Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Damien Anderson a prisoner at HMP Liverpool on 24 October 2018

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*

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 Damien Anderson was found hanged in his cell at HMP Liverpool on 24 October 2018. He was 40 years old. I offer my condolences to Mr Anderson's family and friends.

Mr Anderson died just 36 hours after he arrived at Liverpool to serve a short sentence. He used drugs in the community and began an opiate maintenance programme in prison. While early days in custody can be a significant risk factor for suicide and self-harm, Mr Anderson had been in prison several times before under similar circumstances and had never previously harmed himself or indicated that he had considered this.

I am concerned that prison and healthcare staff did not acknowledge that opiate withdrawal can be a trigger for suicide and self-harm. Nevertheless, I consider there was little to indicate that Mr Anderson was at imminent risk of suicide and it would have been difficult to predict his actions.

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 **May 2019**

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Summary

Events

1. On 22 October 2018, Mr Damien Anderson was sentenced to 18 weeks in prison and was sent to HMP Liverpool. He had been in prison several times before and did not have any history of attempted suicide or self-harm. Prison staff did not start suicide and self-harm prevention procedures (known as ACCT).

2. When he arrived, Mr Anderson told prison and healthcare staff that he used cocaine and heroin and was withdrawing from drugs. A prison doctor prescribed methadone (opiate substitute medication) for Mr Anderson to take the next morning.

3. On the afternoon of 23 October, Mr Anderson was sick in his cell. He told a prison nurse that his withdrawal from drugs had made him vomit. Mr Anderson asked for additional methadone, which was prescribed and issued later that afternoon.

4. At around 4.55am on 24 October, a night patrol officer found Mr Anderson hanged in his cell. He radioed for assistance and another officer opened the cell and began cardiopulmonary resuscitation. Paramedics arrived and recorded that Mr Anderson had died.

Findings

Identifying risk of suicide and self-harm

5. While Mr Anderson had some risk factors for suicide and self-harm, we are satisfied that in the time leading to his death, there was nothing to indicate that he was at increased risk and it would have been difficult for staff to have foreseen his death. Nevertheless, we are concerned that none of the staff to whom we spoke identified that his opiate withdrawal was a risk factor and potential trigger for suicide and self-harm.

Emergency response

6. There was a short delay in opening Mr Anderson's cell while the night patrol officer fetched colleagues to help him, and we are concerned by his statement that he would not consider opening a cell on his own, even in an apparent emergency. There were also unnecessary delays admitting the ambulance to the prison and escorting the paramedics to Mr Anderson's cell.

Recommendations

- The Governor and Head of Healthcare should ensure that staff consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:
    - night staff enter cells as quickly as possible in a life-threatening situation; and

- there are no delays in directing ambulances to the relevant location.

The Investigation Process

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

8. The investigator visited Liverpool on 5 November 2018. He obtained copies of relevant extracts from Mr Anderson's prison and medical records and interviewed one prisoner.

9. The investigator interviewed eight members of staff at Liverpool on 10-11 December.

10. NHS England commissioned a clinical reviewer to review Mr Anderson's clinical care at the prison. He joined Mr Judd for interviews with clinical staff.

11. We informed HM Coroner for Merseyside of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

12. We contacted Mr Anderson's partner to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Anderson's partner asked why he was in a cell on his own. (We have addressed this in paragraph 34, below.)

13. We shared the initial report with HM Prison and Probation Service (HMPPS). They pointed out one factual inaccuracy and we have amended the report accordingly.

14. We shared the initial report with Mr Anderson's partner. She did not make any comments.

15. We also shared the initial report with Mr Anderson's ex-partner. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP Liverpool

16. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 700 adult men. Merseycare NHS Foundation Trust and Spectrum provides healthcare services at the prison.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Liverpool was in September 2017. Inspectors reported that the number of incidents of self-harm was increasing. They found that reception risk assessments were thorough and induction was reasonable. Inspectors also reported that reception health screens were comprehensive and thorough.

18. Inspectors reported that prisoners who needed substance misuse treatment received appropriate first night prescribing. They found that staff were flexible when prescribing opiate substitute medication, although there was a lack of prescriber involvement in patient reviews.

Independent Monitoring Board

19. 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 2017, the IMB reported that the condition of many cells was unacceptable. They also reported concerns about the uneven and untimely provision of medication to prisoners.

Previous deaths at HMP Liverpool

20. Mr Anderson was the nineteenth prisoner to die at Liverpool since October 2015, and the tenth to take his own life. Although we have investigated several previous self-inflicted deaths at Liverpool, there are no significant similarities between the circumstances of these recent deaths and that of Mr Anderson.

Assessment, Care in Custody and Teamwork

21. 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 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. 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. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

22. Mr Damien Anderson served several prison sentences from 2008 onwards, always at HMP Liverpool. He was prescribed methadone (medication used to treat opiate addiction) for much of his time in prison. Mr Anderson was never managed under ACCT procedures and there is no record that he had previously harmed himself. He was released from his last period in custody in December 2017.

HMP Liverpool – 22 October 2018

23. On 22 October 2018, Mr Anderson was sentenced to 18 weeks in prison for theft from a shop. Court staff completed a person escort record (a form that accompanies prisoners on all journeys to communicate information, including about risk factors) and recorded that Mr Anderson used drugs and/or alcohol. They did not record any risk of suicide or self-harm. Mr Anderson arrived at Liverpool at around 4.45pm.

24. A Supervising Officer (SO) interviewed Mr Anderson in reception shortly after he arrived. The SO told us that he recognised Mr Anderson from previous times in custody and recalled that he had previously had substance misuse issues. He could not remember any details of their interaction on 22 October.

25. An officer then conducted a first night interview with Mr Anderson. This is a more detailed interview, aimed at identifying any immediate issues that need to be addressed, including whether there is a risk of suicide or self-harm. The officer told us that he remembered Mr Anderson and recalled that he said that he was dependent on drugs. The officer said that he passed this information to the reception nurse. He told us that Mr Anderson seemed quite happy and asked if he could use the telephone. (New prisoners can make a telephone call in reception, and Mr Anderson telephoned his partner after speaking to the officer.) The officer recorded that Mr Anderson understood why he was in prison and had no issues with this. He also recorded that Mr Anderson said that he had no thoughts of harming himself and had not previously attempted suicide.

26. 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 Anderson said that he was happy to share a cell as he had done in the past, but would rather have a single cell so that he had time to “get his head together”. The officer told us that Mr Anderson was referring to his drug dependency and that he meant he wanted to be in a single cell while he stabilised. He referred the CSRA to the duty governor for his consideration.

27. The deputy primary care manager then assessed Mr Anderson. She recorded that he told her that he had heard voices in 2016 and had seen a psychiatrist. (Mr Anderson did not disclose any mental health concerns, diagnosis or treatment during any of his previous sentences.) She told us that Mr Anderson did not want to be referred to the mental health team and that the only issue that he was concerned about was his drug use. Mr Anderson told her that he smoked crack cocaine and heroin every day in the community and asked to be referred to the substance misuse team. The deputy primary care manager said that Mr

Anderson did not appear to be withdrawing from drugs. She referred him to the substance misuse team for assessment. She told us that she had no concerns about his risk of suicide and self-harm, as he had no thoughts or history of this and his mood was appropriate.

28. A substance misuse practitioner then assessed Mr Anderson. She tested his urine for recent drug use and recorded that the test was positive for cocaine and opiates. She completed a clinical opiate withdrawal scale assessment (COWS), for which Mr Anderson scored six, indicating mild symptoms of withdrawal. The substance misuse practitioner referred him to the reception doctor.

29. The reception doctor assessed Mr Anderson shortly afterwards. He recorded that Mr Anderson said that he had been prescribed methadone in the community but had stopped taking it "a couple of weeks ago". Mr Anderson said that he smoked crack cocaine and heroin, and had last used drugs the previous day. The reception doctor recorded that Mr Anderson had no mental health issues. He prescribed a 10ml dose of methadone for Mr Anderson to take in the morning. He told us that he did not prescribe a dose of methadone for Mr Anderson to take that evening because his COWS score was low, he appeared well and his clinical observations were "fine".

30. The duty governor then spoke to Mr Anderson to assess his risk of sharing a cell. He told us that Mr Anderson said that he wanted a single cell to "get his head together" and that his recollection was that this was because Mr Anderson was "annoyed" at being back in prison. The duty governor said that he remembered having a conversation with Mr Anderson about the ineffectiveness of short prison sentences. He concluded that Mr Anderson could share a cell with another prisoner, and said that Mr Anderson was "okay" with this when he told him. He told us that Mr Anderson did not speak about any other issues and he did not identify any risk factors for suicide and self-harm.

31. Mr Anderson then moved to A Wing, the first night and induction centre. He shared a cell with a prisoner who had also arrived at Liverpool that day. The cellmate told us that he knew Mr Anderson in the community and said that he knew how to get by in prison. The cellmate said that Mr Anderson was withdrawing from drugs but did not speak about any worries he had and did not appear to feel sorry for himself. He said that Mr Anderson spent time joking and spoke about what he planned to do when he was released from prison.

23 October

32. At around 8.25am, a healthcare assistant assessed Mr Anderson. She told us that she knew Mr Anderson from previous sentences and that he had coped well with prison in the past. She said that Mr Anderson appeared to be "struggling" this time but said that he was only serving a short sentence. She completed a COWS assessment and recorded that Mr Anderson scored 16, indicating moderate symptoms of withdrawal. Immediately afterwards, Mr Anderson received the methadone that he had been prescribed the previous evening.

33. In the morning, Mr Anderson completed various aspects of his prison induction. At around 11.40am, a nurse completed a secondary health screen. She recorded that Mr Anderson engaged well and appeared calm. Mr Anderson said

that he had had depression in the past but had no current issues with his mental health. She recorded that she had advised Mr Anderson how to access support if he needed it. She also recorded that Mr Anderson said that he had not previously harmed himself and had no current thoughts of suicide or self-harm.

34. At around 12.25pm, an officer completed a basic custody screen (which is completed to identify a prisoner's needs while in custody). He told us that Mr Anderson said that he had seen the substance misuse team and was happy about the service that they had provided for him. He said that Mr Anderson had no other issues and he did not have any concerns about his risk of suicide and self-harm.

35. At around 1.55pm, a healthcare assistant reviewed Mr Anderson. She recorded that his COWS score was now 12, indicating mild to moderate withdrawal. She sent a message to the duty doctor, to ask her to consider prescribing another 10ml dose of methadone.

36. At around 3.30pm, Mr Anderson was sick in his cell. A nurse attended, and recorded that he had vomited a significant amount. Mr Anderson told the nurse that he was withdrawing from drugs and "needed his methadone". The nurse told him that he would get methadone in the evening, and asked for the doctor to prescribe anti-emetics (medication to prevent nausea and vomiting). She told us that Mr Anderson had no other symptoms, was polite when he spoke to her and did not appear to be struggling.

37. Prisoner cleaners then cleaned Mr Anderson's cell. He showered and was given clean clothes and bedding before he returned to the cell. His cellmate also showered and was given fresh clothes. He moved into the neighbouring cell, for health and safety reasons should Mr Anderson vomit again. Mr Anderson's cellmate told us that the staff were sympathetic to Mr Anderson and did a good job of looking after him.

38. At around 5.15pm, Mr Anderson was given his 10ml dose of methadone. He was also given metoclopramide tablets (an anti-emetic) to take as he required. Mr Anderson was locked in his cell for the night shortly afterwards.

39. Two operational support grades (OSG), were the night patrols on A Wing on 23-24 October. (Unlike other wings, A Wing has two members of staff on duty at night as local procedure is to make an hourly welfare check on all prisoners on their first night in custody.) They received a handover when they started their shift. One told us that Mr Anderson was not mentioned during the handover. (In addition, no one made an entry about Mr Anderson's vomiting in the wing observation book.)

40. At around 7.20pm, one of the OSGs completed a count of prisoners. He told us that he could hear someone coughing or retching as he approached Mr Anderson's landing but was unsure which cell the noise was coming from. When he got to Mr Anderson's cell, he found him lying on his bunk, leaning off the bed. He said that he asked Mr Anderson if he was well and whether he felt sick. Mr Anderson said that he was "fine" and he reminded him how to call for assistance if he needed it. He did not think that he returned to Mr Anderson's cell until the next morning.

24 October

41. At around 4.50am, the OSG began a count of prisoners. CCTV footage shows that he arrived at Mr Anderson's cell at 4.52am. He said that he saw Mr Anderson hanged from a ligature, made of a strip of bedding that he had tied to the bed frame. He radioed a medical emergency code blue, indicating a life-threatening situation. The control room operator telephoned for an ambulance.

42. The OSG then ran down the stairs and returned a few seconds later with the other OSG and an officer, who was visiting A Wing at the time. At 4.53am (now 30 seconds since he first arrived at the cell), the officer unlocked the cell, cut the ligature and laid Mr Anderson on the floor. He began cardiopulmonary resuscitation (CPR) before another officer, who arrived shortly afterwards, relieved him.

43. A nurse arrived at Mr Anderson's cell at 4.55am, and took over the resuscitation efforts. She attached a defibrillator, which instructed her not to apply a shock and to continue CPR.

44. Paramedics arrived at the prison at around 5.00am. An operational support grade escorted the ambulance from the gate to A Wing. In his statement, he wrote that he and a colleague had to open and close the vehicle gates by hand (rather than using the automated system) to allow the ambulance to enter. A second gate was padlocked and another operational support grade had to obtain a key before the ambulance could pass through. The paramedics arrived at Mr Anderson's cell at 5.06am. At 5.13am, they confirmed that he had died.

Contact with Mr Anderson's family

45. A prison family liaison officer and an operational manager visited Mr Anderson's partner on the morning of 24 October, and informed her of his death. Liverpool contributed to the costs of Mr Anderson's funeral in line with Prison Service instructions.

Support for prisoners and staff

46. After Mr Anderson's death, the Deputy Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

47. The prison posted notices informing other prisoners of Mr Anderson'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 Anderson's death.

Post-mortem report

48. A post-mortem examination concluded that Mr Anderson died from compression of the neck due to hanging. Toxicology tests identified methadone and metoclopramide in Mr Anderson's blood. The toxicology also identified that Mr Anderson had used cocaine at some point (noted as likely to be a day or more)

before his death. It also identified that he had taken a small amount of diazepam (medication for anxiety), which he was not prescribed in prison.

Findings

Identifying risk of suicide and self-harm

49. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase the risk of suicide and self-harm and take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures. We have considered whether staff at HMP Liverpool should have recognised that Mr Anderson was at risk and started ACCT procedures.

50. Mr Anderson had been in prison several times before. Each time, like his last, he served a short sentence under treatment for opiate withdrawal. He had no history of suicide or self-harm. Mr Anderson had some risk factors for suicide and self-harm, particularly his withdrawal from drugs, but there were no new risk factors during his final sentence. We are satisfied that there was no reason for staff to consider that he was at increased risk in the hours before his death. We therefore conclude that it was reasonable for staff to judge that he did not pose a risk of suicide or self-harm which warranted ACCT monitoring. We do not consider that staff could reasonably have predicted his actions.

51. However, we are concerned that none of the staff to whom we spoke identified Mr Anderson's opiate withdrawal as a risk factor for suicide and self-harm. PSI 64/2011 identifies substance misuse or detoxification as a potential trigger for suicide or self-harm. While there is no compelling evidence that Mr Anderson was at a raised risk of suicide, we are not satisfied that staff took all his risk factors into account when assessing that risk. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that staff consider and record all the known risk factors of a newly arrived prisoner when determining the risk of suicide and self-harm.

Opiate detoxification

52. A week before Mr Anderson's reception, Liverpool issued new guidelines for the management of drug and alcohol dependent prisoners. The guidelines state that a patient with a positive urine screen for opioids and who gives a history of opioid dependence should be started on a standard methadone induction regime. It states that the first 10ml dose of methadone should be given on first night if the COWS score is five or greater and clinical assessment confirms opioid dependence. The guidelines state that the patient will then receive additional 10ml doses the next morning and afternoon, plus a further 10ml dose, if required.

53. Mr Anderson scored six on COWS on his first night and met the other criteria of the policy. A prison doctor decided not to prescribe methadone for that evening and instead prescribed a dose for Mr Anderson to take in the morning. In total, Mr Anderson received 20ml of methadone after arrival at Liverpool, whereas the policy states that he could have received up to 40ml.

54. The prison doctor told us that he did not prescribe methadone for Mr Anderson's first night because his COWS score was low and he appeared clinically well. He explained that the policy had previously been that a COWS score of 13 was the threshold for first night prescribing. He said that he thought he should use his judgement if the patient scored five or six on COWS and only prescribe if he thought it clinically necessary (for instance, if the patient had visible symptoms of withdrawal such as shaking or sweating). The doctor explained that there were also other considerations, such as the length of time that the patient had used opioid drugs (or been prescribed methadone in the community) and the time since they had last used. He said that the COWS score was a good indicator of withdrawal and need for methadone but there were these other factors to consider.

55. The clinical reviewer agreed with the prison doctor and concluded that Mr Anderson received a good standard of care for his substance misuse issues.

Emergency response

Opening Mr Anderson's cell

56. PSI 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment. At night, officers carry a key in a sealed pouch to use to open a cell in an emergency.

57. An OSG identified that Mr Anderson had hanged himself and he appropriately radioed a medical emergency code blue. He did not initially open the cell himself and instead went to fetch colleagues for assistance. He said that he did this for two reasons: firstly, he knew his colleagues were nearby and he could quickly seek their support and, secondly, he would never open a cell on his own at night and thought that there should always be at least two members of staff present. We recognise that only 30 seconds passed from when the OSG first arrived at the cell until it was opened. However, we are concerned by his statement that he would not open a cell on his own. We recognise that it can be difficult for staff in such situations to make instant decisions but, when there is a potentially life-threatening situation, it is essential to act quickly. The OSG had identified that Mr Anderson had hanged himself and, in these circumstances, we would normally expect prison staff to go into a cell as soon as possible, in case there is a chance of saving someone's life.

Escorting the ambulance to A Wing

58. PSI 03/2013 on medical emergency response codes sets out the actions that staff should take in a medical emergency. It contains mandatory instructions for Governors and Directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the

relevant equipment to the incident and that there are no delays in calling or directing an ambulance. It states that local protocols must prevent any unnecessary delay in escorting ambulances and paramedics to the patient and this must include procedures for admitting ambulances during the night state.

59. There were delays admitting the ambulance to Liverpool. Firstly, the vehicle gate had to be opened and closed by hand rather than automatically. Secondly, prison staff had to locate the key for and unlock an interim prison gate, which should have been arranged before the ambulance arrived to allow swift access. We do not know whether quicker admission of paramedics would have made a difference to the final outcome, but there might be occasions in future in which this is vital. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **night staff enter cells as quickly as possible in a life-threatening situation; and**
- **there are no delays in directing ambulances to the relevant location.**

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