

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Paul Jones, a prisoner at HMP Liverpool, on 26 September 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Paul Jones was found hanged in his cell on 26 September 2018 at HMP Liverpool. He was 36 years old. I offer my condolences to Mr Jones' family and friends.

Mr Jones had been at Liverpool for only 16 days before his death. Although staff correctly identified that he was at risk of suicide when he arrived at Liverpool, he was monitored under suicide and self-harm procedures (known as ACCT) for only three days after this. I consider that the ACCT was closed prematurely while Mr Jones was undergoing alcohol detoxification.

However, as Mr Jones had no recent history of self-harm or attempted suicide and seemed more settled, I consider that it would have been reasonable to have closed the ACCT once the detoxification had been successfully completed, and I do not consider that staff could reasonably have foreseen or prevented Mr Jones' death at the time it occurred.

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**

**January 2021**

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# Summary

## Events

1. On 10 September, Mr Paul Jones was remanded to HMP Liverpool. He had a previous history of anxiety, depression, alcohol abuse and self-harm. Staff began Prison Service suicide and self-harm prevention procedures, known as ACCT, after he said that he had thoughts of self-harm. He was monitored four times an hour.
2. Mr Jones was admitted to the healthcare centre as an in-patient after a health screening showed that he had severe alcohol withdrawal. He successfully underwent a five-day programme for alcohol detoxification.
3. On 11 September, a multi-disciplinary case review assessed Mr Jones' risk of self-harm as low and the frequency of observations was reduced to hourly. He engaged well with staff and told them that he had no thoughts of self-harm. His ACCT document was closed on 13 September.
4. After his detoxification treatment had concluded successfully, Mr Jones was moved to a standard residential wing on 19 September.
5. On the morning of 26 September, Mr Jones had a visit from his solicitor. He subsequently collected his lunch and took it to his cell. At about 1.45pm, a prisoner found Mr Jones hanging in his cell. He called for help and three officers went into Mr Jones' cell and began cardiopulmonary resuscitation (CPR).
6. Staff and paramedics were unable to resuscitate him and at 2.25pm, paramedics confirmed that Mr Jones had died.

## Findings

### Clinical Care

7. The investigation found that Mr Jones' substance misuse and physical healthcare at Liverpool were managed appropriately. The clinical reviewer concluded that his mental healthcare appeared to be of a good standard in terms of medication and support, but standard tools for measuring anxiety and depression were not used. This meant that the effectiveness of his treatment could not be gauged as it would be in the community.
8. The clinical reviewer concluded however, that the overall healthcare Mr Jones received was generally equivalent to that which he could have expected to receive in the community.

### Management of Mr Jones' risk

9. Staff appropriately monitored Mr Jones under ACCT procedures after he told an officer that he was having thoughts of self-harm. He then denied this.
10. We consider that ACCT monitoring was ended prematurely on 13 September, given that Mr Jones was still undergoing detoxification, which is a risk factor and

a potential trigger for suicide and self-harm. We are also concerned that the post closure process did not take place.

11. However, as Mr Jones had no recent history of self-harm or attempted suicide and seemed more settled, we consider that it would have been reasonable to have closed the ACCT once the detoxification had been completed. We do not consider that staff could have foreseen or prevented Mr Jones' death at the time it occurred.

### **Emergency response**

12. The initial radioed code blue emergency response was not heard by the control room staff because it was interrupted by other radio traffic. It was followed up quickly by an urgent message by another member of staff who realised that the control room staff had not responded to the initial message. Although this meant that there was a delay in healthcare staff reaching Mr Jones, we are satisfied that the officer who performed CPR was prompt and competent. We make no recommendation.

### **Legal paperwork**

13. We cannot say whether Mr Jones was upset by any of the legal paperwork he had in his cell. We are satisfied, however, that prison staff would not have been aware of the contents and did not have the authority to remove legal documents from Mr Jones' cell.

### **Allegations on social media**

14. We have found no evidence to support the allegations that Mr Jones was being bullied by staff or that he did not take his own life. The post-mortem found nothing to suggest that Mr Jones had been assaulted before his death.

### **Recommendations**

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, in particular that:
  - an ACCT caremap, with identifiable actions aimed at reducing a prisoner's risk should be completed; and
  - an ACCT post-closure review should take place within seven days.
- The Governor should ensure that family liaison officers remind families that there may be material of a sensitive or upsetting nature in the prisoner's belongings.

## The Investigation Process

15. 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.
16. The investigator visited Liverpool in November 2018. She obtained copies of relevant extracts from Mr Jones' prison and medical records. The CCTV system for I wing was not functioning at the time of Mr Jones' death. The PIN telephone system indicated that he had not made any calls while at Liverpool. There were no control room recordings available.
17. The investigator interviewed 13 members of staff and two prisoners at Liverpool by telephone between November 2018 and March 2019.
18. NHS England commissioned two independent clinical reviewers to review Mr Jones' clinical care at the prison. The investigator conducted joint interviews with one of the clinical reviewers.
19. We informed HM Coroner for Liverpool and Wirral of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The investigator contacted Mr Jones' sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider.
21. Mr Jones' sister was concerned that her brother was allowed to have legal documents about his alleged violent offences in his possession, which she thought might have influenced his state of mind.
22. When Mr Jones' sister read the documents after his belongings were returned to her, she found their contents distressing. She asked why the prison had not warned her beforehand.
23. She was also concerned that soon after her brother's death, a prisoner had posted information on social media sites alleging that her brother had died because staff intimidated him and that he did not take his own life.
24. We have addressed Mr Jones' sister's questions in this report.
25. The initial report was shared with HM Prisons and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies. Their action plan is annexed to this report.
26. Mr Jones family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

# Background Information

## HMP Liverpool

27. HMP Liverpool serves the courts of Merseyside and holds up to 700 adult men. Healthcare is managed by Spectrum CIC in partnership with MerseyCare NHS Foundation Trust and CGL.

## HM Inspectorate of Prisons

28. The most recent inspection of HMP Liverpool was in September 2017. Inspectors found that although reception risk assessments and health screens were thorough, the prison was failing to provide a safe, decent and purposeful environment and incidents of self-harm were increasing. Inspectors concluded that there had been a failure of leadership within the prison and beyond. Since the inspection report was published, a new Governor and healthcare provider have been appointed.

## 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 December 2018, the IMB reported that the prison's inpatient unit was well-equipped and clean. They noted that Liverpool had a high rate of self-harm by comparison with other similar prisons, although a small number of prisoners who repeatedly self-harmed accounted for a high proportion of the incidents. They noted that the number of self-harm incidents by those on ACCTs had continued to decrease over the last quarter of the year.

## Previous deaths at HMP Liverpool

30. There have been fifteen deaths at Liverpool since the beginning of 2017. Mr Jones' death was the fifth self-inflicted death since 2017.
31. We have previously made recommendations at Liverpool about shortcomings in ACCT procedures, particularly about poor risk assessment, the premature closing of ACCTs without caremaps being completed, and the failure to conduct post-closure interviews.
32. In response to a self-inflicted death in October 2016, we recommended that the prison should ensure that the frequency of ACCT observations should reflect the prisoner's risk. Liverpool's action plan indicated that all staff would receive new Suicide and Self Harm training by December 2018.

## Assessment, Care in Custody and Teamwork (ACCT)

33. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner

anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

34. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison.

## Key Events

35. On 9 September 2018, Mr Paul Jones was arrested by Merseyside police charged with breaching a restraining order, assault and grievous bodily harm. He had breached the same restraining order in 2017 and had been given a community order. The victim of two of the alleged offences was his former partner.
36. On 10 September, Mr Jones' Person Escort Record (PER), which accompanied him from police custody to court, recorded that he had attempted to hang himself in 2017. An escorting officer asked him about his previous self-harm history and Mr Jones said, "It's all in the past." A supplementary document to Mr Jones' magistrates court warrant listed his risk/vulnerability factors as "Risk to self and others, suicide, self-harm. Possible mental health".
37. Mr Jones was remanded to HMP Liverpool. It was not his first time in custody.
38. When Mr Jones arrived at Liverpool, he told the reception officer that he had thoughts of self-harm and felt vulnerable because of his mental health but did not say what this meant. The officer told the investigator that Mr Jones stood out amongst the prisoners who had arrived from court because he seemed quite upset and tearful. He told Mr Jones that he would open Prison Service suicide and self-harm procedures, known as ACCT.
39. Mr Jones had last been on an ACCT in February 2013. He told the officer that he should forget what he had said and that he did not have thoughts of self-harm. The officer sought advice from a Supervising Officer (SO), who was working in the reception area. They decided that he would open an ACCT. The frequency of Mr Jones' ACCT observations was set at four times an hour.
40. The officer also completed the cell-sharing risk assessment (CSRA) which is used to determine whether someone would present a risk of violence to another prisoner in a shared cell. He recorded that Mr Jones said that he had seriously assaulted another prisoner in the past and had a tendency to 'lash out' at others. The officer referred the CSRA to the duty governor. She gave Mr Jones an initial assessment as high risk, which meant he would not share a cell.
41. Mr Jones told the SO that he had been drinking 10-12 pints of strong lager daily. His face was red and very bloated. A nurse assessed him in the reception area as needing immediate alcohol detoxification. He had alcohol dependency syndrome, a history of alcohol-related seizures due to withdrawal of alcohol, a depressive disorder and anxiety.
42. Mr Jones' Clinical Institute Withdrawal Assessment of Alcohol (CIWA) score was 26 (a score of 16 or more is considered severe). His Fast Alcohol Screening Tool (FAST) score, which measures how much alcohol is regularly consumed, was 40, which indicated a major problem with alcohol use. Due to his scores, he was referred to a doctor immediately.
43. Mr Jones was seen by a prison GP, who prescribed chlordiazepoxide, an alcohol detoxification treatment. He was admitted as an in-patient to the prison's

healthcare centre under the care of the substance misuse team. The GP also prescribed medication for Mr Jones' symptoms of anxiety and depression.

44. On 11 September, a trained ACCT assessor, an officer, interviewed Mr Jones. Mr Jones told the officer that the allegations against him were false and said that he felt aggrieved at being in prison. He also said that he had tried to kill himself in the past when he was struggling with poor mental health, and that he had experienced recent panic attacks because he was apprehensive about what to expect since being back in custody. When the officer asked him if he had current suicidal thoughts, Mr Jones said that he did not know how to feel and that he felt confused.
45. An ACCT case review took place immediately after the assessment. It was attended by the ACCT assessor, a unit manager, a mental health manager and a healthcare assistant. Although Mr Jones was still undergoing detoxification, no member of the substance misuse team was present. Mr Jones told the staff that he was fed up of being back in prison and was concerned about his accommodation in the community, though he had asked a neighbour to sort it out for him if he were to stay in prison. He denied having any current thoughts of self-harm.
46. The unit manager's summary of the review in the ACCT document said that Mr Jones had made good eye contact and "engaged well". The risk of harm to himself was assessed as low and the frequency of observations was lowered to once an hour. The caremap, which documents practical actions to reduce vulnerability, was not completed, although the ACCT assessor noted on Mr Jones' electronic prison record that he had contacted Shelter about this on Mr Jones' behalf and they were arranging to speak to him.
47. On 13 September, the second ACCT case review took place, which was led by a manager and a mental health nurse. The review summary recorded that Mr Jones' risk was low, that "he engaged really well", and that he had no current thoughts of self-harm or suicide. On the caremap, the manager identified alcohol detoxification, housing and prison employment as ongoing issues for Mr Jones. All present, including Mr Jones, agreed that the ACCT document would be closed. After the review, Mr Jones told a nurse that he did not need support at that time and had no thoughts of suicide or self-harm.
48. A post-closure review, which should take place within seven days, was not arranged.
49. On 17 September, a specialist nurse completed an assessment for the Drug and Alcohol Recovery Service of Mr Jones' detoxification treatment in preparation for his return to the residential wing. A plan was agreed with Mr Jones to attend Alcoholics Anonymous and relapse prevention and recovery groups for peer support.
50. On 18 September, Mr Jones was discharged from the healthcare centre because he had completed the detoxification treatment and showed no signs of withdrawal or concerns. He was moved to A wing, the induction wing, for a day and then on to a single cell on I wing, a standard wing, on 19 September. On the morning of 25 September, a prison GP renewed Mr Jones' prescription for anti-

depressant medication. The GP wrote in his case notes that Mr Jones was “alert ... no thought disorder, no self-harm or suicidal ideation”. At 2.40pm, Mr Jones discussed his previous history of seizures caused by alcohol with a prison GP.

### Events of 26 September

51. At 9.10am on 26 September, Mr Jones’ solicitor visited him for an hour to take instructions for a court hearing scheduled for 12 October. He gave Mr Jones copies of the evidence. They discussed a retraction statement made by the complainant, his likely sentence and prospects for bail. Mr Jones asked his solicitor to submit a bail application to the Crown Court and the solicitor agreed that he would do so. Mr Jones asked him to return before the hearing so they could discuss definitive instructions and he sent an email request to the prison that afternoon.
52. A prisoner, who had been moved into the cell next door to Mr Jones on 24 September, told the investigator that the phone in his cell was not working, so Mr Jones let him use his. (All cells on I wing have in-cell telephones. Prisoners key in their PIN number first and can then ring authorised numbers.)
53. When Mr Jones returned to his cell after his legal visit, the prisoner next door asked to use his phone and Mr Jones waited on the landing outside his cell until he had finished. The prisoner told the investigator that Mr Jones was a quiet individual and they did not discuss his legal visit. They collected lunch from the servery and brought it back to their individual cells, where they were locked in.
54. At about 1.30pm, an officer began to unlock the cells of prisoners on I wing who had activities off the wing that afternoon. He began on the top floor and worked his way down, joining two other officers. He answered the emergency cell bell of a prisoner in cell I3-22 (two cells along from Mr Jones) and unlocked his cell.
55. The officer told the investigator that he was with another officer who had a radio, whose name he could not remember. They noticed that the prisoner’s nose was bleeding and there was blood on the floor. The prisoner said that he had fallen over. An officer radioed for the emergency healthcare responder to go to I wing. He did not use an emergency response code or say why a member of healthcare was needed.
56. At about 1.45pm, the prisoner next door looked through the observation panel of Mr Jones’ cell and saw him hanging from a ligature attached to the upper bunk bed. He shouted to the three officers on the opposite side of the landing for help and made a gesture around his throat.
57. The three officers ran to Mr Jones’ cell and unlocked the door. An officer cut the ligature from Mr Jones’ neck using another officer’s anti-ligature tool, placed him on the floor and began CPR.
58. An SO told the investigator that an officer radioed a medical emergency code blue (indicating a life-threatening situation) but the control room operators did not respond. The SO then called an urgent message (to ensure that the radio airwaves were clear) and a code blue. One of the two control room operators called an ambulance at 1.46pm.

59. The control room operator told the investigator that he only heard the words 'code blue' come over the radio once and that he called for an ambulance straightaway. He also said that he was kept on hold by North West Ambulance Service for four minutes before he was able to give them details of Mr Jones' condition.
60. The other control room operator told the investigator that it was possible a radio message might not be heard in the control room if two messages were being radioed at the same time.
61. A prison paramedic arrived on I wing to treat the prisoner who had a facial injury. He did not record the time he arrived. He wrote in Mr Jones' clinical record that an (unnamed) officer shouted at him to hurry up. He said that he was unaware that a code blue had been called until someone directed him to Mr Jones' cell and that he could see an officer inside performing CPR correctly.
62. The prison paramedic radioed for healthcare staff to attend with a defibrillator and an emergency bag suitable for a code blue emergency. He checked for a pulse and signs of life. He recorded that Mr Jones was not breathing, there were ligature marks and his pupils were fixed and dilated. He instructed the officer to continue with CPR.
63. At 1.58pm, a fast response vehicle arrived at the prison gate and an ambulance arrived at 2.02pm. The paramedics arrived at Mr Jones' cell at approximately 2.10pm and at 2.25pm, they confirmed that Mr Jones had died.
64. An undated letter written by Mr Jones on prison note paper to a friend was found in his cell. He wrote that he was hoping to get bail at his next court appearance on 8 October because he was scared of being sentenced to prison and losing his flat and that he did not think he could go through that experience again.

### **Contact with Mr Jones' family**

65. The prison appointed a family liaison officer (FLO). The FLO and a senior manager visited Mr Jones' mother's address on 26 September, but they were informed by a neighbour that she was no longer living there. Through further enquiries, the FLO contacted Mr Jones' brother and sister and visited them on 27 September, to offer condolences and support. Mr Jones' siblings said that they wanted to tell their mother themselves of his death.
66. Liverpool offered to contribute towards the costs of Mr Jones' funeral in line with Prison Service instructions but Mr Jones' family declined the offer.

### **Support for prisoners and staff**

67. After Mr Jones' death, the deputy governor 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.
68. The prison posted notices informing other prisoners of Mr Jones' 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 Jones' death.

## **Post-mortem report**

69. The post-mortem report gave Mr Jones' cause of death as compression of the neck caused by hanging.
70. The pathologist commented that there were no injuries to suggest that an assault had taken place prior to death.
71. Toxicology results found medications in Mr Jones' body consistent with those prescribed to him. There were no traces of other substances, including alcohol or PS.

## **Information received after Mr Jones' death**

72. Staff said they got the impression from the prisoner next door that Mr Jones had received bad news during a visit with his legal representative on the morning of his death. They also said that they believed that the prisoner and Mr Jones had been talking to each other out of their windows when they were locked in at lunchtime and that he had discovered Mr Jones hanging when he went to check on him after lunch.
73. The investigator contacted Mr Jones' solicitor. He said that Mr Jones was calm during their meeting on the morning of his death, did not exhibit any signs of distress or say that he was considering ending his life. He was shocked to learn that he had.
74. The investigator spoke to the prisoner next door to Mr Jones' cell by telephone. He told her that he did not really know Mr Jones apart from noticing that he was very quiet. He said that he had spoken to Mr Jones because he used his telephone because the one in his own cell was not working and they were in cells next to each other.
75. The prisoner told the investigator that he knew Mr Jones had a legal visit not because Mr Jones had discussed it with him, but because he was familiar with daily routines and saw him leaving the wing with a visits officer who was carrying some documents. He said that they had not spoken about the visit.
76. The prisoner said that he was not close to Mr Jones and they did not talk through their windows or anywhere else that lunch time. He told the investigator that he had intended to go to a friend's cell after lunch but had looked into Mr Jones' cell by mistake and saw him hanging.

## **Social media**

77. On 1 October, one of Mr Jones' brothers told the prison's family liaison officer that a video had been placed on social media sites by a prisoner at Liverpool claiming that Mr Jones' death had been caused by staff malpractice.
78. The prisoner responsible was traced and asked to remove the postings but refused to do so. Disciplinary action was taken against him under the Prison Rules and his sentence was extended by six months for possession of an unauthorised mobile phone.

79. The investigator spoke to the prisoner by telephone. He said that he knew Mr Jones through mutual friends. He said that about a week before Mr Jones' death, they had chatted briefly in the education department. Mr Jones told him that staff in the security department were targeting him with cell searches and that a young officer had been "in his face, pushing him". The prisoner said he had every sympathy for Mr Jones' family and he put the videos on social media as retaliation for Mr Jones killing himself as he regarded the security department staff as "murderers".

# Findings

## Identifying risk of suicide and self-harm

80. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm procedures, requires all staff who have contact with prisoners to be aware of the risks and triggers that might increase the risk of suicide and self-harm and take action.
81. When Mr Jones arrived at Liverpool, there was documentary evidence that recorded that he had harmed himself, but not recently. However, he appeared upset and could not reassure staff that he would not act on suicidal thoughts. The reception officer's actions in testing what Mr Jones was telling him against what was already known about his vulnerability and opening an ACCT was a good use of judgement.
82. Mr Jones had a number of risk factors for suicide and self-harm, including being charged with a violent offence against a family member, undergoing alcohol detoxification, and early days in custody. He also told staff that he was depressed at being back in prison and worried about losing his accommodation in the community.
83. We are concerned that a caremap was not drawn up to identify and address Mr Jones' risk factors until just before the ACCT was closed and that the actions had not been completed when the ACCT was closed. We also consider that it was premature to close the ACCT after just three days, before Mr Jones had completed his alcohol detoxification.
84. Having said that, as Mr Jones had no recent history of self-harm or attempted suicide, we cannot say that it would have been wrong to have closed the ACCT once the detoxification had been completed and Mr Jones had moved to I wing. We accept that he seemed more settled and had not expressed any further thoughts of self-harm, and we recognise that prisons cannot use ACCT to manage every prisoner who is depressed at being in prison. We do not consider that staff could reasonably have foreseen or prevented Mr Jones' death at the time it occurred.
85. We are, however, concerned that no post-closure ACCT review took place and that this omission was not identified. The post-closure process would have given I wing staff an opportunity to check how Mr Jones was managing the transition from healthcare to a residential wing. We are also concerned that there is no documented evidence that I wing staff had any meaningful interactions with Mr Jones during the week he spent on the wing.
86. We make the following recommendation:

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

- an ACCT caremap, with identifiable actions aimed at reducing a prisoner's risk should be completed; and
- an ACCT post-closure review should take place within seven days.

## Clinical care

87. The clinical reviewer concluded that, overall, the healthcare Mr Jones received at Liverpool was generally equivalent to that which he could have expected to receive in the community. The investigation found that Mr Jones' substance misuse and physical healthcare at Liverpool was managed appropriately.
88. The clinical reviewer concluded that his mental healthcare appeared to be of a good standard in terms of medication and support but that standard tools for measuring anxiety and depression were not used. The effectiveness of his treatment could not, therefore, be gauged, as it would be in the community. The clinical reviewer has made a recommendation, which we do not repeat in this report but which the Head of Healthcare will wish to address.

## Emergency response

89. The initial radioed code blue emergency response was not heard by the control room staff as it was interrupted by other radio traffic. It was followed up quickly by an urgent message by another member of staff who realised that the control room staff had not responded to the initial message. Although this meant that there was a delay in healthcare staff reaching Mr Jones, we are satisfied that the officer who performed CPR was prompt and competent.
90. We make no recommendation.

## Legal paperwork

91. It is not clear where the information came from that Mr Jones was feeling low after seeing his solicitor, or whether it was true or not. Although staff appear to believe that a prisoner had formed that impression, and it is noted in the post-mortem report, the prisoner told the investigator he did not discuss Mr Jones' visit with him at all. It is possible that, after seeing his solicitor, Mr Jones thought he was more likely to be convicted or to receive a long sentence, but that can be no more than speculation. Indeed, his solicitor said he spoke to Mr Jones about the complainant retraction statement and made a bail application, actions which would suggest that their meeting was more positive than staff were led to believe.
92. Prison Rule 39 and PSI 49/2011 set out the rules governing communications between prisoners and their legal advisors. Prisoners must be allowed to communicate with their lawyers in confidence. Prisoners' legal paperwork cannot be opened, read or stopped by prison staff and prisoners are entitled to keep it in their cells. This includes letters between the prisoner and his lawyers and any documents and other materials, including those handed over during a legal visit.
93. We have no way of knowing whether any of the material shared between Mr Jones and his legal representatives affected his mood or level of risk. We are clear, however, that prison staff would not have known the contents of the material and did not have any authority to remove any legal paperwork from Mr Jones' cell.
94. Because a prisoner's legal paperwork is legally privileged and we do not consider that it would be appropriate for family liaison officers or other prison staff to read a dead prisoner's legal correspondence with a view to assessing whether its

contents might cause upset. We do, however, consider that it would be helpful for them to remind families that there may be material of a sensitive or upsetting nature in the prisoner's belongings. We recommend:

**The Governor should ensure that family liaison officers remind families that there may be material of a sensitive or upsetting nature in the prisoner's belongings.**

### **A prisoner's allegations**

95. The material posted on social media by a prisoner alleged that staff had harassed or bullied Mr Jones and contributed to his death in some way. The investigator checked intelligence reports and records. She did not find any evidence that Mr Jones' cell had been searched by staff, that he had had a confrontation or disagreement with any member of staff, or that any member of staff had given him a warning or placed him on a disciplinary charge. The post-mortem report did not find any injuries to suggest that Mr Jones had been assaulted before his death or that his death was anything other than an act of self-harm.
96. We have not, therefore, been able to find any evidence to support the prisoner's allegations.

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