PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Liverpool in February 2013

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death of a man, who was found hanged in his cell in February 2013 at HMP Liverpool. He was 24 years old. I offer my condolences to the man's family and friends.

The original investigator left this office during the investigation. A new investigator continued the investigation. A clinical reviewer reviewed the clinical care and treatment that the man received at Liverpool. I am very sorry for the delay in issuing this report.

The man had been released on licence from a previous sentence and was recalled to Liverpool on 29 March 2012, facing further charges. During his previous time in prison he had been supported under suicide and self-harm management procedures. He had also harmed himself while living in the community.

On 3 February 2013, the man told an officer that he felt suicidal. He was anxious about the possible outcome of a disciplinary hearing the next day and about the length of his sentence. At the time, a mental health nurse saw him each day and he was being managed under suicide and self-harm prevention procedures. A wing manager intended to raise the level of observations, but the effect of the changes she made was to reduce the frequency at night. At 6.45am on a morning in February, an officer found the man hanging by a belt attached to the bunk in his cell. Two officers began cardiopulmonary resuscitation and healthcare staff were called. Nurses took over the resuscitation but a paramedic arrived and pronounced the man dead.

He was a troubled young man and it is commendable that the clinical reviewer found that the mental health support he was offered was consistent with best practice. Similarly, for most of his time at the prison, he was managed appropriately under Prison Service suicide and self-harm prevention procedures. However, the investigation identified some deficiencies in their operation. For example, I am concerned that the man's risk of suicide and self-harm was not identified when he first arrived at Liverpool, despite a range of evident risk factors. Nor were support procedures begun until after he harmed himself several days later and he was not referred to the mental health team till then. It is of even greater concern that the level of observations and support did not always reflect his assessed level of risk and, although he had been identified as at increased risk of suicide on 3 February, the frequency of observations the night he died was reduced, apparently inadvertently. We cannot know whether an increase in observations would have changed the outcome for the man, but that possibility cannot be discounted.

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 **December 2014**

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SUMMARY

1. The man was recalled to prison on 29 March 2012, after committing a violent offence while on licence from a previous prison sentence. He was sent to HMP Liverpool. On 14 December 2012, he was convicted and sentenced to nine years imprisonment, with a three year extended licence.

2. At an initial health screen, the man said that he had previously attempted suicide, had been receiving treatment for depression and was under the care of a psychiatrist. He reported that he had harmed himself by cutting during his previous sentence, but said he had no current thoughts of suicide or self-harm. He was not identified as at risk of harming himself.

3. On 4 April 2012, the man cut his arms with a razor blade and said that he was hearing voices. Prison Service suicide and self-harm prevention procedures, known as ACCT, were begun and a nurse referred him to the prison's mental health team. He was managed under ACCT procedures until 4 June, when he seemed to have settled. A review should have taken place on 11 June, but there is no evidence that this was done.

4. On 7 July, another ACCT was opened when the man again harmed himself by cutting and he remained managed under ACCT procedures until 17 January 2013. In December 2012, he was sentenced to nine years in prison. There is no record that healthcare staff assessed him when he came back from court. He told prison officers that he accepted his sentence, but it appears to have had a negative affect on him. At an ACCT post-closure review on 24 January, he said he was coping well and had the support of his girlfriend and family. On 26 January, he allegedly assaulted a member of staff and a disciplinary hearing was arranged for 4 February.

5. On 29 January, the man told a mental health nurse that he had thoughts of suicide every day and was finding it difficult to come to terms with his sentence. He said he was worried that he would be sent to the segregation unit as a result of his disciplinary charge and because of his mental health problems he would not be able to cope. The nurse did not open an ACCT that day but, after speaking to him again, he opened one the next day. The man said that this would not help him.

6. On 3 February, the man told an officer that he was feeling suicidal and was worried about his disciplinary hearing the next day and the possibility of being sent to the segregation unit. The officer suggested to the wing manager that the frequency of ACCT checks should be increased. The manager set them at five times during the day and five times at night. This was an increase during the day but a reduction at night, as previously he had been required to be checked at least hourly. The manager asked a mental health nurse to speak to the man. He told the nurse that he was concerned about his medication and worried about

being segregated and not having a television. He told the nurse that he was looking forward to a visit from his girlfriend and daughter and that he had an appointment with his mental health caseworker the next day. The nurse assessed him as stable and did not consider he was suicidal.

7. An officer checked the man at 1.00am, 3.00am and 5.10am and each time recorded that he appeared to be asleep. At around 6.45 am, an officer conducting a roll check, found the man hanging by a belt attached to the upper bunk. The officer radioed a medical emergency and attempted to resuscitate him but, after getting no response, decided that to continue would be futile. Paramedics arrived and, at 7.05am, confirmed that the man was dead.

8. When he was recalled to prison in March 2012, the man had a number of risk factors which should have indicated the need for an ACCT to be opened and a referral to mental health services, but this was not done until he harmed himself several days later. After that his care was generally good and the clinical reviewer found that he received appropriate care for his mental health problems in line with best practice. ACCT procedures did not always operate as effectively as they should have done, but many of these deficiencies were not related to his death. However, the agreed level of observations and interactions did not always seem to reflect the man's assessed level of risk and we were particularly concerned that the frequency of observations were reduced on the night he died, even though it had been acknowledged that his level of risk had increased. We make three recommendations about these matters.

THE INVESTIGATION PROCESS

9. Notices were issued to staff and prisoners at HMP Liverpool inviting anyone with information about the man's death to contact the investigator. No one responded.

10. The original investigator visited the prison in February 2013 and obtained the man's prison and clinical records. He interviewed members of staff on 24 April. He left the PPO's employment in July 2013 and the investigation was completed by a further investigator.

11. The investigator visited Liverpool on 17 September and spoke to the prison's family liaison officer. She met a detective inspector from the police and the Coroner's Officer. She subsequently interviewed other staff jointly with the clinical reviewer and wrote to the Governor with initial feedback about the preliminary findings of the investigation.

12. Merseyside PCT was initially responsible for appointing someone to review the clinical care the man received at the prison. After their abolition, this responsibility was assumed by NHS England who appointed a clinical reviewer to conduct a clinical review.

13. HM Coroner for Merseyside was informed of this investigation and has provided a copy of the post-mortem report. We have kept the Coroner informed of the progress of this investigation. We apologise for the delay in completing the investigation and the impact on the inquest.

14. One of our then family liaison officers contacted the man's family to outline the purpose of the investigation and to ask them if they had any specific issues they wanted the investigation to consider. The original investigator and the family liaison officer met the man's family at the offices of their legal representatives. On the family liaison officer's retirement, a colleague took over as family liaison officer. In April 2014, the investigator and family liaison officer met the man's brother and aunt. His family have asked for the following concerns to be considered during the investigation.

    - Was their relative prescribed the correct medication?
    - Why, on the night before his death, was their relative not moved to the healthcare unit? (He had been on a previous occasion when he had harmed himself.)
    - Why did their relative have a belt in his possession when he was deemed to be at risk of suicide?
    - Was there CCTV footage of their relative's cell?
    - What support was available to their relative, especially in respect of his history of self-harm? They considered that there was "total neglect by the mental health services".

- Was a transfer order in place for their relative to move to HMP Risley? (The man put in a transfer request on 30 January 2013.)
- The man's family were very upset about how news of his death was broken to them and how the prison treated them afterwards. His family felt that they should have been informed first, although he had named his girlfriend as his next-of-kin.

15. The man's family received a copy of the draft report. They pointed out that his ethnicity was mixed race and not black as stated in the clinical reviewer's report. We have asked the clinical reviewer to amend this in his report. We have also slightly amended the key events to indicate that he was managed under the suicide and self-harm procedures at other prisons.

HMP LIVERPOOL

16. HMP Liverpool is a local prison which serves courts of Merseyside and holds up to 1477 men. There are eight residential wings, some of which have different functions and offer specific services to prisoners, such as drugs treatment, detoxification and resettlement.

17. A number of NHS Trusts provide healthcare services at the prison and there is a purpose-built healthcare centre, which opened in 2007, with outpatient and inpatient facilities. A doctor is on duty every day during normal working hours and nurses are on duty throughout the night. Mersey Care NHS Trust provides treatment for severe and enduring mental health issues, substance misuse and psychological services. Liverpool Community Health NHS Trust provides primary mental and physical health care (including a crisis mental health service) and also treats prisoners who have both substance misuse and mental health problems. Any member of staff who is concerned about a prisoner's mental health can fill in a single point referral form. All mental health teams attend the weekly single point referral meeting, at which prisoners are allocated to one of the teams depending on their needs.

Her Majesty's Inspectorate of Prisons

18. HM Inspectorate of Prisons carried out an unannounced full follow up inspection of Liverpool in October 2013. Inspectors found that the quality of ACCT case management documents was reasonable, assessments were prompt and some reviews were multi-disciplinary with input from the chaplaincy and mental health teams. However, few cases had consistent case managers and the quality of care plans was mixed. Prisoners received good support through crisis intervention nurses and counselling.

19. Inspectors described mental health services as extensive and impressive and noted that prisoners spoke favourably about the support they received. The mental health work load was substantial, but temporary staff shortages at the time were affecting integrated working between health providers and the rest of the prison.

Independent Monitoring Board

20. 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. In its most recent annual report for 2012, the IMB noted that mental health services at Liverpool are considered to be some of the best in the country. However, the IMB also identified that there were a large number of prisoners with personality disorders and that some of these prisoners had to be managed in the segregation unit because of their behaviour. The IMB described the suicide

prevention policy as “positive” and said that staff at the prison took this part of their work very seriously.

Previous deaths at Liverpool

21. During 2012, there were five deaths at HMP Liverpool, two of which were self-inflicted. In one of these cases, an ambulance was not called immediately after an emergency radio code was called. In those investigations, and after the death of a prisoner at HMP Preston in 2012, who had previously been held at Liverpool, we made recommendations about the ACCT procedures.

Assessment Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner’s most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

KEY EVENTS

23. The man was released on licence from a prison sentence on 5 August 2009. On 29 March 2012, his licence was revoked and he was recalled to prison. He went to HMP Liverpool and was subsequently charged with violent offences. During his time at Liverpool and also at Wetherby, he was managed under the suicide and self-harm management procedures. On 14 December 2012, he was convicted and sentenced to nine years in prison with a further three years extension on licence.

24. When he arrived at the prison, a registered mental health nurse in the crisis intervention team carried out an initial health screen. He said that he had been using cannabis every day and that he had been seeing a psychiatrist because he heard his own voice in his head, telling him to harm himself. He said that he felt paranoid and that he had harmed himself by cutting his arms before his last prison sentence. The clinical record shows he had harmed himself during his previous prison sentence and had been managed under ACCT suicide and self-harm prevention procedures.

25. The man told the mental health nurse that he had no thoughts of suicide or self-harm. He did not want to be monitored under ACCT procedures as he did not want to draw attention to himself and just wanted to get on with his sentence. He told the nurse that, while he had been in police custody, a doctor had prescribed him diazepam (used for anxiety) to help calm him down as he had been banging his head on the cell door. He said he had been taking fluoxetine (an antidepressant), tramadol (a painkiller) and lansoprazole (a medication for acid reflux) and a prison doctor prescribed these for him.

26. The man was considered a high risk to other prisoners because of his violent offences and problems managing his anger, and was given a single cell on G wing. On 4 April 2012, he cut his arms severely with a razor blade. While a nurse was assessing his wounds, he became very agitated, pushed a table over, fell to the floor and started to bang his head against the bunk bed. He said that he could hear voices telling him to do “bad things” and to hurt himself and that he wanted to kill himself.

27. The mental health nurse decided that the man should move to the healthcare centre for observation and assessment. He asked a doctor to prescribe the man zopiclone (a sleeping tablet) for three nights and mirtazapine (an antidepressant). The nurse referred the man to the mental health inreach team and opened an ACCT.

28. ACCT reviews were held on 4 April, 12 April (a day later than scheduled), 18 April (a day later than scheduled), 26 April (two days later than scheduled) and 10 May. Two of these reviews were chaired by a custodial manager, one by a

healthcare manager and one by a senior officer (SO). The name of the manager who held the first review is unclear.

29. According to security information reports (SIRs), some prisoners in the healthcare centre complained that the man had been intimidating and aggressive towards then. He had been kicking objects and swinging a snooker cue around. The prisoners said that they stayed in their cell because they were frightened of him and did not feel safe when he was around.

30. Three other security information reports about the man were completed in April 2012. On 11 April, he threw a cup of hot water at a member of staff and later the same day he smashed up a television set. On15 April, he verbally abused a member of staff and threw his dinner through the hatch in his door. He was warned about his behaviour each time.

31. A visiting psychiatrist assessed the man on 16 April. He told the psychiatrist that he was worried about returning to a wing as he was settled in the healthcare centre and might harm someone if he moved. He also talked about his childhood experiences, which he said were distressing. He said that he was expecting a long sentence but that he could cope with that. The psychiatrist arranged to see him two weeks later and a mental health nurse would see him in the interim. When the nurse saw the man a week later, he told her that he was feeling better.

32. On 30 April, the man told the visiting psychiatrist and a senior trainee psychiatrist that he was feeling better and had not had any thoughts of harming himself or suicide. He said that he had not heard any voices telling him to harm himself or others. The psychiatrist did not consider there was sufficient evidence to diagnose a psychotic illness, such as schizophrenia, but believed his symptoms were more likely to be related to his past experiences and current stress. He referred him to the primary care psychology services and arranged to see him in four weeks. The man said he was keen to engage with services, particularly to help manage his anger.

33. On 14 May, the man cut his arms again and staff moved him to a safer cell in the healthcare centre. (A safer cell is designed with minimal ligature points to make suicide or self-harm as difficult as possible.) He told the senior trainee psychiatrist and a mental health nurse that mirtazapine was not working and he was troubled by distressing dreams. The trainee psychiatrist noted that the man seemed to be in a normal mood and did not have any difficulty concentrating. His emotional responses were appropriate; he engaged well during the interview and gave a rational explanation for his behaviour and his symptoms. The trainee psychiatrist increased his dose of mirtazapine and encouraged him to engage with mental health staff to help him find alternative coping strategies other than harming himself. He told the trainee psychiatrist that he was worried about not having contact with his daughter. The mental health nurse contacted social services and confirmed that the man was unable to have contact at that time

because they were assessing his risk to her. The man accepted this. (It was later agreed that he could have contact with his daughter.) An ACCT review was held on 14 May, after he had self-harmed and he was keen to move back to an ordinary wing. He subsequently moved to I wing. The next review was scheduled for 15 May, but took place on 16 May. A supervising officer who chaired the review assessed his level of risk of suicide and self-harm as raised. She noted that he said that cutting was a release and he had no thoughts of suicide.

34. A senior officer held the next ACCT review on 31 May (it had been scheduled for the day before) which a nurse attended. The man appeared much more settled and said he wanted to sort himself out for his daughter. The review considered whether to close the ACCT, but decided that it should remain open because of his recent self-harm.

35. The senior officer held a further review on 4 June, attended by a nurse and a further senior officer at which the man remained settled and said he had not had any thoughts of harming himself for some time. The actions in his careplan had been completed and the review decided to close the ACCT. A post-closure review was arranged for 11 June at 3.00pm, but there is no record that this took place.

36. On 11 June, the man told the senior trainee psychiatrist that his girlfriend and his aunt had told him that friends of the victims of his offences were in the prison and planned to attack him. He said that they were members of a gang but he did not know who they were. He wanted to move to another prison in West Yorkshire. The trainee psychiatrist completed a security information report but prison staff were unable to identify who the prisoners were. They offered to move him to the vulnerable prison unit for protection, but he refused.

37. On 5 July, the man told a prison GP that he was unable to concentrate and was in a low mood. The GP prescribed venlafaxine, another antidepressant, in addition to mirtazapine.

38. At 8.30am on 7 July, an officer found the man had made deep cuts to his arms with a razor blade. He told nurses who treated the cuts, that he had heard voices in his head which had told him to kill himself. An ACCT was opened and staff removed the razor blade.

39. At an ACCT assessment that afternoon, the man said that he had been experiencing bad dreams and hearing voices telling him to kill himself. He said that he had started harming himself when he was 18 years old. He was worried that this was the third time he had cut himself since he had arrived at the prison and that he felt worse after harming himself. He was confused and tired because he was not sleeping properly, and thought he might cut himself again if he did not

manage to sleep. He was due to attend court on 27 July and said he was expecting a long sentence if he was eventually found guilty.

40. A senior officer (SO) chaired the first ACCT review, with an officer, a nurse and the man. The nurse noted that the man had been taking mirtazapine for two months and had recently started taking venlafaxine. She thought that venlafaxine might have impacted negatively on his thought patterns and she advised him not to take any more until his medication was reviewed. (Venlafaxine is linked to higher rates of suicidal behaviours than many other antidepressants.) The nurse arranged a prescription of zopiclone to help him sleep. The level of observations was set at three interactions per day and the same number of observations at night.

41. An ACCT careplan set actions for him to see the psychiatrist and a mental health nurse. The nurse reviewed him later that day and he told her that he had cut himself instead of killing himself as he did not want his daughter growing up knowing he had killed himself. He said that his mother had taken her life which had had a very negative emotional impact on him.

42. The mental health nurse went to see the man again the next day, 8 July, after officers were concerned about him. He seemed very low in mood and told the nurse that he did not think that he could cope any more. She noted that he looked like he had been crying. He said that he had slept better but his dreams were full of dead people and other distressing images that he would not talk about. She arranged for him to move to a safer cell in the healthcare centre.

43. A prison GP saw the man after he moved to the healthcare centre. He arranged for a psychiatrist to see him as soon as possible and stopped the venlafaxine prescription.

44. On 10 July, a clinical psychologist saw the man. He told her that 20 July was the anniversary of his mother's suicide and that he was now the same age as his mother was when she had died. He told her about his dreams and his interrupted sleep patterns. She arranged for him to be prescribed more zopiclone and checked that he wanted to continue with counselling. She ensured that the man had telephone credit so that he could contact his family and checked that he had a television in his cell to provide him with some distraction. On 11 July, he moved to a standard single cell in the healthcare centre.

45. At an ACCT case review on 12 July, the level of observations was raised to five conversations with the man during the day and five observations at night. The mental health team continued to see him. The next ACCT review was arranged for 20 July, the anniversary of his mother's death.

46. On 13 July, a visiting consultant forensic psychiatrist examined the man and noted that he found no evidence of any psychotic symptoms. He said that he had not cut himself as an act of suicide and said that he did not have any plans to kill himself. The consultant forensic psychiatrist did not think there was any need for further psychiatric involvement because the man did not present as having a formal mental illness. He prescribed seven nights' supply of zopiclone to help stabilise the man's sleep pattern and continued the prescription for mirtazapine. The man asked for a longer term prescription for zopiclone but the psychiatrist explained that prolonged use of zopiclone is not recommended as it leads to problems with tolerance and addiction. The psychiatrist did not make any further appointments but said that he would be happy to see the man if he asked to see him in the future.

47. On 18 July, the man complained that he had still not received his zopiclone and a prison GP arranged for it to be issued. On 20 July, he attended an ACCT review and was noted to be low in mood and subdued. There is no record that review noted it was the anniversary of his mother's death. He said that he had fleeting thoughts of harming himself and still heard voices telling him to hurt himself but he had no plans to act on them. The careplan was updated for the man to see a mental health nurse, and for another review of his medication.

48. After the ACCT review, a worker from the Community Justice Liaison Team spoke to the man. He told her that he was not sleeping and was still hearing voices telling him to harm himself. He said that he did not know who was representing him at court. He was worried that he might be assaulted in prison but did not give the names of anyone who he thought might do this.

49. At 9.22am on 21 July, the man told a nurse that he had made cuts to both his wrists and to his neck and throat area. He said that he could not be "arsed anymore". The nurse wrote that he appeared subdued and vacant and would not talk further about why he had harmed himself, but said that he had been trying to get a vein. Nurses treated his injuries and another ACCT review took place. He said he wanted to kill himself so he was moved to the safer cell again. He was given telephone credit so that he could contact his family and an appointment made for a medication review that afternoon. His observations were increased to constant supervision and another ACCT review was arranged to take place in 24 hours. (Constant supervision is when a prisoner is observed continually by a member of staff.)

50. At 4.16pm, a locum doctor examined the man, who said that he was still having problems sleeping, and was hearing voices and seeing dead people. The doctor prescribed diazepam and arranged for him to see the doctor to discuss his medication. At 10.00pm, he was given a zopiclone tablet and, according to the records, slept until 3.00am.

51. At the ACCT review the next day, the man appeared more settled and said that he was much happier. Observations were reduced to three each hour and it was agreed that he should remain in a safer cell for another 24 hours.

52. The man continued to be managed under ACCT suicide and self-harm prevention procedures until 17 January 2013. The ACCT documentation for this period shows that ACCT case managers often changed. While not all reviews were multi-disciplinary, information was obtained from the healthcare team at each review when they were unable to attend.

53. On 25 July, the man told a prison GP that he was feeling very agitated and restless and wanted more sleeping tablets. The GP explained that zopiclone is only a short term medication and suggested that he take propranolol (an anti-anxiety medication) instead. He prescribed him propranolol 80mg each day.

54. On 14 December, the man was sentenced to nine years imprisonment with an extended licence period of three years. There is no record that he saw a member of the healthcare team after his court appearance or that there was an ACCT review immediately after he was sentenced. However, in the ACCT ongoing log, it is noted that he told an officer that he was OK. On 17 December, a mental health nurse asked the man how he felt about his sentence and he appeared to have accepted it.

55. On 17 January, a senior officer held an ACCT review which a mental health nurse attended. The man said that he still had fleeting thoughts of harming himself but that he had a number of protective factors, including his relationship with his girlfriend and his child, which outweighed the risks of self-harm. He said that he was happy for the ACCT to be closed because he saw it as a step forward. He said that he had found relaxation classes helpful. A post-closure review took place on 24 January. At the review, he said that he was coping well and had support from his family and his girlfriend and would approach staff if he needed further support.

56. On 26 January at 4.10pm, the man wanted some crisps when he collected his meal but an officer said that he could not have any. He then allegedly threw his plate and food at the officer and tried to jump over the servery counter to punch the officer. He was charged with a disciplinary offence of assaulting the officer. A hearing was opened at 10.00am on 28 January, but was adjourned until 4 February.

57. On 29 January, a mental health nurse spoke to the man at the request of officers. The man told him that he thought about suicide every day. He said that he had agreed to the previous ACCT being closed even though he had continued to feel suicidal. He was anxious about his sentence and believed his release date was incorrect. The mental health nurse wrote that the man had more or less disengaged and did not want to talk about his concerns. He refused to consider

going to the gym, education or engaging with music and said that these activities made him think about killing himself more. He had also stopped attending relaxation classes.

58. The mental health nurse told the investigator that the man often interacted well with other prisoners, laughing and joking soon after he had expressed suicidal thoughts. He also noted this in the clinical record. He explained that he thought that this demonstrated that the man could distract himself from his negative feelings. He said that the crisis intervention team staff worked with the man for a long time. They had tried to help him to explore his thoughts and feelings, but he was often vague, avoidant and confrontational and said that it did him no good to talk about them.

59. The visiting psychiatrist and the three registered mental health nurses all thought at various times that the man believed that medication alone could help him. The psychiatrist and one of the nurses said that they had felt pressurized into prescribing medication and, in particular, diazepam, as the man said that this was the only medication which helped him. The mental health nurse explained that diazepam is highly addictive and can be misused in prison. Diazepam is a benzodiazepine, and National Institute for Clinical Excellence (NICE) guidelines state that benzodiazepines should only be used for a short term, usually two to four weeks, for anxiety. The man told the nurse that his current medication to help with anxiety (propranolol) was not working and needed to be changed.

60. At his appointment with the mental health nurse on 29 January, the man told him that he had an adjudication (disciplinary hearing) on 4 February. He said that he believed that allowances should be made for him because of his feelings of depression and officers did not understand him. He said that he was expecting to be moved to the segregation unit as a punishment and because of his mental health problems he would not be able to cope there.

61. After the meeting, the mental health nurse wrote in the clinical record that talking to the man in any meaningful way was becoming more difficult. He said that the man became aggressive and confrontational when any therapeutic way of working with his mental health issues was suggested and would not engage. He thought that nothing other than the right medication (probably diazepam) would help him. The nurse summarised that, based on the man's past behaviour, it would be reasonable to assume that his risk to himself would increase, especially if he was found responsible for assaulting the officer.

62. The mental health nurse completed an action plan with two actions. The first was that healthcare staff should consult the visiting psychiatrist and the clinical psychologist about the man's medication, and the second was to discuss his concerns with a senior officer on the man's wing and recommend that another ACCT be opened. At 4.42pm, a locum doctor changed the man's prescription

from propranolol to buspirone (another medication to help reduce anxiety). He also prescribed three nights of zopiclone to help the man sleep.

63. The next day, 30 January, the mental health nurse spoke to the man at 10.00am. He opened an ACCT, although the man said that it would not help him. A supervising officer completed the immediate action plan with four actions:

- To remain in his own cell on the wing. (The man said that he was happy where he was.)
- For staff to have meaningful conversations three times a day and three times a night until the assessment was completed.
- For the man to have continued support from mental health services.
- To ensure that the man was aware of other support, such as Listeners and the Samaritans telephone. (Listeners are prisoners who have been trained by the Samaritans to support other prisoners in distress.)

64. An officer interviewed the man at 2.30pm for an ACCT assessment. The man said that he was still struggling to come to terms with his sentence, that he was happiest in a single cell and that he was employed in a workshop. He said that he was concerned that his release date was wrong. The officer wrote that the man had most recently attempted to kill himself on 7 July 2012 (he appears to have overlooked the incident of 21 July). The man said that he had last cut himself about two months before and that cutting himself did not ease his feelings.

65. The officer noted that the man was not looking after himself physically and that he felt bad about himself. He was not sleeping well and felt lethargic. However, he said that he would now co-operate with therapy, if any practical help was offered. He said that he found his relationships with his girlfriend and daughter, and his family in Huddersfield, supportive.

66. An ACCT review was held immediately after the assessment, and the man said that he was missing his girlfriend and children. Although he frequently thought of suicide, he said he did not have any active plans to carry it out. The man's risk to himself was considered to be raised. The review agreed that staff would continue to have three meaningful interactions with him during the day and observe him hourly throughout the night, at irregular intervals. A careplan was completed with the following objectives:

- Depression – to continue to see mental health nurse. (Noted seen 30 January.)
- Medication – to be reviewed. (Noted completed 30 January.)
- Release date concerns – for custody administration to check this and for the man to put in an application asking for this to happen. (Noted application sent off 30 January.)

- Unsettled at Liverpool – for the man to put in a transfer request. (Noted that an application was sent 30 January.)

67. On 31 January, the man's girlfriend and daughter visited him. The ACCT records indicate that an officer spoke to him after the visit and the man said that he was okay. On 1 and 2 February, it was noted on the ongoing log that he had been out of his cell at association periods and that he had told officers that he was fine.

68. An officer on I wing where the man lived, said that she knew him and sometimes talked to him, but not frequently as she did not work on his landing. She knew that he was on an ACCT and on the morning of 3 February, before 11.30am, she noticed him out on the landing. He told her that he had received a letter, which gave his sentence and release dates, and that he was not happy with it. She said that he appeared to be anxious.

69. The man refused to collect his lunch. The officer tried to persuade him to go and get his meal but he said that he was feeling anxious and his stomach was churning so he did not want it. He said that he would just lie on his bunk and try and get some sleep.

70. Around 3.30pm in the afternoon, the officer saw the man out of his cell, with a sandwich in his hand. She told him that she was pleased that he had got some food but he said he would probably not eat it and asked to speak to her. They went to his cell and he told her that he felt suicidal. She asked him if he was going to do something and he said that he did not know. The officer described the man as having blank, lifeless eyes, so she tried to engage him in conversation. He told her that he was due to attend an adjudication and he was worried that he would be sent to the segregation unit. The officer told him that she did not think that this would happen. She offered him the support of a Listener and the use of the Samaritans telephone, but he said he did not want either. She suggested that his ACCT observations should be increased and he agreed. She then spoke to the supervising officer about this and made an entry in the ACCT document about her conversation with the man. She was then asked to help out on another wing and did not have any further contact with the man.

71. The supervising officer telephoned the mental health crisis intervention team and asked if someone could come and talk to the man. A mental health nurse went to see him in his cell. She told the investigator that the man was worried about his hearing the next day and about being sent to the segregation unit where he would not have a television set. He also told her that he felt like cutting himself because he was anxious about his current medication. He believed that he was not receiving enough buspirone to make a difference. He gave his razor blades to her in an effort to reduce the risk of him cutting himself.

72. The man talked to the mental health nurse about protective factors, such as being settled at Liverpool. He said he had a good friend there. He also talked about his daughter and said that he had sent out visiting orders that day for his girlfriend and daughter to visit during the coming week. He agreed that he would see his caseworker the next day. The nurse then left the man's cell and she said he seemed settled. She said that she had no concerns and did not think that he was suicidal.

73. The nurse then spoke to the supervising officer who changed the level of observations to five each day and five each night. When interviewed, the supervising officer said that she was "was going to increase his observations through the night and the next day until he got to see [his caseworker]". Previously observations at night were required to be hourly so in fact this was a reduction in his night time observations. The nurse told the investigator that she thought increasing his observations was a "safety net". She did not think that he was at an increased risk of self-harm and she told the investigators that she would not have considered increasing his observations given how he presented to her.

74. An officer was on duty on I wing that night and was required to check prisoners who were subject to ACCT monitoring. During the handover he was told that earlier in the day the man had told staff that he wanted to harm himself. At 8.00pm, the officer checked on the man, who was watching television. He asked him if he was okay and he said he was and gave him a thumbs up sign.

75. In his statement to the police, the officer said that he had known the man for some time. He was aware of his mental health problems and had previously seen him in a very low mood. He said that when he checked him that evening he seemed fine. He then had to leave the wing to escort another prisoner to hospital. An officer from J wing covered for him on I wing. There is a different signature in the ACCT ongoing log, which is illegible, which indicates that another officer checked the man at 11.00pm. The assistant night orderly officer signed the log at 11.05pm to show that he had read the log. According to a separate log sheet for prisoners requiring special observations, which was not attached to the ACCT document, the officer returned to the wing at 10.50pm and checked the man at 10.55pm. This check was not noted in the ACCT ongoing log. He also checked the man at 1.00am, 3.00am and 5.10am. He recorded in the ACCT ongoing log that each time he checked the man, he appeared asleep. He used a torch to see through the observation hatch into the man's cell and said that he could see him clearly. There were closed circuit television (CCTV) cameras covering the landing. Police reviewed the footage and noted that the officer walked along with wing checking cells at 5.17am. (The CCTV timings appear to have been fast.) There was no CCTV coverage inside the man's cell.

76. The day staff came on duty at 6.30am. The officer handed over to a colleague and told him that there had been no problems during the night and then he left

the wing. The officer who received the handover had begun a roll check on the highest landing, landing five, and according to his police statement, he was about to check the man's cell when another prisoner shouted to him from the other side of the wing. The officer immediately responded but was unable to clarify who had called out to him. When he resumed the roll count, he started from the end opposite the man's cell. (This was confirmed by CCTV footage.) He checked the remaining cells and, when he reached the man's cell, he opened the observation hatch. The cell light was on and he saw that he was suspended by his neck from the top bunk by a belt. (The head of safer custody said that for reasons of dignity, usually only prisoners being constantly supervised would have a belt removed, or when the prisoner was assessed as being a high and imminent risk to himself.)

77. The officer immediately called a code blue emergency call over the radio and gave his location. (A code blue emergency call is used when a prisoner is unconscious.) The call was logged by the control room staff at 6.45am. (The CCTV footage timing shows 6.48am.) The officer then went into the man's cell and used his anti-ligature knife to cut the belt from around his neck. He was unable to support the man's body and he fell to the floor. He said that when he first saw him, he thought that he had died because his skin was grey, he was not breathing and his eyes were fixed open. The CCTV shows that two officers arrived at the cell about a minute later. One officer checked the man's airway and pulse. She could not hear him breathing or find a pulse so she started to carry out chest compressions. Her colleague alternated compressions with her.

78. The officers continued until a nurse arrived a few minutes later. The nurse had radioed for the emergency bag to be brought from the healthcare office to the cell. An officer went for the emergency bag, which contained a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). He said in his statement to the police that it took him about 30 seconds to return with it.

79. The nurse could not find the man's pulse and said he was not breathing. She attached the defibrillator to him but it did not detect a shockable heart rhythm.) After approximately ten cycles of cardiopulmonary resuscitation all the staff present decided to stop as there had been no respiratory effort from the man and they agreed that it was futile and disrespectful to continue.

80. The prison control room log indicates that an ambulance was called at 6.56am, although the North West Ambulance Service (NWAS) record states that they received the call at 6.54am. This is at least six minutes after the code blue call. The first ambulance responder arrived at 7.02am and a second responder arrived at 7.22am. The first paramedic attended the man's cell and at 7.06am confirmed his death. The ambulance records indicated that the crew were delayed for five minutes at the prison gate but clarified to the investigator that this was the time to reach the man's cell and not a delay at the gate.

81. The man had listed his girlfriend as his next of kin and at approximately 10.30am, the prison's family liaison officer and a chaplain went to inform her of his death. There were no other family members named as next of kin. When they broke the news to his girlfriend, she and her mother, said that they would telephone the man's mother and family to let them know, which they did.

82. At 1.30pm, the man's older brother and other family members went to the prison and the Governor and other members of staff met them. His family wanted to see their relative's body and became upset when they were told that this would have to be arranged through the Coroner. They were upset that he had nominated his girlfriend as his next of kin. His family were not satisfied with the prison's response and because of their distress, we understand that the meeting became heated and they were asked to leave. A different family liaison officer was then appointed to liaise with the man's family. The prison contributed towards the costs of the man's funeral in line with national guidance.

83. Later that day, a debrief was held for the staff who had been involved with the emergency response to offer them support. They said that they found this helpful. However, the wider healthcare team, and in particular the crisis intervention team, said they had not been invited and thought that it would have been helpful to have attended as they knew the man well and had been closely involved in his care.

84. Prisoners were informed of the man's death by a Governor's notice. Those who were being managed under ACCT procedures had their cases reviewed in case they had been affected by his death. All prisoners were offered the chance to speak to a Listener or the Samaritans and encouraged to speak to wing officers if they had any concerns

ISSUES

Clinical care

85. The man had suffered from mental health problems before he went to prison and was being treated for depression in the community. He had harmed himself and said he was seeing a psychiatrist. Despite this, he was not referred to mental health services at his initial health screen in March 2012. However, he was referred five days later, on 4 April 2012, after he had cut himself. After that, he remained under the care of mental health services. A consultant psychiatrist and later two other psychiatrists assessed him. They all confirmed that he was not suffering from a psychotic illness but found that he suffered from depression and on occasions suffered from the effects of insomnia.

86. The man was treated with a variety of antidepressant and anxiety relieving medication and was offered therapy and relaxation classes. He used these therapies to some extent but, members of the mental health team said that he became increasingly adamant that the only thing that would help him was medication, in particular diazepam. The prison crisis intervention team saw him on a number of occasions. He is reported to have been insightful of his condition and was able to seek help from the crisis intervention team when he became stressed. A mental health nurse from the crisis intervention team concluded that the man was not engaging in therapy and when he tried to engage him he became avoidant and confrontational.

87. The clinical reviewer considered that the man was given appropriate medication, and offered therapies in line with NICE guidelines for both depression and self-harm. He said that the level of mental health support offered to him was both appropriate to his presentation and consistent with best practice.

88. On the basis of the clinical review, we are satisfied that the man received appropriate support for his mental health problems at Liverpool. However, we note that when he attended court for sentencing on 14 December, there is no record that he was screened by a member of healthcare staff when he returned after receiving a lengthy sentence. Prison Service Order 3050 (Continuity of Healthcare) has a mandatory instruction that there should be a protocol to ensure that prisoners returning in these circumstances should be screened for any healthcare or suicide or self-harm issues. While this did not affect the outcome for the man, it is important that prisons recognise that court appearances, sentencing and change of status are recognised trigger points for suicide and self-harm and that they screen accordingly. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status,

including court appearances, should be assessed for potential health or suicide and self-harm issues.

Management of risk of self-harm and suicide

89. Staff judgement is fundamental to the ACCT system. ACCT relies on staff using their experience and skills, as well as local and national assessment tools, to determine risk. They must balance this against the prisoner's known risk factors and their presentation. Prison Service Instruction (PSI) 64/2011 states that "all staff who have contact with prisoners must be aware of the triggers that may increase the risk of suicide, self-harm or violence and take appropriate action". A list of potential triggers includes previous deliberate self-harm, mental illness and early days in custody.

90. When he arrived at Liverpool, a number of these factors applied to the man. He was held in police custody before he arrived at Liverpool on 29 March 2012. While there, he had been seen by the police medical examiner because he was agitated and banging his head in the cell. He told his caseworker that he had attempted suicide at a previous prison and he had a history of self-harm in the community and in prison. He had also been recalled and his offence was one of a violent assault. These are all factors which increase the risk of suicide or self-harm. He self-harmed by cutting his arm just days after he arrived at the prison, a further indicator that his risk should have been identified by staff at initial screenings. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

91. While the man was generally supported well by the ACCT process, there were some aspects of the ACCT process which could have been better. A post-closure review did not take place as it should have done following the closure of an ACCT on 4 June 2012. While the first ACCT was open, there were at least four case managers in eight reviews, which did not allow consistency of case management. Not all reviews took place as scheduled. On 29 January 2013, the man told a mental health nurse that he still felt suicidal yet an ACCT was not opened until the following day. On two occasions, the level of observations at night was set at hourly (7 July 2012) or five times per night (30 January 2013)

even though he had either very recently self-harmed or expressed suicidal thoughts and been assessed as being at raised risk of suicide or self-harm. We do not consider that the level of observations reflected his assessed level of risk.

92. As noted, we consider that, overall, the man was well supported by the ACCT process and many of the issues identified are procedural ones which did not impact significantly on his care. However, we are concerned about the apparent confusion about the level of observations set on 3 February. An officer had suggested to the supervising officer that the man's level of observations should be increased as he had told her he felt suicidal. She agreed and believed she was doing so, but the effect of the changes she made was to increase the level of observations during the day and decrease the frequency at night. This meant that, at a time when it was acknowledged that the man's risk had increased, after midnight on 4 February, he was observed only three times until the next roll check, when previously he would have been checked at least six times. Had the level of observations actually been increased, as we consider they should have been, he would have been observed more frequently than once an hour. Crucially, he was not checked after 5.10am until the roll check at approximately 6.48am, during which time he apparently hanged himself and died. We cannot know whether, if more frequent observations been set as intended, he would have been discovered in time for officers to have saved his life. 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:

- **Opening ACCTs appropriately when a prisoner says he is suicidal;**
- **Assessing the level of risk and recording the reasons for decisions;**
- **Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;**
- **Ensuring consistent case management**
- **Holding appropriate case reviews and post-closure reviews as scheduled.**

Emergency response

93. An officer found the man suspended by a ligature made of a belt while conducting a roll check, at approximately 6.48am. He immediately called an emergency code blue over the radio and then went into the man's cell. According to the control room log they did not call an ambulance until 6.56am, nine minutes after receiving the code blue call.

94. The guidance to prisons at the time of the man's death required ambulances to be called urgently whenever there were grave concerns about the immediate health of a prisoner and instructed prison staff not to wait for healthcare staff or others to attend first. The gravity of his position was apparent as soon as he was

found and should have resulted in an ambulance being called immediately. PSI 03/2013, which was issued shortly before this man's death but which was implemented from 28 February 2013, now contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that in the event of a prisoner being unconscious, the control room must call an ambulance immediately. Liverpool's current guidance reinforces that staff should not wait for the night manager or healthcare staff to attend before confirming such an emergency. We are satisfied that Liverpool's current local protocol is now in line with PSI 3/2013 so do not make a recommendation about this issue.

95. We consider that the attempt to resuscitate the man was appropriate. Staff responded quickly, and emergency equipment, including a defibrillator, was collected and used in the resuscitation attempt. After approximately 10 cycles of cardiopulmonary resuscitation all the staff present agreed that it was futile and disrespectful to continue. European guidelines state that attempts at resuscitation should not continue if the outcome would be futile. The clinical reviewer commented that given the clinical expertise of the healthcare staff, the decision to stop was reasonable.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all prisoners returning to the prison after events which could involve a change in status, including court appearances, should be assessed for potential health or suicide and self-harm issues.

2. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular this should ensure that reception and first night staff:

   - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
   - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
   - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

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

   - Opening ACCTs appropriately when a prisoner says he is suicidal;
   - Assessing the level of risk and recording the reasons for decisions;
   - Setting appropriate frequency of reviews and levels of observations which are adjusted as the perceived risk changes;
   - Ensuring consistent case management
   - Holding appropriate case reviews and post-closure reviews as scheduled.