Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Newman a prisoner at HMP Liverpool on 6 October 2017

A report by the Prisons and Probation Ombudsman

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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Carl Newman died on 6 October 2017. He was found hanged in the toilet area of his cell at HMP Liverpool. He was 23 years old. I offer my condolences to Mr Newman's family and friends.

Mr Newman had a history of mental health issues, self-harm and attempted suicide. He spent only four days at HMP Liverpool and lived in the induction unit with very limited time out of his cell.

I am concerned that the very restricted regime in the induction unit meant that Mr Newman did not receive the support he required during his early days in custody. Mr Newman's situation was made worse by the fact that he was not allowed to share a cell because staff did not check his Police National Computer and prison records as they should have done.

I am concerned that staff did not take all Mr Newman's risk factors into account when they assessed his risk to himself as low.

I am also concerned that when Mr Newman was found hanging, there was a delay of five minutes before an ambulance was called and an avoidable delay in paramedics reaching Mr Newman from the prison's gate.

My office has made recommendations about delays in the emergency response in previous investigations into deaths at Liverpool. In March 2018 we made a recommendation to the Prison Group Director for the North West to assure himself that action was taken to address these failings. We have been told that action has been taken since then to improve emergency response procedures and I have asked the Prison Group Director to provide me with an update on that action.

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

Sue McAllister, CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. Mr Newman was released on licence on 26 May 2017 while serving a prison sentence for driving offences. On 3 October, he was recalled to HMP Liverpool charged with a serious offence against his partner.

2. Mr Newman spent the next four days in the induction unit. He did not share a cell because he had been assessed at reception as being unsuitable to do so. Mr Newman had minimal contact with staff and peers during this period. He repeatedly told staff, incorrectly, that he had no history of attempted suicide or self-harm.

3. On 5 October, Mr Newman appeared to be depressed and asked an officer to be moved to another wing and to share a cell with a friend. The officer referred Mr Newman to the safer custody team but did not consider that Mr Newman was at risk of suicide and self-harm because he was making plans for the future.

4. On 6 October, Mr Newman spoke to his partner from an illegal mobile phone. He told her that he wanted to kill himself, but this information was not shared with the prison.

5. At around 11.25am, officers found Mr Newman hanged in the toilet area of his cell. They asked for staff assistance and began cardiopulmonary resuscitation (CPR). Medical staff attended and continued CPR until paramedics arrived. The paramedics took over emergency treatment but at 11.45am, Mr Newman was pronounced dead.

Findings

Identifying Mr Newman's risk of suicide and self-harm

6. Mr Newman's risk factors for suicide and self-harm included the fact that he had been charged with an offence against his partner, the breakdown in their relationship, being recalled to prison, previous involvement with mental health services, and a history of suicide attempts and self-harm in 2014 and 2015.

7. We consider that, if all Mr Newman's risk factors had been taken into account, he should have been identified as being at risk of suicide or self-harm.

8. We are concerned that at Mr Newman's initial health screening, the nurse did not identify Mr Newman's previous history of mental ill-health, suicide attempts and self-harm even though this history was available in Mr Newman's SystmOne medical records (a single shared electronic health record). As a result, staff were not aware of all Mr Newman's risk factors. In addition, Mr Newman's general health assessment was not prioritised. If this assessment had taken place it would have provided another opportunity to review Mr Newman's risk factors and his medical history.

9. Some members of staff who had interactions with Mr Newman did not have adequate ACCT training. This undermined their capacity to identify and assess Mr Newman's risk factors properly.

10. We are also concerned that staff did not properly record their contacts with Mr Newman in NOMIS. (This is an operational database used for the management of prisoners.) This meant that Mr Newman's concerns about his relationship with his partner and about being in a single cell were not shared with other staff.

Cell Sharing Risk Assessment (CSRA)

11. Mr Newman was assessed at reception as not suitable to share a cell. This assessment was not supported by his Police National Computer (PNC) records, which were not available to staff at reception as they should have been. A second CSRA, which should have been carried out, never took place.

12. If the PNC and NOMIS records had been checked, as they should have been, we consider that Mr Newman should have been assessed as suitable to share a cell during his time at Liverpool, but the lack of any second CSRA prevented this. If Mr Newman had shared a cell with a friend, as he requested, his death may have been less likely.

Induction Unit

13. Mr Newman had very limited time out of his cell to interact with officers and peers and experienced a very restricted regime in a single cell the induction unit. The clinical reviewer concluded that such a regime was not conducive to good mental health. We consider that it did not offer Mr Newman the support he needed during his early days in custody.

Clinical Care

14. The clinical reviewer concluded that the healthcare provided to Mr Newman at Liverpool was of a reasonable standard and equivalent to what he could have expected in the community. The clinical reviewer did not have any concerns about Mr Newman's mental healthcare or medication.

Emergency response

15. Staff did not radio a medical emergency code until three minutes after Mr Newman was found hanging. There was a further delay of two minutes before the control room called an ambulance. There was also an avoidable delay in paramedics reaching Mr Newman's cell from the prison's entrance. We cannot say if these delays affected the outcome for Mr Newman, but they could make a crucial difference in other cases.

Recommendations

- The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that all staff who have contact with prisoners:
    - receive adequate training on suicide and self-harm prevention procedures;

- identify all the known risk factors of a prisoner during the initial health screening, including reviewing available sources of information such as SystmOne records;
- arrange general health assessments without delay for prisoners with a history of self-harm and mental health issues; and
- properly record in the prisoner's NOMIS case notes their contact with prisoners, particularly during their first days in custody.

- The Governor should ensure that, in line with PSI 20/2015:
  - Cell Sharing Risk Assessments are based on evidence which is checked for accuracy, and
  - security staff provide PNC records to reception staff without delay.
- The Governor should ensure that there is an agreed and published regime for the induction unit and that particular attention is paid to the welfare of prisoners in single cells
- The Governor should:
  - ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, so that there is no delay in calling a medical emergency code or calling an ambulance, and
  - review arrangements for paramedics' access to a prisoner to reduce avoidable delays.
- The Prison Group Director for the North West should provide the Ombudsman, by 31 March, with a report on the Group Safety Team's findings on the progress made at Liverpool in implementing the PPO's recommendations.

The Investigation Process

16. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact him. No one contacted the investigator.

17. The investigator visited Liverpool on 17 October 2017. He obtained copies of relevant extracts from Mr Neman's prison and medical records.

18. The investigator interviewed 15 members of staff and two prisoners at HMP Liverpool between October and December 2017.

19. NHS England commissioned a clinical reviewer to review Mr Newman's clinical care at the prison. The clinical reviewer carried out seven interviews jointly with the investigator.

20. The investigation was suspended from January until October 2018 pending disclosure of relevant evidence from the police and the Independent Office for Police Conduct (IOPC).

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

22. One of the Ombudsman's family liaison officers contacted Mr Newman's family, to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. The family wanted to know:

    - what was the significance of Mr Newman being placed on an induction wing and the difference between an induction wing and a standard wing;
    - whether Mr Newman should have been monitored regularly;
    - whether HMP Liverpool had any record that Mr Newman had self-harmed;
    - whether the prison received any calls or information that Mr Newman intended to harm himself;
    - when was the last time that an officer had meaningful contact with Mr Newman;
    - how often did staff check on Mr Newman in his cell;
    - whether Mr Newman left his cell at any time before he died and if so when;
    - details of the emergency response and whether staff were appropriately trained to deal with the emergency response; and
      details of the attendance by paramedics during the emergency response.

23. Mr Newman's family received a copy of the initial report. They wrote to us through their legal representatives. They did not raise any comments about specific factual inaccuracies.

24. The prison service also received a copy of the initial report. They made one minor accuracy comment and we have amended the report accordingly.

Background Information

HMP Liverpool

25. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1,400 adult men. Lancashire Care NHS Foundation Trust provides health care services at the prison.

HM Inspectorate of Prisons

26. The most recent inspection of HMP Liverpool by HM Inspectorate of Prisons (HMIP) was conducted in September 2017. Inspectors found that only 22 of the 89 recommendations made following the 2015 inspection had been implemented and that 'the bare statistics of the failure to respond to previous inspection findings do not adequately describe the abject failure of HMP Liverpool to offer a safe, decent and purposeful environment'.

27. The inspection found that many prisoners, especially vulnerable prisoners, spent too long on the induction unit. The regime on the unit was poor and prisoners were locked in their cells for 22 hours a day. Inspectors also found that not enough night officers were available on the induction unit to monitor the welfare of new arrivals regularly or to support prisoners on suicide and self-harm monitoring (known as ACCT). Overall, time out of cell for prisoners at Liverpool was extremely limited.

28. In February 2018, the Justice Select Committee published a report finding that HM Prison and Probation Service (HMPPS) had failed to respond properly to HMIP recommendations to improve safety, conditions and other outcomes for prisoners at Liverpool.

Independent Monitoring Board

29. 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 31 December 2017, the IMB said that the availability of illegal drugs and mobile phones in the prison was a serious concern. The Board was also concerned about the provision of mental health treatment. Mental health teams had high workloads which had to be managed with inadequate levels of frequently overworked staff. The Board also expressed concern about the lack of workshops to provide purposeful activity for prisoners.

Previous deaths at HMP Liverpool

30. Mr Newman was the fifteenth prisoner to die at Liverpool since February 2015. Six of the previous deaths were self-inflicted, seven were from natural causes and the cause of one death was unascertained. In previous investigations, we identified deficiencies with the operation of suicide and self-harm prevention procedures as well as issues in assessing and monitoring risk.

31. Since Mr Newman's death in October 2017, there have been nine further deaths at HMP Liverpool, three of which were self-inflicted. In our investigation into the

death of Mr Anthony Paine on 19 February 2018, we found that staff did not adequately manage his risk of suicide and self-harm.

Cell Sharing Risk Assessment (CSRA)

32. PSI 20/2015, *Cell Sharing Risk Assessment,* sets out the process designed to risk assess prisoners for their potential to murder or violently assault a cell mate in a shared cell. Prisoners who are assessed as 'high risk' are subject to restrictions on cell sharing.

33. The PSI lists indicators that a prisoner poses a heightened risk to share a cell with another prisoner. It requires staff to check various sources of evidence for these indicators, including the Police National Computer (PNC) records which provide details of current and previous convictions and the NOMIS records which provide information about the prisoner's behaviour in prison. PSI 20/2015 also provides that where PNC records are not available at reception, a further CSRA must be carried out on the next working day when details can be checked.

Assessment, Care in Custody and Teamwork (ACCT)

34. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

35. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.

36. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

Key Events

37. On 21 March 2017, Mr Carl Newman was sentenced to 20 weeks imprisonment for driving while disqualified. This was not his first time in prison. On 26 May, Mr Newman was released on licence.

38. Mr Newman had a history of contact with mental health services but had had no mental health interventions or treatments in the 12 months prior to his death. Officers placed Mr Newman on ACCT monitoring on four occasions when he was in prison in 2014 and 2015 because of attempts to hang himself and superficial cuts to his leg.

39. On 1 October, Mr Newman allegedly went to his partner's home and seriously assaulted her. He was arrested the following day. Police noted that Mr Newman was calm while detained and no issues or concerns were identified.

40. Police officers took Mr Newman to a police station. Mr Newman told officers that he had not tried to harm himself in the past, did not suffer from any mental health problems and had no drug or alcohol addictions. Officers assessed that Mr Newman was at low-risk of harm to himself.

3 October

41. On 3 October, Mr Newman appeared at Liverpool Magistrates Court and was remanded in custody to HMP Liverpool. Mr Newman's Person Escort Record (PER, a document that accompanies prisoners as they move between police stations, courts and prisons) recorded that he had cut his arm in 2006 and driven a bike into a bus in 2007. It did not show any recent events of self-harm or attempts to kill himself.

42. At around 1.46pm, Mr Newman arrived at Liverpool. At reception, a Supervising Officer (SO) reviewed Mr Newman's recall documentation and PER. He asked Mr Newman if he had been in prison before and whether he had any concerns about his wellbeing. He said that Mr Newman did not raise any concerns and said that he did not have any suicide or self-harm issues.

43. An officer completed Mr Newman's cell sharing risk assessment (CSRA). This is designed to identify prisoners at risk of assaulting a cellmate in a locked cell. The officer assessed that Mr Newman was a "high-risk" because he told him that he had kidnapped a lorry driver in the past. The officer said that he had also identified that Mr Newman had a history of violence in custody but that he did not check Mr Newman's NOMIS records or his PNC because he did not have access to them. He therefore arranged for a further CSRA to be conducted the next day. This second CSRA never took place.

44. At around 2.56pm, a mental health nurse carried out Mr Newman's initial health screening. Mr Newman told him that he did not take any illicit drugs, was not taking prescribed medication, did not have any thoughts of self-harm or suicide and had not been involved with mental health services. He told the investigator that Mr Newman was well and appeared to be mentally stable. He assessed that Mr Newman was fit for standard location and recorded in his CSRA that he had no medical issues.

45. The mental health nurse did not prioritise Mr Newman's general health assessment which ought to have taken place within the week after his reception. We found no record that the assessment was ever arranged before Mr Newman took his life.

46. An officer interviewed Mr Newman for his first night assessment. Mr Newman told her that he had never been on an ACCT and did not have current thoughts of suicide and self-harm. The officer told the investigator that Mr Newman "seemed very blasé" about being in prison and that he did not present as someone "troubled", so she had no concerns.

47. The officer told Mr Newman about the prison's Listener's Scheme and how to use the emergency cell bell. (Listeners are prisoners trained by the Samaritans to support other prisoners.) Mr Newman signed a communication compact which explained the terms and conditions of using the PIN phone system. He was allowed to make a phone call. The officer gave Mr Newman the number of the Samaritans in case he needed to speak to them.

48. Mr Newman was located in A wing which is the induction unit. His cell had a bunk bed and an en suite toilet facility separated by a door. He was not allowed to share the cell with another prisoner because of the result of his CSRA.

4 October

49. On 4 October, at around 9.30am, Mr Newman attended a prison induction session in the Welcome Centre. A prisoner mentor had intended to ask Mr Newman whether he had any concerns, but Mr Newman left the session and returned to A wing before he could do so. The prisoner mentor told the investigator that Mr Newman said that he was not feeling well and mentioned "something about his medication" which he could not remember. An officer recorded Mr Newman's attendance at the induction session in his NOMIS record but did not note any issues or concerns.

50. Another prisoner who lived on A wing and who was a good friend of Mr Newman, told the investigator that Mr Newman came straight to his cell door after the induction and spoke to him. He said Mr Newman did not present well, did not want to eat or have a shower and did not want to be on his own in his cell.

51. A member of staff from the pharmacy, recorded at 9.41am that she had checked the summary of Mr Newman's medical records and noted that he had recently started to take propranolol (a medication used to treat anxiety) in the community. She passed the information to the prison GP, who prescribed the medication the next day.

5 October

52. During the morning of 5 October, Mr Newman and a prisoner spoke to an officer Mr Newman told the officer that he had been recalled to prison because he had assaulted his partner but that he was very remorseful. Mr Newman said that his partner was willing to forgive him if he changed so he asked the officer about anger management courses that he could do. Mr Newman also asked to share a cell with a prisoner and to be moved to B wing. He told the officer that he did not want to be on his own in his cell and that he would be safe on B wing.

53. The officer told the investigator that Mr Newman looked depressed but he had no concerns because Mr Newman was making plans the future. He referred Mr Newman's case to the safer custody team for them to decide on his move. He also emailed the education lead and asked him to include Mr Newman on the anti-violence programme. A prisoner told the investigator that he thought that the officer did all that he could to help Mr Newman and commended his work.

54. The same day, an offender supervisor completed Mr Newman's Basic Custody Screening (BCS) which is an assessment tool to identify a prisoner's needs and plan for their support on release. He carried out the screening in Mr Newman's cell and told the investigator that Mr Newman did not appear to be sad, anxious or stressed. Mr Newman told him that he had never had any problems with drugs or alcohol and that he had never had any contact with mental health services. The offender supervisor told the investigator that he did not think Mr Newman was at risk of suicide and self-harm.

6 October

55. On 6 October, at around 8.00am, Mr Newman spoke to a prisoner during association on the induction wing. The prisoner said that Mr Newman seemed happy because they were told that they were going to be moved to B wing. The prisoner said that he was "joking and laughing" with Mr Newman on the landing.

56. At 9:00am, Mr Newman was locked in his cell. Between 9.26am and 9.53am, Mr Newman made a number of phone calls and sent text messages to his partner from an illegal mobile phone.

57. After Mr Newman's death, his partner told a police officer that Mr Newman was asking her not to go to court, and to drop the charges against him. She also said that Mr Newman appeared to be "very up and down" and was making threats to kill himself. Mr Newman's partner did not believe that he would kill himself and refused his request. The police found Mr Newman's mobile phone in his cell after his death and examined the SIM card. Only four text messages could be retrieved but they did not include any suicidal statements.

58. At 10.09am, a member of the public spoke to an officer from Merseyside police. (Names were not disclosed to the investigator.) The member of the public told the police officer that Mr Newman was phoning from the prison threatening individuals and threatening to kill himself. We found no evidence that the police took any action or that any one shared this information with the prison.

59. At around 11.21am, a prisoner mentor went to Mr Newman's cell to deliver Mr Newman's telephone PIN card. The prisoner mentor shouted Mr Newman's name but got no response. He opened the observation panel but could not see anybody because Mr Newman had used a towel to obstruct the view. He thought Mr Newman was asleep so he passed the PIN under his door.

Emergency response

60. The investigator reviewed CCTV footage, the control room log and the ambulance service records. The prison told us that the time shown in the CCTV was six minutes behind the actual time, which we took into account.

61. At around 11.24am, three officers arrived at Mr Newman's cell to unlock him for lunch. An officer opened the cell and checked Mr Newman's bed but could not see him. She wondered whether Mr Newman was on a visit or at the healthcare department and alerted another officer that Mr Newman was not in his cell.

62. At around 11.25am, two officers entered the cell. Another officer and Custodial Manager (CM) also attended. An officer opened the toilet door and found Mr Newman hanging from a ligature made of bedsheets which was attached to the light fitting in the toilet. He said that he shouted, "Staff assistance" and "Code blue". (A code blue indicates that a prisoner is unconscious or having difficulty breathing.) An officer cut the ligature and moved Mr Newman to the main area of the cell. Two officers started CPR on Mr Newman.

63. At around 11.26am, a nurse arrived at the cell followed by two other nurses. They took over CPR.

64. A SO radioed a code blue emergency as he was on his way to the cell. The control room officer recorded in the log that the code blue was radioed at 11.28am.

65. At 11.30am, the control room officer called an ambulance and at around 11.35am the ambulance arrived at the prison gate. At 11:40am, paramedics reached Mr Newman and took over CPR. At 11.45am, Mr Newman was declared dead.

Contact with Mr Newman's family

66. At 1.30pm on 6 October, a duty governor and an officer went to the house of Mr Newman's father and broke the news of Mr Newman's death. They offered support.

67. Mr Newman's funeral took place on 22 October 2017. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

68. After Mr Newman's death, a duty governor and Head of Residence and Healthcare, debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

69. The prison posted notices informing other prisoners of Mr Newman's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Newman's death.

Post-mortem report

70. The post-mortem examination found that Mr Newman died of compression of the neck due to hanging. The toxicology examination found no alcohol or drugs in his body.

Findings

Identifying Mr Newman's risk of suicide

71. Prison Service Instruction (PSI) 64/2011, *Safer Custody,* requires all staff in contact with prisoners to be aware of the triggers and risk factors that might increase a prisoner's risk of suicide and self-harm, and to take appropriate action, including starting ACCT procedures. It states that staff must check relevant documents such as the PER, pre-sentence reports, NOMIS and clinical records, for evidence of risk.

72. Mr Newman's risk factors for suicide and self-harm included the fact that he had been charged with an offence against his partner, the breakdown in their relationship, being recalled to prison, previous involvement with mental health services, and a history of suicide attempts and self-harm in 2014 and 2015.

73. Mr Newman repeatedly told staff, incorrectly, that he did not have a history of mental health issues and had not previously been monitored under ACCT and, at the initial health screening, a nurse recorded that Mr Newman had not tried to self-harm in the past and did not have a history of mental health issues.

74. However, Mr Newman had been subject to ACCT monitoring on four occasions when he was in prison in 2014 and 2015 because of attempts to hang himself and superficial cuts to his leg and had a mental health history which was recorded in his SystmOne medical records.

75. This information is available to nurses once they register prisoners on arrival and we are concerned that a nurse did not identify these risk factors from Mr Newman's records. If he had done, staff would have had a fuller picture to assess whether Mr Newman was at risk of suicide and self-harm, given the additional risk factors of his recall and the offence against his partner. Given all these risk factors, we consider that Mr Newman should have been identified as a heightened risk to himself.

76. In addition, a nurse's failure to identify these factors, meant that no one arranged a general health assessment for Mr Newman. The nurse told the investigator that healthcare staff prioritise general health assessments of prisoners with suicide or self-harm issues or a mental health history, but he did not do so for Mr Newman because he was unaware of his history.

77. PSO 3050, *Continuity of healthcare for prisoners*, sets out the expectation that a general health assessment should take place in the week following first reception. It usually takes place on the next day, which is good practice. The failure to arrange a general health assessment was a significant missed opportunity to further review Mr Newman's mental state and risk factors.

78. PSI 64/2011 also highlights the importance of sharing relevant information about a prisoner's risk and provides that staff should record all work and contact with prisoners on NOMIS for this purpose.

79. We are concerned that no officer made any note of their interactions with Mr Newman in his NOMIS record during the four days that he was at Liverpool.

80. On 5 October, an officer identified that Mr Newman appeared depressed. Mr Newman told him about the nature of his offence and that his partner was his victim. Although the officer acted to address Mr Newman's concerns, including referring his case to the safer custody team, he did not record the conversation in NOMIS. This meant that other officers were unable to familiarise themselves with Mr Newman's issues.

81. We are also concerned that some staff have not been adequately trained on ACCT monitoring. A nurse who routinely carries out reception screenings, told the investigator that he had not received any ACCT training since he began working in prisons in 2009. If that is the case, it is unacceptable. A SO and an officer both said that they had not received recent training. The lack of training undermined staff capacity to identify and assess Mr Newman's risk factors. We make the following recommendation:

The Governor and Head of Healthcare should produce clear local guidance about procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, this should ensure that at all staff who have contact with prisoners:

- **receive adequate training on suicide and self-prevention procedures;**
- **identify all the known risk factors of a prisoner during the initial health screening including reviewing available sources of information such as SystmOne records;**
- **arrange general health assessments without delay for prisoners with a history of self-harm and mental health issues; and**
- **properly record in the prisoner's NOMIS case notes their contact with prisoners, particularly during their first days in custody.**

Cell Sharing Risk Assessment

82. Sharing a cell can be a protective factor against suicide and self-harm for many prisoners. On 3 October, an officer assessed Mr Newman as being 'high-risk' to share a cell with another prisoner because Mr Newman told him that he had kidnapped a lorry driver in the past and had identified markers for violence in his warrant. However, the officer did not check Mr Newman's NOMIS and said that he did not have his PNC records. The officer correctly arranged for a second day assessment but the updated PNC records were not printed out so this further assessment did not take place before Mr Newman died.

83. Liverpool is a PNC terminal-owning establishment, which means that it can access the PNC system and print the records in the prison. The prison's security department should, therefore, have provided the PNC records to reception staff, and the second assessment should have been carried out without delay. The prison was unable to tell the investigator why the PNC records were not provided or requested from another source, which they had time to do before Mr Newman died.

84. Mr Newman's PNC records do not show that he had a conviction for kidnapping, and there was only one marker for violence in his NOMIS record since October 2016. We consider that if the PNC and NOMIS records had been checked, as they should have been, Mr Newman would have been assessed as a standard CSRA risk and would have been allowed to share a cell.

85. Mr Newman told an officer and his friend that he did not want to be on his own in a cell and that this was an issue for him. If Mr Newman had shared a cell with his friend, as he requested, his death may have been less likely. We make the following recommendation:

The Governor should ensure that, in line with PSI 20/2015:

- **Cell Sharing Risk Assessments are based on evidence which is checked for accuracy, and**
- **security staff provide PNC records to reception staff without delay.**

Induction unit

86. PSI 07/2015, *Early Days in Custody*, recognises that the first week in custody is a difficult time for prisoners and a period of particular vulnerability for those at risk of suicide and self-harm. The PSI states that officers should focus on safer custody issues and provide additional support to prisoners during this period.

87. Mr Newman lived on A wing, the induction unit, where prisoners are expected to live for a brief period before they are moved to a permanent wing. The aim of the unit is to ensure that prisoners' immediate needs are met and that prisoners are given information about their entitlements and responsibilities, and how to access the support and facilities available to them. The induction unit at Liverpool has a mixed population of new arrivals and vulnerable prisoners and its regime is restricted to avoid vulnerable prisoners mixing with the other prisoners.

88. Under A wing's regime, Mr Newman had less than two hours a day out of his cell, and he did not undertake any meaningful activity apart from attending an induction session on the second day. His friend said that prisoners in A wing spent most of their time locked up in their cells, which he described as being "emotionally draining". He also said that during his time in the induction unit, no officer came to check or speak to him.

89. The friend's account supports HMIP's findings in September 2017 that the regime in the induction unit was particularly poor and that prisoners in the induction unit were locked in their cells for 22 hours a day. This is bound to be particularly difficult for prisoners like Mr Newman who have to spend that time alone in a single cell.

90. In our Learning Lessons Bulletin *Early Days and Weeks in Custody*, published in February 2016, we noted that effective induction involves a lot more than simple provision of information. Regular contact with staff is important. Staff need to talk to the prisoner and check that they are coming to terms with their situation.

91. There is no evidence in Mr Newman's NOMIS records to suggest that staff had any meaningful contact with him in the unit, although we note that Mr Newman's

friend thought that an officer provided Mr Newman with a good level of support for his concerns on 5 October.

92. We share the clinical reviewer's view that the restricted regime Mr Newman experienced during his four days at Liverpool was not conducive to good mental health. We make the following recommendation:

The Governor should ensure that there is an agreed and published regime for the induction unit and that particular attention is paid to the welfare of prisoners in single cells.

Clinical Care

93. Mr Newman had not received any mental health interventions or treatments in the 12 months prior to his death. This included his previous period of imprisonment at Liverpool from March to May 2017. Mr Newman was not prescribed any medication for mental health problems, other than medication for anxiety, although this was prescribed to him sporadically.

94. The clinical reviewer concluded that the healthcare provided to Mr Newman at Liverpool was of a reasonable standard and equivalent to what he could have expected to receive in the community. The clinical reviewer did not have any concerns about Mr Newman's mental healthcare or medication.

Emergency Response

95. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance.

96. A nurse told the investigator that there was confusion during the emergency response because officers asked over the radio for 'staff assistance' but did not radio a 'code blue' emergency immediately on discovering Mr Newman. Healthcare staff therefore did not bring the most appropriate emergency bag to the cell. A code blue was not radioed until about three minutes after Mr Newman was found hanging.

97. Once a code blue is called, this should trigger the control room to call an ambulance immediately. In this case, after the code blue was called, there was a delay of about two minutes before the control room called an ambulance. Although the ambulance arrived quickly, there was a further five-minute delay in paramedics reaching Mr Newman's cell from the prison's entrance, a path that took the investigator no more than a minute to walk. A Paramedic told the police that the delay reaching Mr Newman was largely due to security procedures, such as signing in and handing in of mobile phones, which is unacceptable in an emergency. This delay was entirely avoidable.

98. We consider that the emergency response in this case fell below the required standard. Although the clinical reviewer could not say whether the delay affected the outcome for Mr Newman, in other cases it could be crucial. We make the following recommendations:

The Governor should:

- **ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies so that there is no delay in calling a medical emergency code or calling an ambulance, and**
- **review arrangements for paramedics' access to a prisoner to reduce avoidable delays.**

99. We have identified similar failings in the emergency response in our investigations into previous deaths at Liverpool and made recommendations which the prison has accepted. In our investigation into the death of another prisoner in 2017, we recommended that the Prison Group Director for the North West should assure himself that action was taken to address our previous recommendations.

100. HMPPS responded in June 2018 that the Prison Group Director had established a Group safety team to provide assurance that progress was being made against our recommendations. HMPPS said that a live action plan was in place at Liverpool which combined all recommendations made about safety from reports, including HMIP and PPO recommendations. We were told that this plan was maintained by the Head of Function, and progress was checked by the Group safety team during its assurance and support visits.

101. In the light of the response to our previous recommendation, we now make the following recommendation:

The Prison Group Director for the North West should provide the Ombudsman, by 31 March, with a report on the Group Safety Team's findings on the progress made at Liverpool in implementing the PPO's recommendations.

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Independent Investigations