

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edwin O'Donnell a prisoner at HMP Liverpool on 23 October 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.

The 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 Edwin O'Donnell was found hanged in his cell in the segregation unit at HMP Liverpool on 23 October 2016. He was 26 years old. I offer my condolences to Mr O'Donnell's family and friends.

Mr O'Donnell had a difficult, troubled early life and was familiar with prison from the age of 17. His challenging behaviour led to him being transferred between several prisons and he occasionally spent long periods in segregation units. However, he did not have a recent history of self-harm and, when concerns were raised about the risk he posed to himself, there were serious deficiencies in identifying the nature of that risk and procedural failures in managing it which meant that, ultimately, staff failed to take effective measures to protect him.

Segregation can have a damaging effect on those who may be at risk of suicide and self-harm and this was compounded at Liverpool by a disgraceful physical environment. Mr O'Donnell's cell was dark and dirty with broken windows and at various times lacked running water, working light fittings or an emergency cell bell. Conditions were so squalid that prisoners had to sleep in their clothes to keep warm and were able to throw excrement and abuse at each other through their observation panels. This was wholly unacceptable.

This is not the first time that we have found suicide and self-harm prevention to be inadequate at Liverpool. We raised similar concerns in a report following a death at Liverpool six months before Mr O'Donnell's. The governor must take steps now to address these failings.

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

Richard Pickering
Deputy Prisons and Probation Ombudsman

March 2018

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Summary

Events

1. Mr Edwin O'Donnell was sentenced to a total of six years imprisonment in 2014 for attempted robbery and assault. He was moved to HMP Liverpool in March 2016. It was not his first time at Liverpool where staff knew him well. Apart from one historic instance of self harm in 2008, he had not previously been identified as at risk of suicide or self-harm.
2. Throughout his time in prison, Mr O'Donnell had a history of assaulting both staff and prisoners. He bullied prisoners but was also vulnerable to being bullied. On 23 September he was moved to the segregation unit after setting fire to his cell. Staff began monitoring Mr O'Donnell's risk of suicide and self-harm. The monitoring was stopped the next day after Mr O'Donnell insisted that he had no thoughts of self-harm or suicide and wanted to be in the segregation unit. He remained there for the rest of his time at Liverpool.
3. On 21 October, Mr O'Donnell cut his ear with a razor blade. He told a nurse that he had thoughts of harming himself as he had been constipated for three weeks and did not think healthcare staff were taking him seriously. Staff resumed monitoring Mr O'Donnell under suicide and self-harm support procedures but considered his risk of self-harm and suicide to be low.
4. In the early hours of 23 October, Mr O'Donnell told an officer that other officers would kill him that night. A nurse who spoke to Mr O'Donnell in response to the officer's concern about his behaviour, (which the officer thought might be as a result of withdrawal from drugs) tried to reassure Mr O'Donnell that he was mistaken. The nurse requested that a member of the mental health team should see him but this did not happen. Mr O'Donnell shouted out of his cell at 6.30am that if he died that day, it would be the officers' fault. Mr O'Donnell smeared faeces over his cell walls. He told a prisoner later in the day that he would be dead by 8pm that evening.
5. An officer looked into Mr O'Donnell's cell at 6.45pm but could not see him. He sought assistance of other staff who found Mr O'Donnell hanged and raised the alarm. Healthcare staff and paramedics tried to resuscitate Mr O'Donnell but he had died.

Findings

6. Mr O'Donnell was subject to Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm monitoring at the time of his death in a segregation unit that lacked basic amenities. Prisoners must only be kept in segregation on ACCT under exceptional circumstances. The first period of monitoring in the segregation unit was authorised by the duty governor who considered that there was no viable alternative location for Mr O'Donnell. Staff started the ACCT procedures, accepted Mr O'Donnell's assertions that he was not at risk, viewed his actions as reckless behaviour and stopped monitoring him one day later. They began ACCT procedures for a second time when he cut his ear, but no case review chaired by a senior manager was held to

consider whether the segregation unit was an appropriate place for him. Staff viewed his behaviour as wanting attention for his bowel problems rather than indicating an escalation in risk.

7. We identified significant failures in the management of Mr O'Donnell's risk of suicide and self-harm. His segregation reviews functioned as administrative exercises rather than opportunities to identify and address the risks underlying his behaviour. No one reviewed Mr O'Donnell's escalating level of risk on the day of his death or discussed how to reduce it despite noting several outbursts about his impending death. Mr O'Donnell's behaviour was monitored, with staff observing him at predictable hourly intervals.
8. Mr O'Donnell had a history of anxiety which was flagged up in his clinical record in July 2015. An outstanding appointment for him to begin counselling when he was at HMP Garth was not picked up upon his transfer to Liverpool. The clinical review concluded that a more in-depth initial reception health screen would have found historical self-harm and a history of substance abuse which could have been probed further. Mr O'Donnell's offender supervisor made a referral to psychological services ten days before his death after he told her of mood swings and feelings of paranoia. Healthcare staff were required to visit all prisoners in the segregation unit daily but did not always do so; there were days when no-one saw Mr O'Donnell.
9. Prison staff visited Mr O'Donnell's family after his death and mentioned that he had probably taken "spice", a new psychoactive substance (NPS), in the days before his death. There was historic information that he had used spice in the past and anecdotal information about the availability of spice in the segregation unit. However, there was no evidence from the post mortem and toxicology reports to suggest he had in fact taken NPS.

Recommendations

- The Governor and Head of Healthcare should ensure that a high screening score for anxiety and depression should be considered as part of a mental health assessment.
- All members of staff who have had meaningful contact with a prisoner kept in the segregation unit under prison rule 45 (good order or discipline) should be invited to attend segregation review boards.
- The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:
 - Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
 - The frequency of observations should reflect the prisoner's risk and staff should adjust them when that risk changes.
 - Staff should review a prisoner's risk when they express thoughts of suicide or self-harm.

- A multidisciplinary case review should be held when there is evidence of significant change in risk.
- Staff should check on prisoners subject to ACCT procedures at unpredictable intervals and record their observations.
- The Governor and Head of Healthcare should ensure that healthcare staff attend the prisoners in the segregation unit everyday.
- Nursing staff who attend segregation review boards should record this in the prisoner's clinical record.
- The Deputy Director of Custody should ensure that the facilities management contract to repair cells operates effectively.
- The Governor should ensure that when informing family members of a death, staff avoid speculation until the facts become known.

The Investigation Process

10. The investigator, issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Liverpool on 3 November 2016. She obtained copies of relevant extracts from Mr O'Donnell's prison and medical records.
12. The investigator interviewed 12 members of staff and two prisoners at Liverpool in November, December and January and one member of staff by telephone in March 2017. She wrote to or telephoned eight prisoners who were in the segregation unit at the time of Mr O'Donnell's death who could be traced. Four prisoners responded.
13. NHS England commissioned a clinical reviewer to review Mr O'Donnell's clinical care at the prison. The clinical reviewer joined the investigator for some staff interviews.
14. We informed HM Coroner for Liverpool and Wirral of the investigation who sent the results of the post-mortem examination. The pathologist's report gave the cause of death as asphyxia. Mr O'Donnell did not have any restraint or defensive injuries. We have given the coroner a copy of this report. An inquest in July 2017 into Mr O'Donnell's death concluded that he died an accidental death contributed to by neglect.
15. One of the Ombudsman's family liaison officers, contacted Mr O'Donnell's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr O'Donnell's mother and grandmother responded. Mr O'Donnell's family wanted clarification about whether he was being observed under ACCT procedures and the frequency of such observations. They said that they were unhappy with information the Governor and prison family liaison officer had told them about Mr O'Donnell's last few days before his death and felt that it did not ring true. In particular that Mr O'Donnell had probably taken spice (NPS) as it was 'rife' in the prison, had asked the GP for codeine when he complained of stomach pain, hit his cell mate before going to the segregation unit and had broken his light fitting to obtain a piece of plastic in order to cut his tear-resistant sheet.
16. Mr O'Donnell's family received a copy of the initial report. The solicitor representing his family wrote to us pointing out some factual inaccuracies and omissions. This report has been amended accordingly. They also raised a number of issues that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. Their action plan has been annexed to this report.

Background Information

HMP Liverpool

18. 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. The fabric of the prison has been maintained by Amey, a private-sector facilities management company, since June 2015 under a five year contract. The segregation unit holds up to 15 prisoners in single cells. At the time of Mr O'Donnell's death, four of the cells were out of order.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Liverpool was in September 2017. Inspectors found that there had been broad organisational failure to address basic issues. The prison was not safe enough and nearly two-thirds of the prisoners thought it was easy to obtain drugs. They found reasonable progress had been made in implementing PPO recommendations following deaths but the number of self-harm incidents was increasing. There was no local self-harm prevention strategy, staff did not understand sufficiently well potential triggers for self-harm and the strategic response to reduce self-harm was underdeveloped.
20. Inspectors described the segregation unit as bleak with many damaged and some dirty cells. They reported that although segregation was not used excessively, the environment was very poor and the regime was inadequate for prisoners who were there for a prolonged period. Inspectors noted that relationships between staff and prisoners were reasonable and they managed challenging behaviour sensitively but there was no evidence of individual care plans and reviews were poor.
21. Staff shortages had an impact on all aspects of healthcare. The integrated mental health and substance misuse team did not have sufficient capacity to meet the needs of a complex population but the 'Talking Therapies' service was excellent and provided patients with problems related to anxiety, depression and post-traumatic stress disorder with focused support to enable them to cope better and improve their mental health.

Independent Monitoring Board

22. 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 to December 2015, the IMB reported that the prison had suffered due to a lack of capital investment in the past. It described the segregation unit as unpleasant and lacking in natural light. The IMB was concerned about the strain on staff managing a regime under challenging conditions where cells were continually damaged and flooded.

Previous deaths at HMP Liverpool

23. Mr O'Donnell was the fifth of eight apparently self-inflicted deaths since 2015. In three of those deaths, we identified deficiencies with the operation of suicide and self-harm prevention procedures. In a 2015 self-inflicted death, the prisoner's risk of self-harm was not reviewed after he said he would kill himself.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as 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. Checks should be made at irregular 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. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation unit

25. Segregation units (sometimes known as care and separation units) are used to keep some prisoners apart from others. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by a prison operational manager who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff.
26. Prison Service Order (PSO) 1700 on segregation sets out HM Prison and Probation Service policy regarding the use of segregation for prisoners subject to ACCT procedures. It states that segregation should be used as a last resort and prisoners on an open ACCT plan should only remain in the segregation unit in exceptional circumstances, where all other options have been considered and there is no other suitable location. PSI 64/2011 reinforces this and requires that "prisoners on open ACCT plans must only be located or retained in segregation units in exceptional circumstances. The reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted."
27. A healthcare professional must complete an initial segregation health screen within two hours to determine whether there are health reasons why a prisoner should not be segregated at that time. The duty governor or operational manager should make a decision to segregate based on the health screen after discussion with healthcare, staff and the prisoner. They should document their reasons and the exceptional circumstances in the ACCT plan and on the initial segregation health screen. A governor can sanction initial segregation for up to 72 hours under prison rule 45 (Good Order or Discipline) or under prison rule

53 (4) if a prison disciplinary charge is being considered and until an initial hearing has been held but a self-harm case review and a mental health assessment must be held on all prisoners on an open ACCT within 24 hours. A multidisciplinary segregation review board must be held at least every 14 days.

28. Segregation unit regimes are restricted and prisoners are usually permitted to leave their cells only to collect meals, make phone calls and have a daily period of exercise in the open air. Each cell should have an emergency call button which, when pressed, flashes a light outside the cell and activates a buzzer which can be heard throughout the unit. PSO 1700 says that normal cells within the segregation unit should be well lit and equipped to a similar standard to other locations within the prison.
29. We have completed investigations into 11 self-inflicted deaths in segregation units since April 2014. In five of those cases, prisoners were in the segregation unit with an open ACCT plan.

Key Events

30. Mr Edwin O'Donnell was first remanded to custody when he was 17 years old. On 18 March 2014 he was sentenced to 15 months imprisonment for assault. Following his release in September 2014, he was arrested six days later and remanded into custody at HMP Altcourse on 3 October. On 19 December 2014, he was sentenced to four years imprisonment for attempted robbery.
31. Mr O'Donnell had set fires and self-harmed by cutting himself as a teenager. He had a significant history of drug misuse and first used illicit drugs at the age of 12. His computerised records log several incidents when he was associated with drug use. On 17 October 2014 at Altcourse, he was described by an officer as being in a state of 'high exhilaration and screaming' before becoming unresponsive. His cell mate said he had taken 'mamba', a new psychoactive substance (NPS). Mr O'Donnell admitted to an officer at Liverpool on 25 May 2015 that he was in debt to another prisoner due to NPS. After a transfer to HMP Garth, he was given harm reduction advice by their drug and alcohol service on 22 July 2015.
32. Mr O'Donnell's records show that he made cuts to his arms while in HMP and YOI Stoke Heath in 2008 but there were no more recent recorded incidents of self-harm. In an interview with a consultant forensic psychiatrist at Garth on 19 November 2015, Mr O'Donnell mentioned that he had contact with child and adolescent mental health services as a child but did not give details. He told the psychiatrist he used illicit drugs to help him cope with childhood experiences. He described being referred to a psychiatrist as an adult but refused further mental health support. His clinical record indicated that he did not have any on-going physical health issues and did not take regular medication.
33. Mr O'Donnell's custodial records detailed a history of being charged 41 times under prison rules for breaches of prison discipline including theft, refusing or failing mandatory drug tests, setting fire to cells, damaging property, possession of weapons, threatening and abusive behaviour, assaults against staff and prisoners. Security intelligence indicated that he bullied and was bullied by others. He spent several periods in segregation units because of his behaviour.
34. On 2 February 2015, Mr O'Donnell set fire to his cell at HMP Risley with his cell mate inside. He was moved to the segregation unit and set fire to his mattress on 3 February. He was physically unhurt. After a police investigation, he was charged with arson. Mr O'Donnell was moved to HMP Liverpool on 26 February 2015. With four others, he was charged with stealing property from another prisoner on 30 April and assault. He was moved to Garth on 6 July.
35. On 8 July, Mr O'Donnell was seen by a mental health nurse, A, for a mental health triage assessment. Using the Generalised Anxiety Disorder scale, Mr O'Donnell was found to be experiencing severe anxiety. His case was discussed at a mental health team meeting that day and he was placed on the waiting list for counselling. On 7 December, he saw a counsellor, and

expressed his desire to have some counselling sessions but wanted to defer them until his trial for arson was over.

36. Mr O'Donnell threw a cup of faeces in an officer's face on 8 January 2016 and was moved to the segregation unit. He told an officer on 26 January that he was remorseful about the assault and that he was not proud of the person he was when under the influence of new psychoactive substances. Security intelligence indicated a prisoner rewarded him with a quantity of NPS for assaulting the officer. Also in January, Mr O'Donnell was found guilty of arson at Risley. He was tried at the same time for assaulting a prisoner (his cell mate) and was found not guilty. He told his offender supervisor, A, who prepared a pre-sentence report that he began to ruminate on his life and felt low in mood. He received a further consecutive sentence of two years imprisonment for arson.
37. He remained in Garth's segregation unit from 8 January until he was moved to Liverpool on 9 March. He was seen by Nurse B for an initial health screen. She recorded that Mr O'Donnell did not have thoughts of self-harm and had not tried to harm himself in prison. The nurse asked Mr O'Donnell whether he had taken any drugs in the past month and whether he had used drugs intravenously. He replied that had not. She noted that he did not take medication and had no physical or mental health concerns. Reception staff assessed Mr O'Donnell's risk of sharing a cell with another prisoner as high because he was alleged to have assaulted his cell mate at Risley in 2015. Nurse C arranged to see Mr O'Donnell for a mental health assessment on 27 March but he refused to participate in the assessment. She discharged him from the primary care mental health team's service.
38. On 9 June, Mr O'Donnell was offered support by the drug and alcohol recovery service (DARS). He signed a withdrawal letter confirming that he did not want any contact with DARS.
39. Nurse D saw Mr O'Donnell on 20 July for a Well Man check; he declined to have a mental health assessment that would have included a patient health questionnaire for depression and a generalised anxiety disorder scale. Mr O'Donnell told her that he had self-harmed by cutting himself 'a couple of years ago' (there is no record of self-harm since 2008) and that he felt depressed at times but managed this well. She recorded that she had no current cause for concern and Mr O'Donnell understood where to find help if he needed it.
40. A prisoner reported to staff on 24 July, that he felt under threat from Mr O'Donnell. On 31 July, Mr O'Donnell assaulted a prisoner with a pool ball in a sock. He was charged under prison rules and as punishment, 20 days were added to his sentence.
41. Mr O'Donnell was moved to the segregation unit on 25 August after he assaulted another prisoner. He was charged under prison rules and on 1 September, an additional 25 days were added to his sentence. He remained in the segregation unit until 27 August. A cell sharing risk assessment found his risk to others was high so he was placed in a single cell on normal location.

42. Mr O'Donnell was sentenced to a further 20 months imprisonment on 31 August for the offences of theft and assault in April 2015.
43. On 6 September, Mr O'Donnell told Officer A that he wanted to go to the segregation unit. The officer went into Mr O'Donnell's cell and saw a quantity of synthetic cannabinoid (NPS) in a piece of folded paper, the officer gave Mr O'Donnell a warning under the incentives and earned privileges scheme and charged him with breaching prison rules. A disciplinary hearing took place on 7 September for having an unauthorised article and the charge was proved but the outcome is unclear.
44. On 7 September, Mr O'Donnell barricaded himself in his cell and told staff he wanted to move from the residential unit. After talking to staff, he agreed to dismantle the barricade. He was given a warning under the incentives and earned privileges scheme. No assessment of his risk to himself or others was carried out.
45. On 8 September, Mr O'Donnell had a mandatory drug test. His offender supervisor, B, went to check on him following his recent additional prison sentence. She told the investigator that officers would not unlock Mr O'Donnell because he was agitated and was talking about getting out of Liverpool and 'cutting people up'. She renewed a referral she had made to the substance misuse team and a healthcare support worker, saw Mr O'Donnell on 12 September as part of the drug harm reduction programme. He was ambivalent about taking part but eventually agreed that 'having some support would be a good idea'
46. On 13 September, Mr O'Donnell was told that the recent mandatory drug test had been positive for cannabis, that he would face a disciplinary charge and his visits would be closed. The violence reduction co-ordinator, Officer B, spoke with him about possible bullying but he did not identify any threat against Mr O'Donnell.

Mr O'Donnell's arrival in the segregation unit under first ACCT

47. At 5.20pm on 23 September, Mr O'Donnell set fire to his cell. The alarm was raised and staff went into his cell and placed him in handcuffs while others extinguished the fire. Mr O'Donnell was taken to the segregation unit. Officer C initiated ACCT suicide and self-harm monitoring procedures. She ticked the box in the concern and keep safe section of the ACCT form indicating that Mr O'Donnell was low in mood and added her own concern box, 'indiscipline' which she ticked. Mr O'Donnell told her that he had started the fire so he could move from his residential unit.
48. The duty governor, A, drew up an immediate action plan which said Mr O'Donnell should be located in the segregation unit due to threats to his safety, with hourly observation, access to the Samaritan phone and Listeners (prisoners trained by Samaritans to provide peer support). Mr O'Donnell was segregated under prison rule 53, pending a prison disciplinary charge and hearing for setting fire to his cell.

49. Nurse E, a mental health nurse, conducted an initial screen at 5.39pm to assess whether it was safe for Mr O'Donnell to remain in the segregation unit. She concluded there were no clinical reasons why he could not be segregated at that time. She carried out a brief mental health assessment. Mr O'Donnell did not show an indication of psychosis, he said he felt okay, he denied any thoughts, feelings or plans to harm himself or others. The nurse had no concerns about Mr O'Donnell's physical health apart from a small cut on his right eye brow which he told Nurse F he had sustained when his face banged on the floor during restraint and he strongly denied any suicidal intent. She noted in his clinical record that he was an arson risk to himself and others and that he should continue to be managed under ACCT procedures. He was the second of two prisoners held in the segregation unit on an open ACCT.
50. Mr O'Donnell was observed at hourly intervals. Many of the checks took place hourly, on the hour. The duty governor, A, completed a written authority to keep Mr O'Donnell in the segregation unit on an open ACCT document. He considered other areas where he could go but felt a general prison wing, the healthcare centre or the first night centre for new prisoners were not suitable places for him. He gave no further explanation for this conclusion.
51. On 24 September, Mr O'Donnell was charged under prison rules with setting fire to his cell. The hearing was adjourned pending a police investigation. Officer D, a trained ACCT assessor, completed an ACCT assessment on Mr O'Donnell at 10.30am. Mr O'Donnell told him that he had deliberately engineered a move to the segregation unit by setting fire to his cell and he did not regard it as an act of self-harm. He said he was fine, he had plenty of reasons to live for, had no intention of harming himself and did not want to be on an ACCT plan.
52. On 24 September, Nurse E spoke with Mr O'Donnell again in the segregation unit and carried out another mental health assessment. Mr O'Donnell again denied any past or current thoughts or feelings relating to self-harm. He did not display any signs of thought disorder or paranoid thinking and there was no indication of impairment in his mental functioning. Immediately after seeing him, the nurse took part in an ACCT review which she described in his clinical record as 'unscheduled'.
53. An ACCT case review took place at 2.35pm with a senior manager A, Supervising Officer (SO) A, Officer D, Nurse E and Mr O'Donnell. The senior manager chaired the review and summarised that Mr O'Donnell had no history or suicide or self-harm intent. He was not happy at Liverpool, wanted the ACCT plan to be closed and a transfer to another prison. She described him as very communicative and said he was aware his behaviour was 'very reckless'. The attendees concluded that Mr O'Donnell's initial risk of harm to self was low and the current likelihood of further risk behaviours as low.
54. No risks were identified and the caremap, the tool to reflect a prisoner's needs and how they will be addressed to reduce their risk of self-harm, was left blank. The decision was taken to close the ACCT and a post-closure interview was set for 30 September. SO A updated Mr O'Donnell's computerised records

following the ACCT review, adding Mr O'Donnell's explanation for the fire was that he wanted to escape threats of violence he was experiencing.

55. On 26 September, an operational manager, A, whose responsibilities include managing the segregation unit, completed an initial authority for initial segregation under prison rule 45 (good order or discipline) until 28 September. He left the boxes asking if the prisoner was on an open ACCT (including post closure) and whether continuing segregation had been agreed on the health screen, blank. He wrote that Mr O'Donnell had been charged under prison rules with setting fire to his cell, the matter had been referred to the police and Mr O'Donnell would remain in the segregation unit 'to protect the good order of the establishment'. There is no record of a healthcare professional seeing Mr O'Donnell on 25 September, a Sunday. Dr A saw Mr O'Donnell on 26 September. His note in the clinical record is that there were no issues.
56. No healthcare worker appears to have seen Mr O'Donnell on 27 September. A multidisciplinary prison rule 45 segregation case review took place on 28 September chaired by operational manager, A, and with Nurse E, a supervising officer, a member of the Independent Monitoring Board and a chaplaincy member of staff. Mr O'Donnell denied that he had suicidal intent and did not view starting a fire as an act of self-harm. He said that he wanted to be moved out of Liverpool. The operational manager, suggested a transfer to Garth but Mr O'Donnell thought they would not accept him. Nevertheless, he said he would explore a possible transfer with Garth but it would not take place until the police had finished their investigation into whether there was sufficient evidence to charge Mr O'Donnell with arson. Nurse E wrote in Mr O'Donnell's clinical record that he did not report any physical or mental health concerns.
57. Nurse G, a mental health nurse, visited Mr O'Donnell on 29 September. He told her he had no concerns about his mental health and no thoughts of suicide or self-harm or harming others. Dr B, a GP, saw Mr O'Donnell in the segregation unit on 30 September. He noted in Mr O'Donnell's clinical record that there were no new physical or mental health issues and that he was fit for segregation.
58. On 1 October, Mr O'Donnell made a written complaint under the formal complaint system that he had been in a cell with no lights, water or working toilet for ten days. He received a reply from a prison manager, on 12 October who informed him that 'the works department' was aware of the issue but was under a lot of pressure to carry out repairs and it sometimes fell behind with the work. He said he understood that Mr O'Donnell was now in a cell with electricity and running water.
59. Prisoner, A, who was in the cell next door to Mr O'Donnell told the investigator that his cell was in a similar state of disrepair and he had complained about it to the Independent Monitoring Board. The prisoner slept fully clothed as his windows were smashed; there was no flush on his toilet and no light switch or light. The cell Mr O'Donnell was moved to had a malfunctioning emergency cell bell and ceiling light. The facilities management reporting log recorded that an officer reported the repairs that needed to be made on 22 August.

60. An ACCT post-closure interview took place on 7 October. In response to the question whether the problems that had caused the ACCT to be opened were resolved and how, Supervising Officer B wrote 'yes'. She noted on the rest of the form that Mr O'Donnell had support from family and friends and would turn to staff and Listeners (Samaritan-trained prisoners) for support within the prison but did not have work or activities as he was in the segregation unit. She concluded that the ACCT did not need to be re-opened.
61. On 11 October, Mr O'Donnell flooded his cell. He smashed the glass in his door observation panel and threw rubbish on to the landing. He was charged with breaching prison discipline.
62. Operational manager, B, chaired a multidisciplinary segregation review board on 12 October. There were no specific concerns about Mr O'Donnell's mental health and he authorised segregation to continue until 19 October. Nurse G recorded that Mr O'Donnell asked to move to another prison but said he felt safe and comfortable in the segregation unit as he had drug debts on his previous wing. The segregation review board authorisation documentation does not mention this account.
63. The hearing into Mr O'Donnell's cell flooding took place on 13 October in the morning. The charge was proven and punishment suspended. Mr O'Donnell's offender supervisor, B, visited him in the segregation unit on the same day. He told her he was feeling very unhappy, was suffering from bad mood swings, felt paranoid all the time and could not understand what was happening to him. He said he wanted to go to another prison where he could settle down and feel safe. There is no evidence that Mr O'Donnell's assertions about drug debts were looked into at that time. The offender supervisor told Mr O'Donnell that she had referred him to psychological services for an assessment. She requested that someone from the mental health team should see him regarding his moods and feelings.
64. The mental health team discussed the offender manager's referral on 14 October at a triage meeting for new referrals. It concluded that Mr O'Donnell had had regular contact with the mental health team since he arrived in the segregation unit and he would be seen as scheduled on 15 October.
65. Dr C, a GP, saw Mr O'Donnell in the segregation unit on 14 October. Mr O'Donnell told him that he had constipation and asked if could have lactulose, a laxative medication he had used before. The doctor established that Mr O'Donnell felt otherwise well in himself and was not experiencing pain, vomiting or distress.
66. On 15 and 16 October, Nurse G from the mental health team visited Mr O'Donnell in the segregation unit. He told her on both occasions that he was fine, had no mental health concerns or current thoughts of suicide or self-harm. She wrote that he was medically fit to be held in the segregation unit. Dr D, a GP, saw Mr O'Donnell. His notes state that no issues were raised and he was fit for cellular confinement. No healthcare member of staff saw Mr O'Donnell on 18 October. The doctor visited him on 19 October. His notes said there was 'no acute concern'.

67. A segregation case review took place on 19 October attended by operational manager A, mental health nurse H, Supervising Officer C, an IMB observer, and a member of staff (whose role is unclear). The written account states that Mr O'Donnell was not present as he was 'under the influence'. There is no explanation of where this information came from, what it meant and no one appears to have questioned it. The review documentation said that Mr O'Donnell was compliant with the regime, there were no concerns about his mental health or risk of self-harm and segregation was to continue. The next segregation review date was set for 2 November. The nurse did not write a note of the review in his clinical record as required. Apart from his clinical record, no entries were made in Mr O'Donnell's computerised record between 13 and 20 October.
68. On 20 October, Mr O'Donnell attended a hearing chaired by a senior manager for failing a mandatory drug test in September. The charge was proven and he received an additional 10 days to be served in custody prior to his release.

21 October – second ACCT document

69. Mr O'Donnell cut his ear with a razor blade on 21 October. Officer E was alerted at 3.00pm by a prisoner in a cell next to Mr O'Donnell's, who said that he had 'cut his ear off'. The officer looked at his ear and saw a cut to the top of it. The officer completed a report of injury to prisoner form saying that Mr O'Donnell told him he wanted to see a nurse about his stomach and Mr O'Donnell said it 'was not self-harm'. Mr O'Donnell told Nurse D, who dressed the wound, at 3.40pm that he was feeling 'stressed out' but had not told any of the officers. Apart from a very small bowel movement that morning, he had not emptied his bowels for three weeks.
70. SO C started ACCT suicide and self-harm procedures at 4.00pm to support Mr O'Donnell and put in place hourly observation checks until he could be assessed. He wrote in the ACCT record that the ear was 'partially hanging off'. Nurse D described Mr O'Donnell's wounds on the injury report as 'numerous cuts to right upper ear, still attached. Extensive bleeding.'
71. Dr C saw Mr O'Donnell at 4.20pm after Nurse D had dressed Mr O'Donnell's ear with steri-strips. Mr O'Donnell said he had not opened his bowels for three weeks apart from a very small stool that morning and complained of constipation. He asked for more lactulose laxative to ease it. The doctor told the investigator that he had a good relationship with Mr O'Donnell and, after discussion, prescribed the medication.
72. Dr C said he was aware Mr O'Donnell was under ACCT procedures and asked him about his ear. He said Mr O'Donnell told him he cut himself accidentally while cutting his hair. (The doctor wrote in his clinical record that he was cut accidentally while shaving.) The doctor said he let Mr O'Donnell talk as he did not want to put him on the defensive by asking questions. He did not know about Mr O'Donnell's history of anxiety and told the investigator he had no reason to disbelieve him so he took what Mr O'Donnell said about his bowel movements and his cut ear at face value.

73. On 22 October, Officer F, a trained ACCT assessor, interviewed Mr O'Donnell at 10.00am. Mr O'Donnell said he was not satisfied with the treatment he had been offered regarding his stomach and had decided to cut his ear because he was not being listened to. He told the officer that he was 'mentally fine' and would not harm himself again but admitted to experiencing anxiety and mood swings. He added that if he died because of stomach issues, he had already notified the healthcare department of his request for medical assistance. He did not explain what he meant by this. He was reluctant to discuss his cut ear with the officer, only saying that he did it out of frustration.
74. An ACCT case review took place immediately after the assessment. It was attended by SO B, Officer F, Nurse I (a mental health nurse) and Mr O'Donnell. The nurse told the investigator that before the review began, the SO and the officer said they would probably be able to close the ACCT monitoring as Mr O'Donnell appeared to have had 'a moment of madness' and he was okay now. The nurse repeated Dr C's comments from the clinical record to Mr O'Donnell, that his cut was a shaving accident. Mr O'Donnell was very upset by this and said it was not true, he had cut himself deliberately. The nurse felt that Mr O'Donnell's clinical record had not given him a full picture of the circumstances of the self-harm and he thought that the ACCT monitoring procedures should remain in place.
75. The case review did not formally assess Mr O'Donnell's risk or the likelihood of him being at risk. The caremap, an ACCT document, which should list the actions necessary to reduce Mr O'Donnell's risk of suicide or self-harm, listed one action, for Nurse I to arrange for a doctor to see Mr O'Donnell on 24 October. An ACCT case review was arranged for 26 October. It did not identify any further measures to keep Mr O'Donnell safe and observation checks remained unchanged at hourly. A senior manager did not consider whether there were exceptional reasons for keeping him in the segregation unit.

23 October 2016

76. At about 3am, Mr O'Donnell was talking to Officer G, who was on night duty in the segregation unit. He told the officer he was convinced that his cell door was going to be opened during the night and his life would be taken. At 3.40pm, he shouted to the officer that he should 'stop them'. The officer wrote in Mr O'Donnell's ACCT monitoring document and recorded that Mr O'Donnell was making little sense and he wondered whether he might have taken an illicit substance earlier that day. The officer told the investigator that he had not seen Mr O'Donnell under the influence of drugs before but his behaviour was not normal for him. The Officer asked Nurse J who was on night duty, to speak to him.
77. Nurse J was perturbed at what Mr O'Donnell was saying rather than how he was saying it. He could not see Mr O'Donnell as his cell light was off but his observation panel was open so he listened to him. The nurse did not think Mr O'Donnell was under the influence of an illicit substance (and did not ask him if he had taken anything). He told the investigator that Mr O'Donnell was orientated and lucid but the content of what he was saying 'didn't sit right'. Mr O'Donnell kept repeating 'people think I'm paranoid'. The nurse tried to

reassure Mr O'Donnell that staff did not carry keys at night so they could not go into his cell. The nurse Fletcher told the investigator he updated the task entry in System One, the computerised healthcare record, that the mental health nurse should see Mr O'Donnell in the morning. There is no evidence that a member of the mental health team visited him before his death.

78. Officer G told the investigator that Mr O'Donnell kept shouting out to him so he went to Mr O'Donnell's door. Another member of staff's night torch flickered and Mr O'Donnell became convinced that officers were coming for him. He asked the officer if he was acting strangely. The officer thought Mr O'Donnell's behaviour might have been influenced by running out of 'spice' (NPS). He admitted he had not thought of Mr O'Donnell as being under its influence before but the behaviour he was seeing was not normal for Mr O'Donnell. He told the investigator that it was not uncommon to see lines trailing down from B wing above the segregation unit or on the exercise yard and that staff could not stop contraband as prisoners would break their windows to get it. Nurse I told the investigator that staff in general talked about there being a problem in the segregation unit with illicit substances being passed to prisoners. Also, prisoners there had presented in a way that raised nursing staff's concern that there were particular problems with NPS.
79. Prisoner A, the prisoner who was in the cell next to Mr O'Donnell, told the investigator that at about 6.30am, Mr O'Donnell shouted out of his cell that should he die that day, officers killed him. He also shouted out his mother's telephone number and said that someone should tell her. Prisoner B, who was in the segregation unit at that time, wrote to the investigator and said that Mr O'Donnell said he was going to kill himself. Prisoner C, a prisoner who was also there at that time, wrote to the investigator that he heard Mr O'Donnell tell an officer that prison officers were going to kill him.
80. The segregation unit daily record does not show any visits by healthcare staff, the independent monitoring board or governors (it was a Sunday). After 7.30am, all ACCT observation entries were written on the hour or at five minutes to or. At 8.55am, Mr O'Donnell said to an officer, when asked, that he did not need to see the Chaplain. At 8.30am, SO began a dirty protest log on Mr O'Donnell as he had smeared faeces on the walls of his cell. At about 11am, three prisoners began flooding their cells and throwing faeces out of their cells and across the landing as the glass in their observation panels was either smashed or absent. A control and restraint team of staff in protective clothing was deployed to remove each of the three prisoners in turn so that staff and cleaners could clean up their cell and the landing. Mr O'Donnell's cell was not included but he said to one of the cleaners that the staff were coming for him. Mr O'Donnell told the SO that he would clean his cell but changed his mind and at 12.00pm said that he was on a dirty protest.
81. Officer Mark H noted in the wing observation book that two prisoners were shouting abuse at Mr O'Donnell throughout the lunch hour. He told the investigator the prisoners were shouting that Mr O'Donnell was a sex offender and that he should kill himself. He asked them to stop and they laughed at him but stopped at about 1.00pm. The officer said he checked with Mr O'Donnell that he was alright and he said he was. Prisoner D, a prisoner who worked as

a cleaner in the segregation unit, described it as banter and that prisoners would take the 'mickey' out of each other. Prisoner E, a cleaner, said he did not think the prisoners meant it literally as they would be shouting out abuse and the next minute Mr O'Donnell would be talking with them. At 3.00pm, SO B wrote in his ACCT plan that Mr O'Donnell was talking to one of the cleaners and not showing signs of anxiety or low mood.

82. Mr O'Donnell refused his evening meal just before 5pm. SO B wrote in the ACCT plan that he was 'calm and settled'. Prisoner E told the investigator that as he and Mr Wells were about to leave the unit for the evening at about 5pm, Mr O'Donnell called out to him and said he was going to kill himself rather than let officers harm him. He told him not to talk like that and would bring him some books to read and some tobacco in the morning. Mr O'Donnell replied that he would be dead by 8pm that evening. He said he went up to SO B and told her what Mr O'Donnell had just said. He said she replied that he was on an ACCT. Prisoner D told the investigator that SO B then asked Mr O'Donnell how he was and whether he was going to do anything silly.
83. SO B told the investigator that none of the prisoners told her that Mr O'Donnell had said he would kill himself. She said she had asked Mr O'Donnell if he was going to do something stupid in response to one of the cleaners asking her if Mr O'Donnell was going to be okay. She said that Mr O'Donnell did not give her any indication that he would harm himself and she would not have left him unsupported if he did.
84. Prisoner A said he heard Mr O'Donnell say he would kill himself and watched SO B through his observation panel in front of Mr O'Donnell's cell. She asked Mr O'Donnell if he was going to do 'anything stupid' and he replied 'no'. Prisoner A had tried to chat with Mr O'Donnell through the heating pipes but did not get much of a response. He felt that Mr O'Donnell was still annoyed because prisoner A had sworn at him that morning. He offered Mr O'Donnell some tobacco but Mr O'Donnell did not reply.
85. Officer I checked Mr O'Donnell at 6pm. He wrote in the ACCT plan that Mr O'Donnell was walking around his cell and would not engage. At 6.45pm after noticing that he was not responding to other prisoners shouting out, he wrote in the ACCT document that Mr O'Donnell was not visible in his cell or responding. The officer telephoned custodial manager (CM) A, who said he would bring more staff. The CM picked up a shield to use as protection as he was concerned that Mr O'Donnell might attack them.
86. CM A said that the main light in Mr O'Donnell's cell was not working so he relied on a night light in the toilet area which gave off minimal light. He saw that Mr O'Donnell appeared to be sitting with his legs stretched out in front of him. Mr O'Donnell's head was slumped forward with a ligature from his neck, attached to the washbasin taps. The CM cut and removed the ligature from Mr O'Donnell's neck. CM B helped CM A move Mr O'Donnell back into the main part of the cell and CM A radioed an emergency code blue (prisoner not breathing) at 6.56pm. CM A and Officer I began cardiopulmonary resuscitation (CPR). Nurse K and Nurse L responded to the emergency call. Nurse K asked the officers present to move Mr O'Donnell to the landing as it was difficult to

see in the cell due to the lack of light and the floor was wet. The first responder arrived at 7.04pm and ambulance arrived at 7.10pm. Paramedics continued trying to resuscitate Mr O'Donnell but recorded that he had died at 7.15pm.

Contact with Mr O'Donnell's family

87. Mr O'Donnell had named his mother as his next of kin. The Governor, A, and prison family liaison officer, Reverend A, drove to the address provided but no one was home so they returned to the prison. The governor asked for police assistance with locating Mr O'Donnell's family contact details. Cheshire police broke the news of Mr O'Donnell's death to his mother at about 1am on 24 October. The governor and Reverend visited Mr O'Donnell's mother at 11am. The prison offered to contribute to the cost of Mr O'Donnell's funeral in line with national policy.
88. The family liaison log, a record of contact with Mr O'Donnell's family, said that the Governor gave the family as much detail as he knew of the events leading to Mr O'Donnell's death. The log recorded that his family were told it was strongly suspected that Mr O'Donnell had taken spice (NPS) over the weekend he had died.

Support for prisoners and staff

89. Managers debriefed the staff involved in the emergency response and offered them support. Staff notified prisoners of Mr O'Donnell's death and offered them support. Officers reviewed prisoners assessed as at risk of suicide and self-harm in case the news of Mr O'Donnell's death had affected them.

Post-mortem report

90. The post-mortem examination took place on 24 October. The pathologist report gave the cause of death as asphyxia. Toxicology tests showed no trace of alcohol, prescribed or illicit drugs including synthetic cannabinoids or NPS.

Findings

Assessment of risk of suicide and self-harm from March to September 2016

91. PSI 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether Liverpool should have recognised Mr O'Donnell as at risk of suicide earlier and started ACCT monitoring before he set fire to his cell.
92. The PSI lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm, substance misuse, mental illness. Staff in reception should assess new prisoners' risk of suicide and self-harm and be alert to any increased risk.
93. Mr O'Donnell arrived at Liverpool in March 2016 with some historic risk factors. He had a history of drug abuse, he had set fire to several cells as a way of avoiding difficult situations, he had bullied and been bullied but he had no recent history of self-harm. When he arrived, he told an officer and a nurse who interviewed him in reception that he had no thoughts of suicide or self-harm. Although a more in-depth initial reception health screen would have found historical self-harm and a history of substance misuse which could have been probed further, we are satisfied that staff considered his risk and it was reasonable for them to conclude that Mr O'Donnell did not need to be monitored under ACCT procedures when he arrived at Liverpool.
94. Mr O'Donnell refused to take part in two scheduled mental health assessments on 27 March and 20 July during a Well Man check. His history of anxiety and outstanding appointment for counselling at Garth were not picked up on when he was at Liverpool. We make the following recommendation:
 - **The Governor and Head of Healthcare should ensure that a high screening score for anxiety and depression should be considered as part of a mental health assessment.**

The initial decision to segregate Mr O'Donnell

95. Prison Service Order (PSO) 1700 details the procedures to follow when segregating prisoners. As segregation is an extreme and isolating form of custody, prisoners at risk of suicide or self-harm should be placed there only as an exceptional measure on the authority of a senior manager. A qualified healthcare professional must complete an initial health screen for all segregated prisoners. The purpose is to make a snap shot assessment of a prisoner's mental health when deciding whether to segregate them.
96. PSO 1700 and PSI 64/2011 both advise against the use of segregation for prisoners at risk of self-harm where possible and require that prisoners on open ACCTs must only be located in segregation units in exceptional circumstances, the reasons must be clearly documented in the ACCT plan and include other options that were considered but discounted.

97. In a Learning Lessons Bulletin we issued in June 2015, we examined learning from investigations into the self-inflicted deaths of prisoners who were segregated at the time of their deaths. The bulletin pointed out that segregation reduces some protective factors against suicide and should be used only in exceptional circumstances for those at risk of taking their life.
98. On Mr O'Donnell's arrival into the segregation unit on 23 September, the duty governor considered the health screen, options for moving him to a different location within Liverpool and authorised his move to the segregation unit but a full multi disciplinary review did not take place until 28 September. There appeared to be some reluctance to acknowledge that Mr O'Donnell was at risk at all. Officer C described Mr O'Donnell's behaviour in the ACCT as 'indiscipline', rather than giving consideration to it being an act of self-harm and this was not challenged by the duty governor. The ACCT process did not, though, provide him with any added protection as Liverpool's local practice is to check all prisoners in the segregation unit hourly, which was the same frequency the ACCT case review endorsed.
99. We consider the initial decision to segregate Mr O'Donnell after he set fire to his cell was not unreasonable provided it had adequate safeguards in terms of managerial oversight and was fully reviewed within 48 hours. However, the circumstances were not so exceptional that he should be held in the segregation unit on an open ACCT for a further five days without review. Once the support measures for suicide and self-harm were stopped the day after they were initiated, there was a failure to consider that the post-closure interview had not taken place and Mr O'Donnell could still be at risk.

Mr O'Donnell's continuing segregation

100. After initial charges were laid for setting fire to his cell, there was no local investigation of the reasons Mr O'Donnell gave (threats of violence, drug debts) for wanting to be there in the first place. Officer J wrote in his computerised case notes that Mr O'Donnell had threatened to harm a prisoner or member of staff. The matter was seen as arson to be investigated by the police and there was no urgency behind Liverpool's actions beyond assertions that a transfer to Garth would be considered.
101. Mr O'Donnell's behaviour and condition deteriorated significantly from 11 October when he flooded his cell, told his offender manager he was experiencing mood swings and could not understand what was happening to him. Despite a mental health referral by his offender supervisor and a suggestion at the review on 19 October that he may have been under the influence of drugs, there was no change in how Liverpool assessed or managed his level of risk, which was rising, or considered the frequency of staff observation using ACCT procedures which remained hourly.
102. As he did not tell nursing staff how he was feeling, the confusion he described to his offender supervisor was not viewed as a deterioration in his mental health. She could and should have been invited to segregation review meetings where all relevant information should have been assessed and an effective strategy devised to support him. At the 19 October review, instead of querying how it was possible that he might have taken drugs and what risks this posed, it was

accepted by those present that Mr O'Donnell was unable to attend the review due to being 'under the influence'. The opportunity to review whether the segregation unit was an appropriate place for him, taking into account any developments during the previous week, was lost. No one updated his non-clinical computerised case records between 13 and 21 October, during which time his condition deteriorated markedly.

- **All members of staff who have had meaningful contact with a prisoner kept in the segregation unit under Prison rule 45 (good order or discipline) should be invited to attend segregation review boards.**

2nd ACCT document

103. ACCT procedures were put in place for the second time after Mr O'Donnell cut his ear on 21 October. No operational manager considered formally whether there were exceptional reasons for holding him in the segregation unit or alternative locations. This is contrary to the mandatory actions laid out in PSO 1700. It is difficult to understand why his level of risk was not considered at the case review or meaningful measures put in place to support him.
 104. Mr O'Donnell told only Nurse D he had been stressed – this may have indicated that he needed to be observed more closely and frequently – but observations remained at one an hour. Contrary to the instructions in the PSI, the checks were conducted and recorded at regular hourly intervals which would have allowed Mr O'Donnell to predict when the next check would be.
 105. On the morning of Mr O'Donnell's death, Officer G and Nurse J were concerned that Mr O'Donnell was talking about death in a bizarre and unsettling way. Prompted by concerns from other prisoners, SO B sought assurances from Mr O'Donnell that he would not harm himself but no one considered increasing the frequency of observation, which was low for a vulnerable prisoner in a sub-standard physical environment, who was in the midst of a dirty protest, had worried staff earlier in the day with his irrational outbursts, talked about staff wanting to kill him and had faced verbal abuse from other prisoners.
 106. Mr O'Donnell's time in custody had been lengthened significantly through further convictions and imposition of additional days for breaching prison discipline; he wanted to get away from prisoners on his residential unit; he had set fire to his cell. Mr O'Donnell was not sufficiently protected by the ACCT process which was designed to identify prisoners at risk of suicide and self-harm, manage and support them. Liverpool did not see Mr O'Donnell's risk was increasing, even after he harmed himself by cutting his ear. No one considered an enhanced case review. Mr O'Donnell's circumstances should have invited more managerial scrutiny but instead seem to have been met, with a few exceptions, by a sense of detachment and a willingness to accept Mr O'Donnell's presentation at face value. Even the GP who spoke to him about his ear was remarkably complacent, accepting that he cut himself by accident. The acute deterioration in Mr O'Donnell's condition during 23 October warranted a multidisciplinary review of his risk.
- **The Governor should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular:**

- **Prisoners at risk are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.**
 - **The frequency of observations should reflect the prisoners risk and staff should adjust them when that risk changes.**
 - **Staff should review a prisoner’s risk when they express thoughts of suicide or self-harm.**
 - **A multidisciplinary case review should be held within 24 hours of an ACCT plan being opened and when there is evidence of significant change in risk.**
 - **Staff should check on prisoners subject to ACCT procedures at unpredictable intervals and record their observations.**
107. Mr O’Donnell was not taking regular medication or complaining of on-going physical health issues until 14 October when he asked for constipation relief medication, which Dr C prescribed. According to his clinical records, Mr O’Donnell did not raise the issue with any staff of his discomfort until 21 October when he cut his ear. Healthcare did not ask him whether his condition had improved and on several days no member of healthcare staff visited the segregation unit, contrary to PSO 1700 which stipulates that prisoners there must be seen everyday. Mr O’Donnell’s clinical record shows no healthcare staff visits for 25th and 27th September, 1st, 4th, 6th, 9th, 13th, 18th and 20th October. PSO 1700 which provides guidance on segregation unit policy says that a doctor must visit the unit at least every three days, and on other days, a registered nurse or healthcare officer should be present.
108. We are concerned that several opportunities for effective mental health team intervention were missed. Mr O’Donnell declined a mental health assessment in March 2016 and was discharged from the team caseload. He declined a further assessment in July. He had contact with mental health team nurses while in the segregation unit but while he insisted to them he was fine, he flooded his cell on 11 October and told his offender manager on 13 October he was suffering from mood swings. Although his case was discussed, there was no change in the mental health team approach as he did not express these feelings directly to a nurse. This was a missed opportunity.
109. On the morning of his death, Mr O’Donnell exhibited strange behaviour that concerned Officer G and Nurse J who set out their concerns in the ACCT document and clinical record respectively but these were not escalated, picked up or acted upon by the mental health team or operational managers.
- **The Governor and Head of Healthcare should ensure that healthcare staff attend the prisoners in the segregation unit everyday.**
 - **Nursing staff who attend segregation review boards should record this in the prisoner’s clinical record.**

The segregation unit

110. The physical condition of the segregation unit was appalling with broken windows, allowing prisoners to throw excrement onto the landing and abuse at each other, to access illicit substances while requiring them to sleep in their clothes to keep warm. Lights were broken and inadequate. This restricted Officer I's ability to check where Mr O'Donnell was in his cell, delayed the realisation that there was a ligature around Mr O'Donnell's neck and hampered attempts to resuscitate him as staff simply did not have sufficient light to see what they were doing.
111. PSO 1700 on segregation says that prisoners should be 'housed in cells that provide safe and decent conditions ... normal cells are well lit and equipped to a standard similar to that found on normal location in a prison, including integral sanitation, in-cell electrics and tv aerial points'. The deputy governor, told the investigator that for several months in 2016, Amey did not have any electricians and the service had to be sub-contracted. She said the Deputy Director of Custody chaired a quarterly meeting to ensure an improvement in delivery and the segregation unit was currently undergoing refurbishment of cells.
- **The Deputy Director of Custody should ensure that the facilities management contract to repair cells operates effectively.**

Drug misuse

112. Mr O'Donnell had a history of drug misuse which, by his own admission, helped him cope with memories of his damaged childhood. Prison intelligence, mandatory drug testing and breaches of prison discipline show there were indications he was using drugs in 2016. The segregation unit held little data in case notes and observation books on the availability of drugs despite a widespread belief and acceptance among many staff and managers that prisoners there were using illicit substances. Very little appears to have been done to address these concerns.
113. The investigator examined Mr O'Donnell's computerised case notes and clinical records, unit observation book, intelligence reports and interviewed two segregation unit officers and a manager who had significant contact with him in the 24 hours leading to his death. While there were anecdotal comments from staff that prisoners in the segregation unit had access to drugs, the only recorded incidents that hinted at the possibility of drug use were the comment on the segregation review documentation, Mr O'Donnell's comment to a nurse at the review on 12 October of drug debt and his strange behaviour in the early hours of 23 October, (which suggested drug use to Officer G but not to Nurse J).
114. Liverpool has not provided us with evidence that Mr O'Donnell had taken 'spice' before his death. The post mortem examination and toxicology results did not find NPS present in his body at the time of his death.
- **The Governor should ensure there is a protocol in the segregation unit of the steps staff should take if they consider a prisoner to be under the influence of drugs.**

Contact with Mr O'Donnell's family

115. When a death occurs in a custodial setting, a family is obliged to take on trust, initially, the information they are given. Liverpool's family liaison log sets out the contact the prison had with Mr O'Donnell's family had from his death until funeral arrangements were in hand. The log says it was strongly suspected Mr O'Donnell had taken NPS during the weekend of his death and that this information was given to the family.

- **The Governor should ensure that when informing family members of a death, staff avoid speculation until the facts become known.**

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