Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jimmie Palmer-Hoyes a prisoner at HMP Liverpool on 27 January 2017

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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*

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.

On 26 January, prison staff discovered Mr Jimmie Palmer-Hoyes hanged in his cell at HMP Liverpool. He was 50 years old. I offer my condolences to Mr Palmer-Hoyes' family and friends.

On reception at Liverpool, staff appropriately placed Mr Palmer-Hoyes on suicide prevention measures because he had self-harmed in police custody. He subsequently denied any thoughts or intent to self-harm. However, he spoke of feeling anxious and fearful of other prisoners and applied for vulnerable prisoner status. Staff could not find evidence to support this application, which was appropriately considered but declined.

The management of Mr Palmer-Hoyes' risk of suicide and self-harm was generally reasonable in the circumstances but, not for the first time at Liverpool, I still identify some weaknesses in the delivery of those measures.

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 **September 2017**

Contents

Summary

Events

1. On 25 January 2017, a Magistrates Court remanded Mr Jimmie Palmer-Hoyes to HMP Liverpool, charged with attempted murder. A Suicide and Self-Harm (SASH) warning form indicated that, while in police custody, Mr Palmer-Hoyes had been banging his head on the wall of his cell. As a result, a Supervisory Officer (SO) opened an Assessment, Care in Custody and Teamwork (ACCT) document so that Mr Palmer-Hoyes would be managed under procedures to address his risk of suicide and self-harm.

2. As he went through the reception process, Mr Palmer-Hoyes denied having any current thoughts of suicide or self-harm but stated that he was anxious about being in custody. He disclosed that he had last been in prison 15 years earlier. Nursing staff indentified that Mr Palmer-Hoyes used illicit drugs and was receiving methadone in the community. He was prescribed 40mls of methadone and placed on a detoxification programme. Once the reception process was complete, staff took Mr Palmer-Hoyes to the first night wing (A wing) and located him in a single occupancy cell.

3. Mr Palmer-Hoyes was observed once an hour under the ACCT monitoring procedures. At 10.15pm that night, he passed a letter under his door to the night officer, stating that he thought that he was under threat from other prisoners and felt like harming himself. The night officer spoke to Mr Palmer-Hoyes who denied any further thoughts of self-harm and got into bed.

4. On 26 January, an ACCT assessment was carried out with Mr Palmer-Hoyes. During the assessment, he spoke of feeling anxious and said that he thought other prisoners would attack him. He was reassured that this was not the case but remained anxious, applied for vulnerable prisoner (VP) status and was interviewed about this the same day.

5. He was asked who he felt under threat from and replied that he did not feel threatened by anyone in particular, but thought that he could be. It was explained to Mr Palmer-Hoyes that he would not be placed on the vulnerable prisoner wing, as this would not be appropriate. He would remain on the first night wing and eventually move across to the detoxification wing. Staff reassured him that he had no reason to be afraid.

6. Following the ACCT assessment and the interview regarding his VP application, Mr Palmer-Hoyes attended an ACCT case review, chaired by a SO. During the case review Mr Palmer-Hoyes was recorded as being upset that his VP application had not been accepted. As a result, the SO recorded Mr Palmer-Hoyes' level of risk of injury to himself as 'raised'. Despite this, the review team decided to reduce the frequency of ACCT observations, from hourly to once every two hours. Mr Palmer-Hoyes remained upset about his VP application and was anxious about mixing with other prisoners.

7. Mr Palmer-Hoyes was observed by an Operational Support Grade (OSG) at 7.20pm on 26 January, who briefly spoke with him. Mr Palmer-Hoyes acknowledged that he was alright and raised no issues.

8. During a further check at approximately 11.30pm, the OSG found Mr Palmer-Hoyes with a ligature around his neck, which he had tied to the bed frame. He called to Mr Palmer-Hoyes, but got no response, and immediately used his radio to call a medical emergency 'code blue' alerting nursing and prison staff to the situation. Other prison staff and nursing staff attended and started cardiopulmonary resuscitation (CPR) until paramedics arrived at 11.45pm. Paramedics took over resuscitation attempts, providing Mr Palmer-Hoyes with adrenaline and other intravenous medication, but he remained unconscious. At 12.04am, paramedics pronounced Mr Palmer-Hoyes dead.

Findings

Assessment, care in custody and teamwork (ACCT)

9. Mr Palmer-Hoyes' risk of suicide and self harm was appropriately identified. His concerns were addressed and the actions taken were effectively communicated. Measures put in place to manage his risk were proportionate and reasonable in the circumstances. However, contrary to PSI 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)* the ACCT assessor did not attend the initial ACCT case review.

Vulnerable prisoner application

10. Mr Palmer-Hoyes' application for VP status was reviewed appropriately. Staff explained that as there was no evidence of a threat, despite Mr Palmer-Hoyes' concerns, being located on the VP wing would not be appropriate for him. Staff reassured Mr Palmer-Hoyes that he would remain on A wing for at least five days and then move to the detoxification wing where he would be safe.

Recommendations

The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:

- The ACCT assessor, as set out in PSI 64/2011, should attend the Initial multidisciplinary case review. Where this is not possible, the assessor must provide a handover to the case manager, and record that they have done so in the ACCT document.

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 and obtained copies of relevant extracts from Mr Palmer-Hoyes' prison and medical records. He interviewed five members of staff at Liverpool in March 2017.

13. NHS England commissioned a clinical reviewer to review Mr Palmer-Hoyes' clinical care at the prison. She joined the investigator for the staff interviews.

14. We informed HM Coroner for Liverpool and Wirral of the investigation. He sent us the results of the post-mortem examination and we have given the coroner a copy of this report.

15. One of the Ombudsman's family liaison officers contacted Mr Palmer-Hoyes' family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. Mr Palmer-Hoyes' father responded. He asked for details of when the ACCT was started, the reasons why, and what measures were put in place as a result.

16. Mr Palmer-Hoyes father was provided with a copy of the draft report, and has not highlighted any factual inaccuracies.

Background Information

HMP Liverpool

17. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1400 adult men. Lancashire Care NHS Foundation Trust provides health care services at the prison.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Liverpool by HM Inspectorate of Prisons (HMIP) was conducted in May 2015. Inspectors found that the prison was not safe enough and nearly half of the prisoners thought it was easy to obtain drugs. Levels of self-harm were low compared to similar prisons but inspectors were particularly concerned at the number of deaths. They found that the quality of suicide and self-harm prevention procedures was variable, with the quality of case management being inconsistent and often weak.

19. The range and quality of mental health services were good, and working relationships between prison and mental health staff were effective. Inspectors reported that over 55% of discipline staff had mental health awareness training which helped identify and support prisoners with mental health problems.

Independent Monitoring Board

20. 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 latest annual report, for the year January to December 2016, the IMB stated that there was a gap in services at Liverpool for personality disorders and serious mental health issues. On Safer Custody, the board stated that the Safer Custody Team had proved the value of its strategy, and the hard work that it had put in had yielded dividends. Discussion at their meetings had gone a long way in contributing to its success over the year.

Previous deaths at HMP Liverpool

21. Mr Palmer-Hoyes was the sixth apparently self-inflicted death since 2015. In three of those deaths, we identified deficiencies with the operation of suicide and self-harm prevention procedures.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as being at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of harm. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. Mr Palmer-Hoyes was remanded into custody to HMP Liverpool by Magistrates' Court on 25 January 2017, charged with attempted murder. This was Mr. Palmer-Hoyes' second time in prison, having served a custodial sentence 15 years earlier.

24. On his reception at Liverpool, a SO was the first person to speak with Mr Palmer-Hoyes. The SO said that the clerk at the Magistrates Court had informed him that Mr Palmer-Hoyes would be accompanied by a suicide and self-harm warning (or SASH) form.

25. The SASH form indicated that Mr Palmer-Hoyes had deliberately run into a wall while in police custody, banging his head against the wall, but indicated no other suicidal or self-harm attempts or concerns. The SO said that Mr Palmer-Hoyes had bandages on both arms. Mr Palmer-Hoyes did not speak much during the reception procedures and he appeared quite low in mood. Despite this, he said that Mr Palmer-Hoyes did not express any fears for his own safety or thoughts of self-harm. Nevertheless, he decided to open an ACCT document.

26. Mr Palmer-Hoyes was seen and assessed by a nurse. She said that he conversed well, made good eye contact and nothing indicated that she should be concerned. She had been passed the SASH form and was aware that an ACCT had been opened. As standard procedure in such cases, she referred Mr Palmer-Hoyes to the Mental Health team. She said that during the healthscreen, Mr Palmer-Hoyes was fixated on being prescribed methadone. She said that he had a dressing on his right hand and when asked about this, he said he had injured it when attacking a man. He said that the police had taken him to hospital the day before.

27. The nurse made an appointment for nursing staff to review Mr Palmer-Hoyes' hand injury and the dressing was subsequently reviewed and changed on the 26 January by another nurse. Mr Palmer-Hoyes was given an appointment for a further dressing change on 28 January.

28. Mr Palmer-Hoyes was assessed for drug and alcohol issues by a nurse using three clinical tools which indicated mild opiate withdrawal. The pharmacy where Mr Palmer-Hoyes collected his methadone in the community confirmed his dose as 40mls daily. A prison GP prescribed a half dose of 20mls methadone alongside other withdrawal medication.

29. Once the reception process was completed, Mr Palmer-Hoyes was located on the first night centre, A wing. Staff observed Mr Palmer-Hoyes hourly as part of the ACCT observations, and he was also monitored by staff from the integrated drug treatment service (IDTS) as part of detoxification arrangements. Mr Palmer-Hoyes had agreed to engage with the IDTS team and a care plan was created. Mr Palmer-Hoyes would be monitored twice daily for any signs of withdrawal over his first five days in custody.

30. At 10.15pm on 25 January, Mr Palmer-Hoyes passed a letter under his door to the night officer stating that he felt himself to be under threat from other prisoners and felt like harming himself. An OSG spoke to Mr Palmer-Hoyes, who told him

that he was anxious about being in custody. He spend spent some time talking with Mr Palmer-Hoyes and recorded that Mr Palmer-Hoyes settled down, denied any further thoughts of self-harm. The observations remained at hourly, although documentation indicates that he carried these out more regularly. For the remainder of the night Mr Palmer-Hoyes was recorded as being asleep.

31. At 9.45am on 26 January, a SO completed an ACCT assessment with Mr Palmer-Hoyes. The SO said that Mr Palmer-Hoyes appeared down and, initially, was not making very good eye contact but was lucid and answered the questions he put to him. He described Mr Palmer-Hoyes' overall demeanour as one of remorse because, until now, he had kept out of trouble for 15 years. He said that he recalled Mr Palmer-Hoyes stating that he was 51 years old and this was not the right time for him to come back into custody and to be facing this particular charge. He described him as rather downcast and feeling sorry for himself.

32. Mr Palmer-Hoyes said that he felt that he was at risk. He said he had been on a vulnerable prisoner wing when he had last been in custody, 15 years earlier and that people would be after him. Mr Palmer-Hoyes had previously asked about VP status and the ACCT assessment was suspended to give him the opportunity to discuss his VP application.

33. A Custodial Manager (CM), a manager on the vulnerable prisoner wing at Liverpool, had gone to A wing to consider any VP applications submitted by new prisoners. He said that, wherever possible, at Liverpool, unless the prisoner is a sex offender, a suitable safe location will be found for them away from the VP wing.

34. The CM asked Mr Palmer-Hoyes the reason for his VP application. Mr Palmer-Hoyes claimed that everybody was accorded VP status for his alleged offence (attempted murder). The CM explained that this was not the case. He said that if Mr Palmer-Hoyes could identify who was posing the threat, a suitable location within the prison could be identified. Mr Palmer-Hoyes said that he was not under threat from anybody in particular, but had heard that he would be in danger because of what he had been told about being in prison.

35. The CM told Mr Palmer-Hoyes that based on the information available he would not be given VP status but would remain on A wing and eventually move to the detoxification wing. He said that Mr Palmer-Hoyes did not seem distressed when he told him that his application had been declined and he appeared to have no concerns.

36. Mr Palmer-Hoyes returned to complete the ACCT assessment with a SO and told him that he had not been granted VP status. During the assessment, Mr Palmer-Hoyes said that he had not self-harmed for 25 years and did not feel suicidal. He also stated that "it only takes a few minutes". Mr Palmer-Hoyes said that he was anxious, paranoid and afraid of being around other prisoners.

37. Mr Palmer-Hoyes subsequently attended an initial ACCT case review, chaired by a SO. An officer said that he did not attend the review as he was required elsewhere, and he could not recall whether he had spoken to anyone about the assessment.

38. The SO said that when she arrived on duty on 26 January, she read a note attached to the observation book, which had been handed in by Mr Palmer-Hoyes, in which he mentioned feeling vulnerable. The case review was also attended by a mental health nurse and a prison chaplain. The SO said that she explained to Mr Palmer-Hoyes that she could not overturn the decision regarding his VP application. However, she reassured him that he would stay on A wing for five days of observation by the DDU staff, and that H wing had been deemed a suitable location for him as he was on a methadone programme.

39. The mental health nurse confirmed that Mr Palmer-Hoyes continued to engage in the review despite the decision not to grant his VP application. She said that Mr Palmer-Hoyes was reassured by staff and signposted towards the chaplaincy, the Samaritans, to Samaritan-trained listeners on the wings, and to the integrated mental health team (IMHT) should his mental health deteriorate or he needed someone to talk to. Both the SO Richmond and the mental health nurse said that Mr Palmer-Hoyes gave no indication of any intention to self harm at the review and appeared to be actively engaging. Following the review, it was agreed that observations would be reduced from one every hour to six during the day and six at night (once every two hours). The assessment of the risk of harm Mr Palmer-Hoyes posed to himself remained at 'raised'. The SO explained that this was because his application for VP status had been refused.

40. On 26 January, Mr Palmer-Hoyes attended an appointment with a prison GP in the substance misuse clinic. Mr Palmer-Hoyes was prescribed a further 40ml dose of methadone, his regular dose. As Mr Palmer-Hoyes had been involved in his ACCT review he had not attended an induction talk with the DARS (Drug and Alcohol Rehabilitation Service), but a pack containing information on the service including a referral pack and information about New Psychoactive Substances (NPS) was posted into his cell.

41. Little is recorded about Mr Palmer-Hoyes over the remainder of the day. However, the ACCT document indicates that, when he was checked at 2.45pm, he was upset and crying, and told the member of staff that it was due to not being given VP status. Mr Palmer-Hoyes also refused to collect his evening meal as he told staff he felt that he was under threat. The prison was unable to find any evidence to substantiate Mr Palmer-Hoyes' concerns. Staff collected his evening meal for him, and it was recorded that he was happy about this.

42. On the evening of 26 January, an OSG was on night duty on A wing. He completed an ACCT check on Mr Palmer-Hoyes at 7.20pm, and spoke with him briefly. He said that Mr Palmer-Hoyes was sitting on his mattress, which he had placed on the floor. He acknowledged that he was alright and raised no issues. The OSG checked again at 8.45pm, and recorded that Mr Palmer-Hoyes was sitting, smoking a cigarette and watching television. He did not raise any concerns.

43. At approximately, 11.30pm, the OSG checked on Mr Palmer-Hoyes and other prisoners subject to ACCT monitoring. When he looked into Mr Palmer-Hoyes' cell, he saw him with a ligature around his neck, which he had tied to the bed frame. He called to Mr Palmer-Hoyes but got no response.

44. The OSG used his radio to call a code blue medical emergency, alerting nursing and prison staff to the situation. (A code blue indicates that a prisoner is either unconscious or has difficulties breathing.) A CM was the night orderly officer. When he heard the call over his radio he immediately made his way onto A wing. The OSG said that he broke the seal on his emergency night pouch to gain access to the cell key, and as he did so the CM and nursing staff arrived. The OSG said that he entered the cell and cut the ligature. He lowered Mr Palmer-Hoyes to the floor before removing the ligature from around his neck.

45. A nurse responded to the code blue call. When she arrived, staff had already begun performing cardiopulmonary resuscitation (CPR). She continued CPR with the assistance of other nursing staff and officers, until paramedics arrived at 11.45pm. Paramedics took over resuscitation attempts, providing Mr Palmer-Hoyes with adrenaline and other intravenous medication, but he remained unconscious. At 12.04am, paramedics pronounced Mr Palmer-Hoyes dead.

Contact with Mr Palmer-Hoyes' family

46. An officer was appointed as the prison's family liaison officer. He visited the home of Mr Palmer-Hoyes' father and informed him of his son's death. He informed the family of the processes that would follow and answered any immediate questions. The prison contributed to the funeral costs, in line with national policy.

Support for prisoners and staff

47. After Mr Palmer-Hoyes' death, a governor de-briefed the staff involved. Members of the staff care and welfare team made themselves available to those staff that required their support.

48. The prison posted notices informing other prisoners of Mr Palmer-Hoyes' death, and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm prevention in case they had been adversely affected by the death.

Post-mortem report

49. The Coroner has confirmed that the initial post mortem concluded that the cause of death was neck compression due to low suspension hanging. Results from toxicology indicate that Mr Palmer-Hoyes had not taken any illicit substances prior to his death.

Findings

Assessment, care in custody and teamwork (ACCT)

50. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody*). During his short time at Liverpool, Mr Palmer-Hoyes was subject to ACCT monitoring. A full ACCT assessment and a first case review, chaired by a SO and attended by a mental health nurse and member of the chaplaincy, was completed on 26 January.

51. A SO completed the ACCT assessment, but did not attend the case review. He could not recall whether he had spoken to the previous SO about Mr Palmer-Hoyes prior to leaving the wing. PSI 64/2011 states that the assessor must: *attend the case review, whenever possible (if they cannot attend, they must meet with the Residential / Case Manager prior to the first case review and give a detailed summary of the assessment discussions and key issues).*

52. During the ACCT review, the SO noted that Mr Palmer-Hoyes was upset after being refused VP status. Because of this, the review considered that Mr Palmer-Hoyes' level of risk to himself should remain at 'raised'. However, Mr Palmer-Hoyes did not state any intent to harm himself and engaged well with staff. This prompted the SO and others present at the ACCT review to reduce the frequency of his observations by half - from hourly, to once every two hours.

53. The review considered that Mr Palmer-Hoyes' risk was still raised following the refusal of VP status and took the decision to reduce the frequency of observations. In doing so, it drew on the views of all present and, notwithstanding the benefit of hindsight, was reasonable in the circumstances.

54. We have raised concerns about the management of the ACCT process at Liverpool on previous occasions. 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. In particular:

    - **The ACCT assessor as set out in PSI 64/2011 should attend the Initial multidisciplinary case review. Where this is not possible, the assessor must provide a handover to the case manager, and record that they have done so in the ACCT document.**

Vulnerable prisoner application

55. The CM's decision on 26 January in respect of the application for vulnerable prisoner status was justified. Mr Palmer-Hoyes' concerns were discussed, they were not found to have any substance and he was reassured that he had no reason to be fearful of other prisoners. He was reassured that he would remain on A wing and would then move to the detoxification wing where he would receive appropriate support.

Clinical care

56. The clinical reviewer concluded that the care Mr Palmer-Hoyes received was of a good standard, at least equivalent to that which he could have expected to receive in the community.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141