53. On 11 February, a substance misuse worker saw Mr Molyneux for a substance misuse review. Mr Molyneux said he had not done the in-cell work as he had lost it. She re-issued the work and told Mr Molyneux she would see him in three weeks time.
54. On 19 February a nurse opened an ACCT document and completed the concern and keep safe form, after Mr Molyneux said he had heard voices that told him to kill himself and he was willing to act on this by hanging himself. Later that evening the nurse completed an ACCT immediate action plan and moved Mr Molyneux to share a cell with a Listener. He assessed Mr Molyneux as being at a raised risk of suicide and self-harm and asked staff to check him at least once an hour. On 20 February, an officer assessed Mr Molyneux under ACCT

- procedures. Mr Molyneux said he heard voices telling him to hang himself. He said he had a Spice addiction and was being bullied for a cell mate's debt.
55. For the remainder of February, two further ACCT case reviews were held. On 22 February, a SO and a nurse held the first review with Mr Molyneux. (First ACCT case reviews should be held within 24 hours of the ACCT being opened and this first case review should have been held on 20 February.) Mr Molyneux said he had fleeting thoughts of self-harm but had no thoughts of acting on them. However, he said he was concerned for his safety as a former cell mate's debt had followed him. The SO assessed that Mr Molyneux was at a low risk of suicide and self-harm, and reduced the level of observations to three over the course of the day and three over the course of the night. The SO completed the caremap with one action: for Mr Molyneux to move wings.
 56. On 29 February, staff held an ACCT case review with Mr Molyneux. Those present agreed that his risk of suicide and self-harm was low and agreed to close the ACCT because he was no longer judged as being at risk of self-harm. They set a post-closure interview for 7 March. No interview was held that day, however, on 8 March, the SO conducted the ACCT post-closure interview with Mr Molyneux. He said he had no concerns and would speak to staff or Listeners if he had any problems. No further ACCTs were opened.
 57. A prison GP also saw Mr Molyneux on 22 February to review his medication. Mr Molyneux requested a lower dose of mirtazapine. He said he was aware that he might feel more depressed on a lower dose and would consider an alternative anti-depressant. Mr Molyneux said he heard voices telling him to kill himself. The GP noted that Mr Molyneux was already under the care of the mental health team and, at that time, on an open ACCT. The GP recorded the reduction in mirtazapine from 30mg to 15mg, to be given to Mr Molyneux at 4.00pm each day. This was to be reviewed in four to six weeks time.
 58. On 9 March, the substance misuse worker saw Mr Molyneux in his cell for a substance misuse review. She recorded that Mr Molyneux was clearly under the influence of an illicit substance. Mr Molyneux admitted he had used Spice that morning. He had not completed the in-cell work and she told him that he should complete the work set for him and she would see him in three weeks time.
 59. On 27 March, a nurse saw Mr Molyneux in the treatment room on G wing. He said he had been assaulted by other prisoners. Mr Molyneux said that he had been stabbed with a pen on the back of his left hand and that he had a wound on his left forearm. She recorded that there was a 1mm puncture mark on Mr Molyneux's left hand, a superficial cut on the left forearm, small redness under the left eye, and two very small puncture sites to the back of his head along with a superficial graze. She cleaned the wound to the head and applied two small steri-strips. The remaining wounds were cleaned and required no further treatment. Mr Molyneux said he had not told prison officers about the assault because he feared repercussions from other prisoners. She recorded that she advised him to inform prison officers. She told the investigator that she was an agency nurse and had been working at Liverpool since October 2015. She had never received an induction and was unaware of any local protocols for completing reports after a prisoner had been assaulted.

60. A SO was on duty that afternoon. Mr Molyneux told her he had been assaulted. She assumed that the documents required by Liverpool's violence reduction policy for reporting an assault had been completed by another SO, who had been on duty in the morning. The other SO told the investigator that although he had been on duty that morning he was not aware that Mr Molyneux had been assaulted.
61. On 29 March, Mr Molyneux saw a prison GP as he complained of pain in his left hand. The GP recorded that Mr Molyneux had a superficial wound to his left hand. The GP spoke to the vascular registrar at the hospital and arranged for Mr Molyneux to leave the prison to be seen at A&E that day. (On 31 March the hospital confirmed in writing that there was no tendon, nerve or vascular injury or active infection to Mr Molyneux's hand.)
62. On 30 March, a SO placed Mr Molyneux on report for smashing the observation panel in his cell door and climbing onto the wing office roof. The following day, the Head of Security & Intelligence held an adjudication with Mr Molyneux. Mr Molyneux provided a letter in mitigation in which he said he was sorry but had done those things to get attention as he had been assaulted. He said he wanted a move to another prison as he feared for his safety. He said he had suicidal thoughts and, if not moved, he would act upon them. He also said he had contacted his solicitors. He found Mr Molyneux guilty of breaking prison rules and put him on basic regime for 21 days. This meant Mr Molyneux had no access to a television or canteen items for 21 days. He did not open an ACCT.
63. Mr Molyneux's prison phone records show that he made two calls to his solicitor, on 30 March and 1 April. The investigator contacted the solicitors, Mr Molyneux's legal representatives, to ask if the firm could assist the PPO investigation and share any information Mr Molyneux had given. They said they were unable to assist.
64. On 1 April, Mr Molyneux saw a SO because he said he feared for his safety, had issues with prisoners throughout the prison and wanted to move off the wing. He told her that he wanted to move to A Wing. The SO told Mr Molyneux that there was a process to be followed in order to be granted Vulnerable Prisoner (VP) status. He would have to name the prisoners from whom he believed that he was under threat and, based on the information provided, a decision would then be made as to the safest place in the prison for him. Mr Molyneux provided the names of eight prisoners resident on five different wings, none of whom were resident on A Wing. The SO told Mr Molyneux the VP application form would be completed and a custodial manager would interview him as soon as possible. The SO made an entry to this effect in Mr Molyneux's prison computer record at 11.19am.
65. At 10.16pm, an OSG found Mr Molyneux hanging from the window bars by a ligature made from bedding. Mr Molyneux had also constructed a barricade behind the cell door. He called for urgent assistance on his radio and described what he saw. He did not give the code blue emergency call. The control room log shows the message was called over the radio at 10.16pm. He told the investigator that he was aware of the national instruction to use an emergency

code when someone is found not breathing but he was shocked at finding Mr Molyneux hanging, and simply called for urgent assistance.

66. Staff responded. On arrival, the manager used his radio to call code blue. The control room log shows the code blue was called over the radio at 10.18pm. It took staff four minutes to force their way past the barricade and enter the cell. Once in the cell they immediately cut the ligature, placed Mr Molyneux on the floor and began cardiopulmonary resuscitation (CPR). The control room staff called an ambulance at 10.18pm.
67. Two nurses continued resuscitation and used an automated external defibrillator (which administers electrical shocks to restore a normal rhythm). The defibrillator found no shockable rhythm, so the nurses continued with CPR. Paramedics arrived at 10.28pm and took over Mr Molyneux's care. At 10.52pm, the paramedics pronounced Mr Molyneux dead.

Contact with Mr Molyneux's family

68. The governor visited Mr Molyneux's mother at her home, at 12.30am on 2 April. They broke the news of Mr Molyneux's death and offered their condolences.
69. On 4 April, the governor and appointed family liaison officer visited Mr Molyneux's mother again to offer support. In line with Prison Service guidance, the prison contributed to the costs of the funeral.

Support for prisoners and staff

70. After Mr Molyneux's death, the governor held a debrief for the staff involved in the emergency response, including healthcare staff, to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.
71. The prison posted notices informing other prisoners of Mr Molyneux's death, and offering 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

72. A post-mortem examination found that the cause of death was hanging. There was no evidence of any drug use.

Findings

Management of risk of suicide and self harm

73. Staff correctly opened an ACCT on 25 August, after Mr Molyneux arrived at Liverpool from court with a suicide and self-harm warning form. A SO completed an immediate action plan and assessed Mr Molyneux as being at a raised risk of suicide and self-harm. He set the level of observations at one per hour. We consider the initial level of observations appears relatively low for someone considered as being at a raised risk of suicide.
74. This ACCT was closed on 2 September, with a post-closure interview scheduled for 9 September. PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, which sets out the Prison Service's framework for delivering safer custody procedures, states that post-closure interviews must be conducted within seven days of an ACCT being closed. No post-closure interview was held.
75. On 26 November, staff appropriately opened an ACCT when Mr Molyneux alleged he had swallowed a razor blade. An officer completed an ACCT immediate action plan and assessed Mr Molyneux as being at a raised risk of suicide and self-harm. He set the level of observations at five times over the course of the day and five over the course of the night. We consider that this assessment and level of observation was appropriate.
76. At the first case review on 27 November, a SO and a nurse assessed Mr Molyneux's risk of further self-harm as being low and closed the ACCT. We consider that both the assessment and decision to close the ACCT was not appropriate given Mr Molyneux's level of risk. Mr Molyneux had a well documented history of self-harm, and it was less than 24 hours after he said he had swallowed razor blades.
77. Staff appropriately reopened the ACCT on 30 November, after Mr Molyneux said he heard voices that told him to harm himself. There were a further nine subsequent ACCT reviews, all multidisciplinary, with appropriate assessments of Mr Molyneux's level of risk and level of observation. That ACCT was closed on 5 February, with the post-closure interview scheduled to be held by 12 February. Again no post-closure interview was held.
78. A nurse appropriately opened an ACCT on 19 February, after Mr Molyneux told them that he had heard voices that told him to kill himself. A manager completed an immediate action plan and assessed Mr Molyneux as being at a raised risk of suicide and self-harm. He moved Mr Molyneux into a cell with a Listener and set the level of observations at one per hour.
79. At the first case review on 22 February, a SO and a nurse assessed Mr Molyneux's risk of further self-harm as being low and reduced the level of observations to three over the course of the day and three over the course of the night. Liverpool failed to follow the mandatory instruction contained in PSI 64/2011 to hold the first case review within 24 hours of an ACCT being opened. This is a significant failing.

80. Although the ACCT caremap devised on 1 December specified as one of its objectives that Mr Molyneux should get a job, his assessment as a high security risk prisoner on arrival at Liverpool on 25 August, effectively prevented this. This was understood by those participating in the ACCT process. Although Mr Molyneux's level of security risk was to be reviewed in January, there was little urgency in doing so as Mr Molyneux's admissions of taking Spice and occasional self-harm would not have allowed any change in his status. The other objective set out in the caremap was for Mr Molyneux to engage with the psychology team. This was regarded as a means of assisting and supporting him with a view to improving his behaviours, helping him through a future security assessment, and ultimately getting him into employment. While this was reasonable, the addition of more immediate objectives on which Mr Molyneux could have practically engaged might have assisted more effectively his progress towards the positive behaviours that would have helped him into employment.
81. We are particularly concerned that an ACCT was not opened on 31 March, after Mr Molyneux had informed staff, in writing in the context of his adjudication, that he had suicidal thoughts and would act on them if he was not moved to another prison. It is impossible to know whether being on an ACCT would have prevented Mr Molyneux from taking his own life on 1 April. However, we judge that it was a significant failing that no action was taken following Mr Molyneux's clear statement of suicidal intent.
82. In a thematic report about risk factors in self-inflicted deaths published in April 2014, we identified that assessments of risk too often placed insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. Mr Molyneux had a number of factors known to increase the risk of suicide and self-harm which are identified in our thematic report and in Prison Service instructions: he had told staff that he had suicidal intent, had a history of self-harm, had a history of use of NPS, and had mental health issues. Assessment of his risk was continuously raised and lowered but it is not always clear from the record what was discussed or considered or why these decisions were arrived at. 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:

- **Understanding their responsibilities and the need to share all relevant information about risk;**
- **Considering and recording all the known risk factors of a prisoner when determining their risk of suicide or self-harm;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting and recording appropriate levels of observations which are adjusted as the perceived level of risk changes;**
- **Setting ACCT caremap actions which are specific and meaningful and which are aimed at reducing prisoners' risks to themselves;**
- **Conducting ACCT reviews as specified in the national instructions;**
- **Conducting ACCT post-closure interviews as specified in the national instructions.**

Management of violence and anti-social behaviour.

83. Guidance on the effective management of violent prisoners is contained in PSI 64/2011. The national instruction states “*Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected*”. Liverpool has a local protocol for violence reduction and anti-social behaviour which sets out the steps staff are required to follow to support victims of violence, and the actions to be taken to address a perpetrator’s behaviour.
84. A nurse had not received any induction on the prison’s policies and protocols. She recorded that she told Mr Molyneux to tell staff that he had been assaulted. A SO said he was unaware that Mr Molyneux had been assaulted, and another SO assumed that a further SO had instigated the violence reduction procedures as he had been on duty that morning.
85. We consider that, other than the medical attention he was given and the initiation of procedures to move him to another wing, Mr Molyneux did not receive the level of support from staff that he could have expected following his assault and make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand the local violence reduction protocol and their responsibilities after an act of violence which:

- **Ensures staff efficiently and effectively communicate the nature of the act of violence;**
- **Ensures staff support and protect victims;**
- **Ensures staff take appropriate measures against perpetrators to address violent or anti-social behaviour.**

New Psychoactive Substances

86. Mr Molyneux made candid admissions as to his history of Spice use on arrival at Liverpool on 25 and 26 August and again at Hindley in September. Thereafter, on several further occasions he told prison officers and nurses during mental health reviews and ACCT reviews that he had used Spice within Liverpool. He agreed to work with substance misuse recovery groups at the prison but, as late as 20 February, said he was addicted to Spice. There are concerns that use of NPS can produce a range of bizarre behaviours or paranoia. Although Mr Molyneux sometimes told staff that he had done things which he then retracted shortly afterwards, in view of his history, staff should have taken his claims seriously. No one considered whether Mr Molyneux’s actions might have been influenced either directly by drug use or by a fear of violence resulting from drug-related debt.
87. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. We make the following recommendation:

The Governor should ensure there is an effective supply reduction strategy to help eradicate the availability of new psychoactive substances, and that staff are vigilant to signs of its use and know how to respond when a prisoner appears to be under the influence of such substances

Clinical Care

88. The clinical reviewer judged that overall the care that Mr Molyneux received from healthcare staff at HMP Liverpool was equivalent to the care he would have received in the community. He comments that Mr Molyneux appeared to have been a very challenging individual with a long history of illicit drug use and unpredictable behaviour.
89. However, the clinical reviewer was concerned that the toxicology report could find no evidence of mirtazapine in Mr Molyneux's blood sample. It therefore has to be assumed that he was not taking the prescribed medication. Additionally, medication reviews did not take place promptly.
90. The clinical reviewer commented that the drug rehabilitation service did not record entries on a prisoner's medical records in System 1. This meant that Mr Molyneux's records were not, in effect, correctly maintained as there was little opportunity for comprehensive oversight of a prisoner's clinical history and therefore no coordinated approach to his care by all health providers at Liverpool. Although no actual failing arose in respect of Mr Molyneux, Liverpool's record-keeping does not comply with General Medical Council and Nursing and Midwifery Council standards. We concur with the clinical reviewer's comments and make the following recommendation:

The Head of Healthcare should ensure all health care providers record all interventions in a prisoner's primary medical records so all information is documented enabling appropriate continuity of care for each prisoner.

Emergency response

91. PSI 03/2013 *Medical Emergency Response Codes*, issued in February 2013, contains mandatory instructions for 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 all prison staff must be made aware of, and understand, this instruction and their responsibilities during medical emergencies.
92. This national instruction required prisons to have a two level code system, which differentiates between a blood injury and all other injuries – usually code red, and code blue. Liverpool's local protocol states the control room should call an ambulance automatically as soon as any emergency code is radioed. The OSG did not use an emergency code and there was therefore a delay of two minutes before an ambulance was called. This delay would not have affected the outcome for Mr Molyneux, however it might be crucial in other emergencies in the future. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies which:

- **Ensures staff efficiently and effectively communicate the nature of a medical emergency;**
- **Ensures staff call for an ambulance immediately after an emergency code message is radioed.**

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