Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ian Galtress a prisoner at HMP Liverpool on 14 October 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Ian Galtress was found hanged in his cell at HMP Liverpool on 14 October 2018. He was 47 years old. I offer my condolences to Mr Galtress' family and friends.

Mr Galtress had a significant history of substance misuse in the community and a history of depression. He successfully completed a methadone detoxification programme at Liverpool.

I am concerned that the deterioration in Mr Galtress' mental health was not identified and addressed as early as it should have been and was not seen as a risk factor for suicide and self-harm. The prison officer who was his key worker had not seen him in the five weeks before his death.

Staff should have referred Mr Galtress to the mental health team earlier. When Mr Galtress was eventually assessed (a day before he died) the assessment was not sufficiently thorough.

I am also concerned that Mr Galtress failed to take his antidepressant medication on four occasions in the week before he died and that healthcare staff did not take any action in response. The clinical reviewer believes that the missed medication could have affected Mr Galtress' mood.

As in previous investigations, we found delays during the emergency response at Liverpool. My office has made previous recommendations about this to the Governor and in January 2019 I escalated my concerns to the Prison Group Director for the North West.

In March 2019, we received an action plan from the prison in response to my recommendations. The Prison Group Director also wrote to me with an update on the progress of the actions taken. I welcome the Prison Group Director's commitment to ensure full compliance with our recommendations. We will be assessing the effectiveness of the actions the prison is taking in future investigations.

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 McAlister, CB
Prisons and Probation Ombudsman **September 2019**

Contents

Summary

Events

1. On 19 June 2018, Mr Ian Galtress was remanded to HMP Liverpool on a charge of robbery. Mr Galtress suffered from depression and had a significant history of substance misuse in the community. He had no recorded history of self-harm.

2. He successfully undertook a methadone maintenance reduction programme at Liverpool and staff initially had no concerns about him.

3. On 5 August, Mr Galtress assaulted another prisoner. The assault was unexpected and had no apparent motive. Officers moved Mr Galtress to another wing and placed him on a disciplinary charge.

4. On 16 September, Mr Galtress stabbed his cellmate in the face several times with a broken mop handle while he was asleep. Again, there was no apparent motive. Officers moved Mr Galtress to the segregation unit, where he stayed until 21 September. Mr Galtress was not allowed to share a cell after this and was dismissed from his work.

5. On 8 October, a prisoner spoke to Mr Galtress and noted that his mental health was deteriorating. Other prisoners on the wing were also noting a deterioration. The prisoner told an officer about his concerns, including that Mr Galtress appeared to be angry, frustrated and paranoid. The officer went to speak to Mr Galtress but did not consider him to be at risk of suicide or self-harm. The officer said that he was more concerned about the risk Mr Galtress might pose to other prisoners.

6. On the morning of 13 October, a prisoner who was trained as a Listener by the Samaritans raised concerns about Mr Galtress' mental health with an officer. The officer immediately telephoned the mental health team. A mental health nurse reviewed Mr Galtress that evening. Mr Galtress told the nurse that he felt that his mental health was deteriorating and he wanted to self-isolate. The nurse found no obvious signs of depression and did not consider him to be at risk of suicide or self-harm. She referred Mr Galtress for another mental health assessment. (This did not take place before his death.)

7. On 14 October, at around 10.33am, a prisoner saw Mr Galtress hanged in his cell, through the observation panel. He immediately told an officer who called for staff assistance. The officer tried unsuccessfully to open the cell but Mr Galtress had barricaded the door. Other officers attended and at around 10.40am they managed to remove part of the barricade. An officer entered the cell and started cardiopulmonary resuscitation (CPR). Nurses also attended and continued with resuscitation.

8. At around 10.45am, paramedics reached Mr Galtress' cell and took over emergency treatment. At 11.12am, Mr Galtress was pronounced dead.

Findings

Assessment of risk

9. Mr Galtress had a history of substance abuse and depression, but he initially gave no cause for concern. However, his mental health appears to have begun deteriorating from August 2018, although this was not obvious at first.

10. The first real sign of this was his unexplained assault on his cellmate on 16 September and we consider that it would have been good practice to have referred him for a mental health assessment at this point.

11. We also consider that there were two key missed opportunities to identify Mr Galtress' risk to himself: 8 October (when another prisoner expressed concerns to staff about Mr Galtress' mental health) and 13 October (when a Listener told staff that he thought Mr Galtress' mental health was deteriorating).

12. We are concerned that staff failed to identify Mr Galtress might be a risk to himself on these occasions because they placed too much reliance on Mr Galtress' assertions that he had no thoughts of self-harm, and did not give sufficient attention to the fact that a deterioration in mental health may be a risk factor for self-harm or suicide. We consider that it would have been good practice to have monitored Mr Galtress under suicide and self-harm prevention procedures (known as ACCT) while his mental health was assessed further.

13. We are also concerned that the prison officer who was Mr Galtress' key worker only saw him once (on 8 September) and had no further contact with him in the five weeks before he died. This was another missed opportunity to have identified Mr Galtress' deteriorating mental health and to have provided him with support.

Mental Healthcare

14. The clinical reviewer concluded that the mental healthcare provided to Mr Galtress at Liverpool was not equivalent to that he would have received in the community. Mr Galtress' mental health should have been assessed earlier and when it was assessed the night before he died, the nurse did not thoroughly explore his risk factors and stressors.

15. We are also concerned that the monitoring of Mr Galtress' compliance with his antidepressant medication was poor. He missed four doses in the week leading up to his death. This may have been a sign of relapse and should have been investigated. The clinical reviewer considered that missing these doses may have affected Mr Galtress' mood.

Emergency response

16. As in several previous investigations into deaths at Liverpool, we found that the first officer who discover Mr Galtress hanged did not call a medical emergency code. There was also an unacceptable delay of around seven minutes in paramedics reaching Mr Galtress' cell from the prison's entrance. We have identified similar issues in previous investigations and will monitor the prison's existing action plans to address our concerns.

Recommendations

- The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular, that they:
    - identify and consider all risk factors when determining the level of risk of self-harm and suicide; and
    - take appropriate action to address known risk factors, such as making referrals to the mental health team.

- The Governor should ensure all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact in line with the prison's key officer scheme.

- The Head of Healthcare should ensure that, where prisoners have previously been managed by mental health services, there is early communication with these services to aid risk assessment.

- The Head of Healthcare should ensure that relevant staff:
    - are adequately trained on mental health awareness and assessments; and
    - carry out mental health assessments using all relevant information and mental health assessment tools and that they thoroughly explore all factors which could affect a prisoner's mental health.

- The Head of Healthcare should ensure that a robust system is in place for flagging non-compliance with medication, and that there are clear guidelines for healthcare staff about the management of medication and dealing with non-compliance.

The Investigation Process

17. 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.

18. The investigator obtained copies of relevant extracts from Mr Galtress' prison and medical records.

19. The investigator interviewed nine members of staff and three prisoners at Liverpool on 27 and 28 November 2018. He interviewed two other members of staff by video-link on 19 December 2018.

20. NHS England commissioned a clinical reviewer to review Mr Galtress clinical care at the prison. She conducted 12 interviews jointly with the investigator.

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. We contacted Mr Galtress' family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They wanted to know what was done to support Mr Galtress with his substance misuse issues and whether he undertook any rehabilitation programmes at Liverpool.

23. We have addressed these questions in this report.

24. Mr Galtress' family received a copy of the initial report. They wrote to us through their legal representatives. They made comments as a result of our report which we have addressed in separate correspondence.

25. The prison service also received a copy of the initial report. They responded to our recommendations. They did not raise any accuracy comments.

Background Information

HMP Liverpool

26. HMP Liverpool is a local prison serving the courts of Merseyside. It holds up to 1,148 adult men. Spectrum provides health care services at the prison.

HM Inspectorate of Prisons

27. 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 their 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".

28. The inspection found that the integrated mental health and substance misuse team did not have enough capacity to meet the needs of the complex population at Liverpool adequately. The inspection found several men who had waited for an appointment for very long periods. Medicines management was reasonable but there was poor supervision of medicine administration.

29. Inspectors also found that the quality of ACCT documents was inadequate and the overall strategic response to reducing self-harm was underdeveloped. Actions from meetings where self-harm was discussed did not feed into the safer custody action plan. The potential triggers for self-harm and suicide, for example, the prevalence of drugs, the imminent smoking ban and the many men with mental health conditions were not well understood.

30. 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

31. 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

32. Mr Galtress was the tenth prisoner to die at Liverpool since October 2016. Six of the previous deaths were self-inflicted and three were from natural causes. The cause of one was unascertained. Since Mr Galtress' death, there have been four further deaths at HMP Liverpool.

33. In our investigation into the death of a prisoner in October 2017, we found that staff did not take all his risk factors into account in assessing his risk. In our investigation into the death of a prisoner in February 2018, we found deficiencies in the mental healthcare provided and also had concerns about staff assessment of his risk of suicide and self-harm.

Key Events

34. On 19 June 2018, Mr Ian Galtress was remanded to HMP Liverpool for robbery. His trial was listed for 19 November. Mr Galtress had been in prison before and had been released on 27 April. He had a significant history of substance misuse in the community and was on a methadone maintenance programme when released from custody. He did not have a recorded history of suicide attempts or self-harm.

35. At his initial health screening, Mr Galtress told a nurse that he was taking mirtazapine (an antidepressant). Mr Galtress tested positive for cocaine and opiates and admitted using heroin and 'crack' in the community. Mr Galtress said that he did not have any thoughts of suicide or self-harm. The nurse recorded that Mr Galtress appeared to be settled and raised no concerns. He referred Mr Galtress to the GP for a general health assessment, and to the substance misuse and mental health teams.

36. The same day, an officer completed Mr Galtress' 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 Galtress was "high-risk" because he had made racist comments, but could share a cell with prisoners of the same race. The officer recorded that Mr Galtress had no thoughts of suicide or self-harm.

37. Mr Galtress was moved to a single cell on A wing, the induction unit, where he lived for five days. Officers then moved Mr Galtress to I wing, a residential wing.

38. On 20 June, a prison GP reviewed Mr Galtress. The prison GP recorded that Mr Galtress had suffered from depression within the previous two years, although the clinical reviewer found no formal diagnosis. She noted that Mr Galtress was taking medication for his depression but had never been admitted to a mental health hospital, self-harmed or tried to kill himself.

39. The prison GP assessed that Mr Galtress was not delusional or psychotic and his mental capacity was fine. She diagnosed Mr Galtress with Opiate Dependence Syndrome and planned to continue with his methadone maintenance programme. Mr Galtress started with a prescription of 30ml of methadone which was gradually reduced. Mr Galtress received support from the Drug and Alcohol Recovery Team (DART) while detoxifying at Liverpool.

5 August

40. On 5 August, Mr Galtress punched a prisoner twice in the face, knocking some teeth out. This was unexpected and followed a period where officers had recorded no concerns about Mr Galtress. An officer downgraded Mr Galtress' Incentives and Earned Privileges level to basic for 28 days and placed him on a disciplinary charge. Mr Galtress said he did not know why he had done it and felt awful and would like to apologise. The assault was reported to the police, who interviewed Mr Galtress. Mr Galtress did not make any comments and the police could not establish a motive for the assault. Mr Galtress was not charged with any offence before he died.

41. The assaulted prisoner told the investigator that he had not had many interactions with Mr Galtress before he was assaulted. He said that the attack had been unexpected and he did not know why Mr Galtress punched him.

42. Mr Galtress was moved to H wing, the substance misuse recovery unit, where he shared a cell.

43. On 8 September, an officer spoke to Mr Galtress and introduced himself as his key officer. The officer recorded that Mr Galtress was settling well on H wing and was interacting well with his peers. The officer recorded no concerns. He did not speak to Mr Galtress again.

44. During the following eight days, officers recorded no issues in Mr Galtress' NOMIS (the electronic records system) or in the wing's observation book. An officer told the investigator that Mr Galtress presented as a quiet prisoner on the wing who raised no concerns. Another officer said that Mr Galtress appeared to be calm and "kept things to himself".

16 September

45. On 16 September, at around 2.00pm, Mr Galtress stabbed his cellmate in the face with the metal part of a broken mop handle while he was asleep. The cellmate told the investigator that during the assault Mr Galtress was asking him "where the parcel was" and to "give him the knife". He said he did not have any knife and knew nothing about any parcel. He managed to press his cell bell for help.

46. He told the investigator that Mr Galtress was not under the influence of drugs at the time but occasionally took PS on the wing. He also said that Mr Galtress had become paranoid and he was concerned about his behaviour. He said that on the morning of 16 September, he had told staff about his concerns and requested a move to another cell. There is no record of this request.

47. Three officers attended the cell and restrained Mr Galtress. The first officer said that Mr Galtress told him after the assault that "he had lost his head" and did not know why he had attacked him.

48. The officers moved Mr Galtress to the segregation unit and submitted a security intelligence report. The first officer placed Mr Galtress on a disciplinary charge and a CM assessed that Mr Galtress should not share a cell with any other prisoner in the future. The assault was reported to the police but no investigation had taken place before Mr Galtress died.

49. On 16 and 17 September, two nurses carried out a segregation health screening on Mr Galtress. The nurses assessed Mr Galtress as being suitable for segregation and noted that he was not acutely unwell. Mr Galtress spent five days in the segregation unit where officers recorded no concerns.

50. On 18 September, Mr Galtress case was discussed at a Safe Meeting (a meeting on violence reduction issues). The head of safer custody chaired this meeting and it was decided that Mr Galtress would be sent back to H wing. Staff considered that a return to H wing was the best option for Mr Galtress as he

would receive adequate support for his substance misuse programme and his poor mental health.

51. On 21 September, Mr Galtress returned to H wing. A mental health nurse reviewed him. Mr Galtress told her that he had had a mental health breakdown in 2014 and 2015 and received support from the Stein Centre (a community mental health team).

52. On 1 October, Mr Galtress successfully completed his detoxification programme and stopped taking methadone. Four days later, Mr Galtress told the mental health nurse that he was coping well and had no withdrawal symptoms. She noted Mr Galtress was planning to start taking naltrexone (a drug used following detoxifying to help patients not to relapse) and booked an appointment with a prison GP on 10 October. The mental health nurse told the investigator that she could not remember Mr Galtress' presentation but she did not record having any concerns about him.

53. On 8 October, at around 11:00am, another prisoner spoke to Mr Galtress. He noted that Mr Galtress' mental health had deteriorated. He told the investigator that Mr Galtress was paranoid and suspicious of other prisoners without reason. He also said that Mr Galtress told him that he could "harm another prisoner or himself". He was very concerned and told an officer about his conversation with Mr Galtress.

54. The officer spoke to Mr Galtress, submitted an intelligence report and made a note in Mr Galtress' NOMIS records. He told the investigator that he asked Mr Galtress whether he felt like harming himself but Mr Galtress replied that he did not want to self-harm. He did not think that Mr Galtress presented with any risk factors for suicide or self-harm. The officer told the investigator that he was concerned about the safety of other prisoners but not about Mr Galtress' welfare.

55. On 13 October, at around 10.00am, a prisoner spoke to Mr Galtress. He told the police that Mr Galtress had told him that it would soon be the two-year anniversary of his separation from his ex-partner. He said that Mr Galtress was "a little down". He went back to his cell as he was not concerned. (Mr Galtress' OASYS assessment shows that Mr Galtress separated from his ex-partner in 2014 due to his drug and alcohol misuse. Mr Galtress said that he had suffered an "emotional breakdown" when he separated.)

56. At around 11.00am, another prisoner approached an officer on H wing. (He had been trained by the Samaritans as a 'Listener' to support other prisoners and had been supporting Mr Galtress since he returned from the segregation unit.) He told the officer that he had concerns about Mr Galtress' mental health. The officer told the police that she did not ask any questions but immediately telephoned the mental health team. As nobody answered she left a voice message.

57. At around 4.00pm, a mental health nurse listened to the voice message and went to review Mr Galtress. An officer said that the nurse asked him to be present as she did not feel safe with Mr Galtress, given his recent assaults.

58. Mr Galtress told her that he felt that his mental health was deteriorating and he wanted to self-isolate. He said that he had had a mental health breakdown in 2014 and 2015 when he had problems in his marriage and job. He said that other prisoners wanted to hurt him but he did not provide any names or detail.

59. She recorded that Mr Galtress had worked with a Community Practice Nurse (CPN) at the Stein Centre in the past. She noted that Mr Galtress was taking 15mg of mirtazapine but she told the investigator that she was aware that Mr Galtress had missed some doses. She did not try to find out why Mr Galtress had missed his medication or take any action to ensure he complied with his medication. She said that this was because the situation "was being managed by a GP".

60. She told the investigator that she did not note any obvious signs of depression in Mr Galtress. The officer told the investigator that Mr Galtress was talkative during the assessment but appeared paranoid. He said that Mr Galtress did not give any indication that he was going to harm himself. The nurse referred Mr Galtress for a further mental health assessment.

Events on 14 October 2018

61. The investigator reviewed CCTV footage, Body Worn Camera (BWC) footage, the control room log and the ambulance service records. The investigator found no significant discrepancies between these sources.

62. On 14 October, at around 8.30am, an officer attended Mr Galtress' cell to unlock him for association. The officer told the investigator that Mr Galtress was stood at the back of his cell and did not note anything concerning.

63. At around 10.05am, an officer went to Mr Galtress' cell to unlock him for association. Mr Galtress did not want to leave the cell and asked the officer to lock his door. Mr Galtress said that he was fine but "feeling tired". The officer said that Mr Galtress was standing up and "did not appear to be worried" so he was not concerned.

64. The officer told the investigator that he did not note anything unusual in Mr Galtress' cell so he agreed to lock his door. He said that although prisoners do not often ask to be locked in during association, it is not unknown as they may want to sleep or not be disturbed.

65. At around 10.33am, a prisoner walked past Mr Galtress' cell and thought that Mr Galtress was shouting his name. He looked through the observation panel and saw Mr Galtress hanging. Mr Galtress had used bedsheets as a ligature which he had attached to a metal bar beside the cell window. The prisoner told the police that he unsuccessfully tried to open the cell door, at which point he panicked.

66. About 40 seconds later, the prisoner ran along the landing and found an officer. The prisoner said that he could not explain properly to the officer what he had seen but managed to push him towards Mr Galtress' cell door. The officer looked through the observation panel and saw Mr Galtress hanging. He unsuccessfully tried to enter the cell but the door was barricaded. (Mr Galtress had used two lockers and two chairs to barricade himself in.) The officer

immediately shouted for “staff assistance” but did not radio an emergency medical code.

67. About 15 seconds later, four officers arrived. They continued trying to open the door.

68. At around 10.34am, a fifth officer also attended. The fifth officer asked officers whether Mr Galtress was self-harming but they told her he was hanging. She said that she immediately radioed a code blue emergency. (A code blue emergency indicates that a prisoner is unconscious or having difficulty breathing.) A custodial manager (CM) attended the cell and helped officers to remove the barricade.

69. At around 10.35am, the control room officer requested an ambulance. At around 10.38am, the ambulance arrived at the prison gate.

70. At around 10.40am, the CM and the other officers moved part of the barricade away of the door. The CM entered the cell through a small gap. The CM told the investigator that she managed to cut the ligature and Mr Galtress fell on the floor. She then started CPR. A supervising officer (SO) also entered the cell and helped to remove the remainder of the barricade. A nurse then entered the cell and continued with CPR.

71. At around 10.45am paramedics reached Mr Galtress’ cell and took over emergency treatment. At 11.12am, Mr Galtress was pronounced dead.

Post-mortem report

72. The post-mortem examination found that Mr Galtress died of neck compression and hanging.

73. The toxicology examination found no alcohol or drugs in his body. Mirtazapine was detected, but at the lower end of the range of concentrations expected with therapeutic use.

Contact with Mr Galtress’ family

74. At 3.30pm on 14 October, a prison manager went to Mr Galtress’ mother’s house and broke the news of his death. He offered support.

75. Mr Galtress’ funeral took place on 9 November. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

76. After Mr Galtress death, the head of safer custody 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.

77. The prison posted notices informing other prisoners of Mr Galtress’ 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 Galtress’ death.

Findings

Assessment of risk

78. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, provides a non-exhaustive list of a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. These require staff to take appropriate action, such as starting ACCT procedures or referring prisoners to the mental health team.

79. PSI 64/2011 also covers the management of prisoners diagnosed with depression. It provides guidelines to staff which include effective liaison between healthcare staff and wing officers.

80. Mr Galtress had some risk factors for suicide and self-harm - his history of significant substance misuse and depression – but these factors are common to many prisoners and he had no history of suicide or self-harm. We are, therefore, satisfied that it was reasonable for staff to assess that he did not need to be managed under ACCT procedures when he first arrived at Liverpool or for his first three months in prison. Although he punched another prisoner on 5 August, without any apparent motivation, there was nothing at the time to suggest that he was a risk to himself, rather than to others.

81. After this, however, it appears that Mr Galtress' mental health deteriorated. The first real sign of this was his assault on his cellmate on 16 September which Mr Galtress could not explain, other than saying he had "lost his head". From this point on other prisoners and some staff began to describe Mr Galtress as 'paranoid' and 'suspicious'. It would have been desirable for staff to have referred Mr Galtress for a mental health review after the unexplained assault, although we note that he had a mental health review on 21 September and was seen again by the same mental health nurse on 1 October, with no concerns identified on either occasion.

82. Mr Galtress' mental health appears to have continued deteriorating and we consider that staff missed two opportunities in October to identify and address Mr Galtress' risk to himself:

8 October

83. On 8 October, another prisoner was sufficiently concerned about Mr Galtress' mental health to tell an officer. An officer recorded that the prisoner said that Mr Galtress may "explode again" as he lately appeared agitated and distressed and should be "watched and needed extra support". Mr Galtress himself told the officer that he did not know why but he was feeling very angry and wanted to hurt somebody but said he did not want to self-harm.

84. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison'. We identified that staff often place too much weight on how a prisoner presents and what he says about self-harm, rather than considering existing risk factors. We highlighted that prisoners will often withhold the extent of their distress from staff, and evidence of risk should, therefore, be fully balanced against how the prisoner presents.

85. The officer told the investigator that he was concerned about the risk Mr Galtress posed to other prisoners and did not consider he was a risk to himself on 8 October. We consider that the officer placed too much reliance on Mr Galtress' assurances that he did not want to self-harm and not enough on his risk factors. Although we recognise that the risk to others was the most obvious risk, a prisoner whose mental health is deteriorating may also be a risk to himself and we consider that the officer should have referred Mr Galtress to the mental health team and considered opening an ACCT. If Mr Galtress had had a mental health review at this point, it would have been possible to have investigated his stressors and risk factors in depth.

13 October

86. On 13 October, a prisoner who had been trained as a Listener by the Samaritans told an officer that he was concerned about Mr Galtress' mental health. The officer appropriately telephoned the mental health team and left a message. However, when she did not get a response, we consider that the officer should have gone to speak to Mr Galtress and assessed the situation for herself. As it was, it was another five hours before anyone from the mental health team listened to the message.

87. The mental health nurse subsequently spoke to Mr Galtress, accompanied by an officer. Mr Galtress said his mental health was deteriorating and he wanted to self-isolate, and the officer described him as paranoid.

88. The clinical reviewer has concerns about the adequacy of the mental health nurse's assessment, which we discuss below. We consider that this was a missed opportunity to identify the extent of Mr Galtress' mental deterioration, to assess his risk and to share any concerns with prison officers. We consider that there were sufficient grounds for concern for the mental health nurse and the officer to have considered opening ACCT procedures. If this had happened, it is unlikely that the officer would simply have agreed to Mr Galtress' unusual request to lock him in his cell during association the following day.

Meaningful contact

89. We also consider that staff would have been more likely to have identified Mr Galtress' risk to himself if they had had more meaningful contact with him. As a result, it was prisoners, not staff who noticed that Mr Galtress' mental health was deteriorating.

90. Liverpool operates the 'key officer' scheme which has been implemented across the prison estate since September 2017. The scheme is designed to help reduce violence and self-harm by encouraging meaningful contact and positive relationships between officers and prisoners. Under the scheme each officer is responsible for five to six prisoners and has time allocated to enable them to have at least one meaningful conversation each week with each of those prisoners. Key officers should support prisoners through all aspects of day to day life in the prison. This includes prisoners who are reserved or isolated and do not want to engage.

91. Although Mr Galtress had been at Liverpool since 19 June, his key worker did not see him until he met him for an introductory session on 8 September. He did not have any other interaction with Mr Galtress before his death five weeks later. Although Mr Galtress was in the segregation unit for six days in September after his assault on another prisoner, we would have expected his key worker to have spoken to him on his return to check on his wellbeing, offer support and identify any concerns. If the key worker scheme had been working well, we would also have expected the officer to have noticed and raised concerns about the deterioration in Mr Galtress' mental health in the weeks before his death.

92. Mr Galtress' key worker told the investigator that he did not speak to Mr Galtress in the five weeks after 8 September because his managers did not allow him time to fulfil his key worker responsibilities. If this was indeed the case, it is a cause for real concern.

93. In its inspection of Liverpool in September 2017 HMIP found that not all prisoners were being seen as often as stipulated in the key worker policy. It is worrying that this was still the case a year after the inspection.

94. We are concerned that staff failed to identify Mr Galtress' deteriorating mental health as a risk factor for suicide and self-harm. They over-relied on his presentation in assessing his risk and viewed him simply as a risk to others. As a result, he did not receive the support and monitoring that he needed. We make the following recommendation:

The Governor should ensure all prisoners have meaningful contact with identifiable wing officers who regularly check their wellbeing and record their contact in line with the prison's key officer scheme.

The Governor and Head of Healthcare should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines. In particular that they:

- **identify and consider all risk factors when assessing a prisoner's level of risk of self-harm and suicide; and**
- **take appropriate action to address known risk factors, such as referrals to the mental health team.**

Clinical care

Substance Misuse

95. Mr Galtress successfully completed a drug detoxification programme on 1 October. The clinical reviewer found that Mr Galtress' withdrawal symptoms were appropriately monitored using the Clinical Opiate Withdrawal Scale (COWS) and that his substance misuse support was of a reasonable standard and was equivalent at least to that which would have been received in the wider community.

Mental healthcare

96. The clinical reviewer concluded that the mental healthcare provided to Mr Galtress at Liverpool was not equivalent to that which he would have received in the community.

97. Healthcare staff did not obtain information from the community mental health team who had previously treated Mr Galtress. As a result, when his mental health began to deteriorate in September/October 2018, they had no information about his earlier breakdown or the form it took.

Assessment

98. During the mental health assessment carried out on 13 October, Mr Galtress told the mental health nurse that his mental health was deteriorating and reported that he wanted to self-isolate. He also told her that he had had a previous mental health breakdown when his marriage broke down in 2014, but she did not try to identify whether the anniversary was a destabiliser that might be a trigger for suicide or self-harm. She noted that she would liaise with the Stein Centre about his previous breakdown and treatment, but the clinical reviewer considers that this information should already have been available.

99. The clinical reviewer found that the mental health nurse did not sufficiently explore Mr Galtress' concerns and stressors and failed to identify Mr Galtress marked signs of mental health deterioration, including his paranoia, anxiety and agitation, and the fact that he had been missing his antidepressant medication. (The medication issue is discussed further below.)

100. The clinical reviewer also considered that the mental health nurse should have explored further what Mr Galtress said about the deterioration in his mental health and his feelings that he wanted to withdraw socially and that she should have considered placing Mr Galtress under observation via the ACCT process while further information on his mental health history was sought and further assessments could be completed. This would also have enabled better communication with prison staff about Mr Galtress' presentation.

101. The clinical reviewer noted that the mental health nurse and her team leader, acknowledged during interview that some further training on risk assessing and formulation could be valuable to the mental health team. She said that the organisation has a duty to ensure that protected time is given for development in this area of mental health with a formal update at least every three years (in line with the Department of Health's guidance on best practice in managing risk). The clinical reviewer also noted that the mental health nurse and her team leader also expressed some significant concerns about the limited time they have to assess patients and about their workload generally.

102. In our Learning Lessons Bulleting, *Prisoner's Mental Health*, published in January 2016, we said that it is important for health professionals to consider not just the symptoms but also any other factors which could affect the development of a person's potential depression. This might include social isolation, quality of interpersonal relationships and previous experience with medication. Assessors should make use of all the resources available to reach an accurate understanding of the existence and severity of a prisoner's mental health condition. We make the following recommendations:

The Head of Healthcare should ensure that, where prisoners have previously been managed by mental health services, there is early communication with these services to aid risk assessment.

The Head of Healthcare should ensure that relevant staff:

- **are adequately trained on mental health awareness and assessments; and**
- **carry out mental health assessments using all relevant information and mental health assessment tools and that they thoroughly explore all factors which could affect a prisoner's mental health.**

103. The clinical reviewer has made a number of other recommendations which the Head of Healthcare will need to address.

Medication

104. Mr Galtress was taking one 15mg tablet of mirtazapine daily for his depression. He held this medication in possession until he was segregated on 16 September, after which it was dispensed to him on a daily basis. However, the medication was not dispensed on 21 and 22 September and, again, on 4,5,9 and 13 October (the week leading up to his death).

105. The reason for this is not recorded in Mr Galtress' medical records and healthcare staff could not explain it. The clinical reviewer noted that if a patient regularly declines medication, this may be an early indicator of relapse and should be followed up by a clinician.

106. On 13 October, the mental health nurse did not take any steps to find out why Mr Galtress had missed his medication or to address the issue. She said that she did not take any action because the situation "was being managed by a GP".

107. When prisoners do not comply with mental health medication, it can have seriously detrimental effects on their ability to cope and can lead to an increased risk of suicide. The clinical reviewer was concerned that the process for dispensing medication, monitoring compliance and follow up of medication at Liverpool was poor. She said that when medication is not dispensed the reason should be clearly documented in the prisoner's medical records.

108. Toxicology analysis after Mr Galtress' death showed that the amount of mirtazapine present in his system was at the lower range of therapeutic use and the clinical reviewer considered that the low antidepressant levels may have affected Mr Galtress' mood.

109. We make the following recommendation:

The Head of Healthcare should ensure that a robust system is in place for flagging non-compliance with medication and that there are clear guidelines for healthcare staff about the management of medication and dealing with non-compliance.

Emergency Response

110. When an officer saw Mr Galtress hanging in his cell on 14 October, we consider that he should have called a code blue emergency. Instead, he called for "staff assistance" and the code was not radioed until a minute later by another officer.

In a medical emergency every minute counts and can make the difference between life and death.

111. There was also a significant delay of about seven minutes in the ambulance reaching Mr Galtress from the prison gate. We consider that a seven-minute delay for paramedics to reach a prisoner during a life-threatening situation is not acceptable. It can make a difference between life and death as paramedics are better trained and equipped to deal with these situations than prison officers and prison healthcare staff.

112. We cannot say, however, whether the delays during the emergency response affected the outcome for Mr Galtress and the clinical reviewer commended the actions of healthcare staff.

113. We have 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. In January 2019, in our report on our investigation into the death of another prisoner at Liverpool in October 2017, we again found that staff did not use the emergency codes appropriately and that there was also an avoidable delay of about ten minutes in paramedics reaching the prisoner from the gate. We made recommendations to the Governor to address these issues at the time.

114. In March 2019, the prison accepted our recommendations and provided an action plan. The prison said that a Governor's notice to staff on Medical Emergency Protocols was re-issued in October 2018 and in February 2019, outlining the key points from PSI 03/2013, including details of the appropriate use of code red and code blue and a reminder that an ambulance must be called immediately in the event of an emergency. The notice will continue to be re-issued at three-monthly intervals.

115. The prison also said that the Head of Safer Custody has implemented a 12-month plan for training staff in Emergency Response in Custody (ERIC). The aim is for all staff at Liverpool to have completed training by May 2019. The prison also told us that paramedics' access protocols were reviewed in January 2019 and a laminated guidance sheet for gate staff is displayed in a prominent position in the gate lodge to ensure that emergency vehicles are escorted to required locations without any unnecessary delays.

116. We welcome these actions and encourage the Governor to continue working on improving the emergency response at Liverpool. We will be assessing the effectiveness of the prison's actions in further investigations if the issue arises again.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141