Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Samuel Hayden, a prisoner at HMP Liverpool, on 12 March 2021

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.

Our 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 Samuel Hayden was found hanged in his cell at HMP Liverpool on 12 March 2021. He was 28 years old. I offer my condolences to Mr Hayden's family and friends.

The contents of telephone calls that Mr Hayden made before his death (which were not known to prison staff at the time) indicate that his relationship had ended and that this caused him great distress. While he had this and other risk factors for suicide and self-harm, I consider that there was little to indicate to staff that he was at imminent risk of suicide at the time of his death.

This is, however, a reminder to prison staff that even those prisoners who appear to be progressing well might still be vulnerable to suicide and self-harm. I am concerned by the quality of staff interaction through the key worker scheme, particularly in the weeks before Mr Hayden's death, and that this would have limited their ability to identify any emerging risk factors and support Mr Hayden.

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

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **October 2021**

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Summary

Events

1. On 31 July 2020, Mr Samuel Hayden was recalled to HMP Liverpool about a year and a half since his release on licence. He had occasionally harmed himself during previous periods of custody. On his arrival at Liverpool, prison staff started suicide and self-harm prevention procedures, known as ACCT, due to Mr Hayden's low mood and history of self-harm. They stopped monitoring him around six weeks later.

2. Over the following months, Mr Hayden received mostly positive reports from prison staff and started work as a wing cleaner and on the servery. A wing manager recorded that the job had a very positive impact on Mr Hayden and gave him increased confidence with staff and fellow prisoners.

3. On 18 February 2021, Mr Hayden's wing began a restricted regime after being classified as COVID-19 outbreak site. His role as a wing worker meant that Mr Hayden spent more time out of his cell than most prisoners during this period.

4. On 11 March, Mr Hayden made nearly 100 telephone calls to his partner, the majority of which were unanswered. When they spoke, Mr Hayden's partner told him that she wanted to end their relationship. (Mr Hayden's telephone calls were not monitored by prison staff until after his death.)

5. At around 7.40am on 12 March, an officer found Mr Hayden hanged in his cell, with rigor mortis established. Paramedics later confirmed that Mr Hayden had died.

Findings

6. Mr Hayden had some risk factors for suicide and self-harm, although not all were known to prison staff at the time. In particular, staff did not know that Mr Hayden's relationship had ended. We are satisfied that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death.

7. We are concerned that staff did not have meaningful contact with Mr Hayden in the weeks before he died. Key worker entries in this time were generic, often word for word repeats of previous entries, with little evidence that a meaningful conversation had taken place or that current issues had been discussed.

Recommendations

- The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.

The Investigation Process

8. 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. He obtained copies of relevant extracts from Mr Hayden's prison and medical records.

9. The investigator interviewed eight members of staff at Liverpool in April 2021. NHS England commissioned a clinical reviewer to review Mr Hayden's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff. All the interviews were conducted by video or by telephone because of the restrictions in place in response to the COVID-19 pandemic.

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

11. One of the Ombudsman's family liaison officers contacted Mr Hayden's mother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hayden's mother asked the following questions:

    - why was Mr Hayden sent to HMP Liverpool;
    - what was the cause of his distress;
    - were Mr Hayden's telephone calls listened to;
    - was cardiopulmonary resuscitation started;
    - what was the reasoning for the order in which family members were contacted after Mr Hayden's death;
    - why were prisoners locked up for 23 hours a day in February 2021?

12. We have addressed these questions in this report.

13. We shared the initial report with HM Prison and Probation Service (HMPPS). They identified one typing error.

14. We also shared the initial report with Mr Hayden's mother. She did not make any comments.

Background Information

HMP Liverpool

15. HMP Liverpool is a local prison holding up to 750 adult men. J Wing is a smaller wing and is run as a wellbeing unit for prisoners who need additional support with their personal or physical wellbeing. Prisoners can either self-refer to the unit or be referred by staff, and an admissions panel considers each request. Prisoners on J Wing have in-cell telephones.

16. Spectrum Healthcare UK Trust provide physical healthcare services, and Merseycare NHS Trust provide mental healthcare services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Liverpool was in August to September 2019. Inspectors found that levels of self-harm had increased and were high compared to similar prisons. They reported that the management of suicide and self-harm was hindered by a lack of focus on key issues.

18. Inspectors also found that relationships between staff and prisoners were good. They reported that the keyworker scheme was delivered well and underpinned good, constructive relationships between staff and prisoners. Inspectors also reported that J Wing provided a safe and positive environment for prisoners.

19. Inspectors also reported that the mental health team provided a wide range of services, with a strong multidisciplinary working model.

Independent Monitoring Board

20. 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 2019, the IMB reported that the increasing number of incidents of self-harm was a worrying concern and was high compared to similar prisons. They reported on the relaxed and purposeful environment on J Wing, staffed by officers who were committed to the unit.

Previous deaths at HMP Liverpool

21. Mr Hayden was the thirteenth prisoner to die at Liverpool since March 2019, and the third self-inflicted death. We have not yet completed our investigations into the previous two self-inflicted deaths.

Assessment, Care in Custody and Teamwork

22. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and 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 multidisciplinary review meetings involving the prisoner.

23. 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 worker scheme

24. The key worker scheme is a key part of HMPPS's response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS's *Manage the Custodial Sentence Policy Framework*. This says:

- All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
- Key workers must have completed the required training.
- Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
- Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

COVID-19 (coronavirus)

25. COVID-19 is an infectious disease that affects the lungs and airways. It is mainly spread through droplets when an infected person coughs, sneezes, speaks or breathes heavily. On 11 March 2020, the World Health Organisation (WHO) declared COVID-19 a worldwide pandemic.

26. In response to the initial pandemic outbreak, HM Prison and Probation Service (HMPPS) introduced several measures to try and contain the outbreak - to be implemented at local level, depending on the needs of individual prisons. (An outbreak is defined as two or more prisoners, or staff, who are clinically suspected, or have tested positive for COVID-19 within 14 days.) A key strategy is 'compartmentalisation' to cohort and protect prisoners at high and moderate risk; isolate those who are symptomatic; and separate newly-arrived prisoners from the main population. Other measures include social distancing and the use of personal protective equipment (PPE).

Key Events

27. Mr Samuel Hayden was convicted of a number of offences from 2009 onwards and served several short sentences in Young Offender Institutions and prisons. As a child, he was diagnosed with attention deficit hyperactivity disorder (ADHD) for which he was prescribed medication for several years. Mr Hayden had some recorded history of self-harm. In 2015, he told a prison nurse that he had previously tried to hang himself and that he had taken heroin with the intent to kill himself. In 2016, he told prison staff that he had harmed himself by swallowing various (unknown) items.

28. In January 2017, Mr Hayden was sentenced to four and a half years in prison for supplying Class A drugs and actual bodily harm. Later in the year, prison staff recorded that he had cut his arms and torso with a razor blade. Mr Hayden was released from custody in December 2018.

HMP Liverpool

29. On 31 July 2020, Mr Hayden was recalled to HMP Liverpool. On arrival at Liverpool, Mr Hayden was emotional and said that he felt "lost" due to his recall and that he was not expecting it. Reception staff recorded that he said that he had no thoughts of harming himself. They started ACCT procedures due to Mr Hayden's low mood and his history of self-harm.

30. A prison nurse assessed Mr Hayden in Reception. He recorded that Mr Hayden said that his most recent self-harm was two years earlier and that he had no current thoughts. The nurse recorded that Mr Hayden was prescribed propranolol (medication for anxiety) but that he had no current drug or alcohol issues. He referred Mr Hayden to the mental health team.

31. On 1 August, a Supervising Officer (SO) recorded at an ACCT case review that Mr Hayden felt low and upset that he had been accused of a rape that he said he had not committed. (Mr Hayden was never charged with this offence.)

32. On 3 August, Mr Hayden's referral was discussed at the healthcare multidisciplinary team meeting. He was added to the ADHD pathway and referred to the GP to manage his anxiety.

33. On 5 August, Mr Hayden's keyworker recorded that he was more settled as he had been able to contact his family by telephone. She noted that Mr Hayden was less stressed as it now looked like "nothing would come" of the rape charges he had been concerned about. Later in the month, she recorded that Mr Hayden was progressing fairly well, had not caused any "bother" on the wing and was happy to meet his targets in prison so he could work towards release and get on with his life.

34. On 14 August, Mr Hayden told an ACCT case review that he had fleeting thoughts of self-harm but no intention of acting on them. Three days later, Mr Hayden was briefly segregated when he smashed a cell and threatened his cellmate.

35. On 18 August, a prison GP reviewed Mr Hayden. He recorded that Mr Hayden described a long history of anxiety and low mood. Mr Hayden said that he had

"tried to hang himself a couple of days ago" but had not previously told staff about this. The frequency of ACCT observations was increased as a result. He prescribed a course of sertraline (an antidepressant).

36. The next day, Mr Hayden's partner telephoned the prison and told staff that she was worried about him and his mental health. Prison staff listened to a telephone call that Mr Hayden had made to his partner and recorded that he was "in great distress about his mental health and threatening to self-harm". (All prisoners' telephone calls are recorded. In the case of Category C prisoners, like Mr Hayden, security staff listen to some calls at random or if staff have intelligence that might indicate information about the safety of individuals, or the prison has been discussed.)

37. The following week, Mr Hayden was moved to J Wing, the wellbeing unit. On 26 August, a SO recorded at an ACCT case review that he felt safer and less anxious following the move.

38. On 4 September, Mr Hayden was sentenced to an additional year in custody, consecutive to his previous sentence for assault and making threats to kill.

39. On 14 September, Mr Hayden's new keyworker following his wing move, recorded that Mr Hayden had settled well on J Wing and mixed well with other prisoners. He recorded that Mr Hayden felt more positive on J Wing and had "found his feet" since the wing move.

40. On 18 September, a learning disability nurse assessed Mr Hayden. She recorded that Mr Hayden would remain under the care of the learning disability team, although there was no formal learning disability diagnosis.

41. On the same day, a SO recorded at an ACCT case review that Mr Hayden was very mature in his attitude towards his sentence, life and responsibilities. She recorded that he had very little thought of self-harm. The case review team agreed to close the ACCT procedures.

42. Later in September, and in October, the keyworker recorded that Mr Hayden was cheerful and said everything was going as well as it could be. Mr Hayden applied for enhanced status under the prison's Incentives and Earned Privileges (IEP) scheme (which aims to encourage and reward responsible behaviour in prisons), which he was later awarded.

43. On 27 October, a prisoner handed a note to staff which named several prisoners allegedly involved in using and trading illicit drugs on J Wing. Mr Hayden was named as "smoking Spice [a psychoactive substance] and swapping meds [prescription medication]". That day, a nurse recorded that he had observed Mr Hayden concealing his propranolol at the medication hatch. (Mr Hayden's medication was supervised, meaning he had to take it in front of the nurse who issued it.)

44. On 28 November, the keyworker recorded that Mr Hayden remained upbeat and that his behaviour was always positive. He recorded that Mr Hayden had no issues to raise.

45. On 22 December, the keyworker made a key work entry. He recorded that Mr Hayden had no outstanding issues and that he exercised every day and used the gym when he could. He recorded that Mr Hayden had not yet found a job in the prison.

46. On 4 January 2021, another officer was appointed as Mr Hayden's new keyworker (as the previous keyworker no longer worked at Liverpool). On 7 January, he made a key work entry which was a word for word repeat of the previous keyworker's last entry. On 13 January, he repeated the entry again.

47. On the same day, the learning disability nurse reviewed Mr Hayden. She recorded that Mr Hayden spoke about the benefits of living on J Wing and that he had positive relationships with staff and other prisoners. Mr Hayden did not speak of any issues in prison and discussed plans for the future on his release from prison. She told us that Mr Hayden understood his medication and said that he was benefitting from it. The learning disability nurse said that he did not have any recognised learning support needs and that they agreed that he should be discharged from the learning disability caseload. She told us that Mr Hayden remained on the prison's ADHD pathway, but was still on the waiting list for this service when he died.

48. On 22 January and 26 January, the keyworker recorded that Mr Hayden was settled on J Wing. He recorded that Mr Hayden regularly used the gym, which was beneficial for his wellbeing. Shortly afterwards, Mr Hayden began working as a wing cleaner and on the servery, for which he received positive reports.

49. On 4 February, a SO recorded that she had completed a welfare check on Mr Hayden. She recorded that Mr Hayden had regular contact with his partner by in-cell telephone.

50. On 12 February and 15 February, the keyworker made entries which were word for word repeats of the SO's previous entry. These were the last key work entries that he made, due to a period of sick leave. He told us that during the COVID-19 pandemic there was little change from day to day, which is why entries were repeated. He said that Mr Hayden was well liked on the unit and required little support from staff.

51. On 18 February, J Wing began a restricted regime after being classified as a COVID-19 outbreak site after three prisoners tested positive for the virus. (Mr Hayden was not one of the prisoners who tested positive.) This meant that fewer prisoners than usual were unlocked at any one time to reduce the number of prisoners mixing with each other, although as a servery worker, Mr Hayden was able to spend more time out of cell than most of his peers.

52. On 19 February, Mr Hayden's medication was stopped as he had not collected it for three days. A nurse signed a 'Refusal of Treatment' disclaimer on Mr Hayden's behalf, crossing a box to designate that Mr Hayden had given verbal consent for him to do so. No-one made an entry in Mr Hayden's ongoing record to indicate that they had spoken to Mr Hayden to ascertain why he had not collected his medication or whether any follow-up action was required.

53. On 25 February, an officer recorded that Mr Hayden was doing a great job on the servery during the restricted regime. She noted that he was very independent and rarely needed support.

54. On 6 March, an SO recorded that Mr Hayden was carrying out his work to a good standard. She noted that Mr Hayden was aware of support available and had "no problems speaking to staff". The next day, an officer made another positive entry about the quality of Mr Hayden's work and attitude.

11 March

55. An SO recorded that J Wing was now no longer on a restricted regime. She spoke to Mr Hayden in the morning as part of a standard welfare check and recorded that he continued to work well in his job as a cleaner and servery worker. She recorded that the role was "the making of [Mr Hayden], giving him the confidence to engage with staff and peers alike" and that he was "a real asset to the wing". The SO told us that she had no impression at all that Mr Hayden was struggling or in distress.

56. Mr Hayden made over 100 telephone calls on 11 March, most of which were unanswered. He made 98 calls to his partner, of which 14 were answered, and 17 calls to his grandmother, of which two were answered. Mr Hayden also made 12 telephone calls to his cousin, three to a friend, and two to his brother, all of which were unanswered. (None of these telephone conversations were monitored by staff at the time.) We have detailed below key points from Mr Hayden's conversations:

- At lunchtime, Mr Hayden made six calls to his partner. During the calls, Mr Hayden spoke aggressively about aspects of their relationship. His partner said that she loved him but wanted to move on from the relationship.

- At 5.25pm, Mr Hayden spoke to his partner. He said that he wanted to kill himself and would do it if he could "get my hands on some pills".

- At 5.33pm, Mr Hayden spoke to his partner. She told Mr Hayden that she loved him but reiterated that the relationship had ended.

- At 5.53pm, Mr Hayden spoke to his partner. She again confirmed that the relationship had ended.

- At 6.56pm, Mr Hayden spoke to his grandmother. He said that he felt low and that he had had enough of prison.

- At 7.41pm, Mr Hayden spoke to his grandmother. He said that he had "no hope … had enough … never felt so lonely in my life … I don't want to be here". The call ended when Mr Hayden ran out of telephone credit and he did not therefore make any further calls.

57. During the evening, an officer twice saw Mr Hayden in his cell. He thought the first time was at around 5.30pm, when prisoners who work full-time (such as Mr Hayden) are unlocked for a period of time to socialise with peers and complete domestic tasks. The officer told us that Mr Hayden indicated that he would come out of his cell. He said he did not see Mr Hayden leave the cell, but other prisoners later said that Mr Hayden had done.

58. The officer thought that his second visit to the cell was at around 6.40pm, as part of a round locking the cells of those who had been out. He told us that he could not remember what Mr Hayden was doing at the time and there was no indication that he was in distress.

12 March

59. At 4.56am, an operational support grade completed a count of prisoners. He used a torch to look into each cell, including Mr Hayden's. He told us that Mr Hayden appeared to be standing at his window looking out. He said that it was not unusual for a prisoner to do this and he had no concerns at the time.

60. At around 7.40am, Officer A began a welfare check of all prisoners. At 7.42am, he arrived at Mr Hayden's cell. He looked through the observation panel and told us that he thought he saw Mr Hayden standing by his cupboard. After a few seconds, he returned to Mr Hayden's cell. He told us that he was concerned because Mr Hayden did not usually get up early and he had appeared quite still.

61. On his return, Officer A identified that Mr Hayden was hanging from a ligature that he had attached to the cell window. He shouted to his colleague, Officer B, to radio for assistance. Officer B radioed a 'code two' message, which is not a recognised radio code. (Code blue is the message used to identify a medical emergency when a patient is not breathing.) The control room operator and response nurse both recognised that the call was an emergency and responded immediately including telephoning for an ambulance.

62. Both officers went into the cell and cut the ligature. Officer A told us that Mr Hayden was cold to the touch and he thought that he was dead. The staff did not therefore begin cardiopulmonary resuscitation. A nurse was the first nurse responder. She recorded that rigor mortis was evident (meaning that Mr Hayden had been dead for some hours). Paramedics arrived at 7.57am and confirmed that Mr Hayden had died.

Contact with Mr Hayden's family

63. At 11.20am, the Governor and a family liaison officer visited Mr Hayden's partner, his nominated next of kin, and informed her of his death. At 12.00pm, they visited Mr Hayden's grandmother (whose address was also held at the prison) and informed her. During this visit, they obtained Mr Hayden's mother's work address and visited her afterwards.

Support for prisoners and staff

64. After Mr Hayden's death, an operational manager 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. The prison posted notices informing other prisoners of Mr Hayden's death and offering support.

Post-mortem report

65. A post-mortem examination identified the cause of death as compression of the neck caused by hanging.

Findings

Identifying the risk of suicide and self-harm

66. 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 Liverpool should have recognised Mr Hayden as at risk and begun ACCT procedures to support him.

67. Mr Hayden had some risk factors for suicide and self-harm. He had harmed himself in the past, including during periods of prison custody, and had been prescribed anxiety medication for several years. There was intelligence that he had used drugs in prison (albeit some months before his death). Most significantly, evidence in the telephone calls he made before his death indicates that Mr Hayden struggled greatly with the breakdown of his relationship. The content of these calls was not known to prison staff at the time.

68. While Mr Hayden had these risk factors, and we have some concerns about staff-prisoner relationships, we are satisfied that there was little to indicate to staff that he was at immediate risk of suicide and self-harm at the time of his death. If prison staff had managed Mr Hayden under ACCT procedures at the time of his death, it is unlikely that monitoring levels would have been sufficiently frequent to prevent his suicide, if he had planned it.

Staff-prisoner relationships

69. Under the Offender Management in Custody model, each prison officer is the named key worker for five or six prisoners and should be allocated an average of 45 minutes per week to spend on key work duties with each prisoner, including having regular meaningful conversations with each prisoner. In March 2020, HMPPS suspended key work due to the COVID-19 pandemic. On 12 May 2020, key work was reintroduced but delivered in a more limited way in line with an Exceptional Delivery Model, where priority prisoners received key work. Mr Hayden was identified as a priority prisoner because of his vulnerabilities.

70. At Liverpool, Mr Hayden received frequent key work sessions throughout his time at the prison. The entries were initially of good quality with evidence that Mr Hayden's individual needs and issues were discussed, and assistance provided where appropriate. However, entries made in 2021 were much poorer in quality, often word for word repeats of previous entries, and showing little evidence that a meaningful conversation had taken place or that Mr Hayden's current issues had been discussed.

71. We appreciate the pressures that prisons are under, particularly with providing consistent staffing during the COVID-19 pandemic and the impact this has on key work. However, we consider the key worker role to be vital in helping to ensure meaningful engagement between staff and prisoners and identifying any underlying issues a prisoner might have. More consistent or meaningful key worker sessions

might, for example, have identified that Mr Hayden was having difficulties in his relationship. We make the following recommendation:

The Governor should ensure that there is an effective key worker scheme which provides meaningful and ongoing support to prisoners.

Stopping medication

72. On 19 February 2021, Mr Hayden agreed to stop taking his medication after having not collected it for three days. There is no record that anyone asked him why he had not collected his medication or considered whether any follow-up action was required.

73. The nurse manager told us that since Mr Hayden's death they have introduced new procedures to monitor prisoners who stop their antidepressant medication. A medication technician will now see the prisoner within three days to discuss the potential consequences of stopping the medication, explain potential withdrawal symptoms and signpost for support. Within seven days, a healthcare professional will complete a mood review and identify any emerging withdrawal symptoms.

74. As these changes have been made since Mr Hayden's death, we do not make a recommendation.

Emergency response

75. 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 prisons 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 an ambulance. It stipulates that if a medical emergency code is called by radio, an ambulance must be called immediately.

76. Liverpool's Medical Emergency Protocol instructs the use of the emergency codes 'red' and 'blue' to comply with PSI 03/2013. Examples of the circumstances in which staff should use code blue are when the prisoner has difficulty breathing or is unconscious.

77. Officer B radioed 'code two' rather than 'code blue' when he requested emergency assistance. While he did not use a recognised code, the staff who responded all appeared to understand that 'code blue' was the intended message and acted accordingly. Nevertheless, after Mr Hayden's death, the Governor reissued the local Medical Emergency Protocol (as Notice to Staff 38-21). We do not therefore make a recommendation.

Family liaison

78. Mr Hayden's mother told us that she was concerned that she was not told of Mr Hayden's death until after his partner and grandmother had been informed.

79. PSI 64/2011 instructs that following a death in custody, prisons "must promptly notify the next of kin and any other person the prisoner has reasonably nominated

to be informed". It instructs that prisons must record a next of kin for each prisoner and that prisoners may identify more than one next of kin or family member who they wish to be contacted. PSI 64/2011 also instructs that, wherever possible, prison staff must visit the next of kin in person to break the news of the death. During the COVID-19 pandemic, prisons have been given the option of breaking the news of a death over the telephone instead of visiting in person, to reduce the risk of transmitting the virus.

80. Mr Hayden nominated his partner as his next of kin and did not nominate anyone else to be contacted in an emergency. Shortly after his death, the Governor and a family liaison officer visited Mr Hayden's partner to inform her of his death. This was appropriate and in line with national instructions.

81. Liverpool also held the address of Mr Hayden's grandmother, and the telephone number, but not the address, of his mother. They wished to break the news in person, rather than over the telephone, so, after visiting Mr Hayden's partner, they chose to visit his grandmother and informed her before subsequently visiting his mother, having obtained her work address.

82. Once prison staff had visited Mr Hayden's partner, they had fulfilled the requirements of PSI 64/2011. It is good practice that they chose to inform other family members shortly afterwards. Having done so, they were faced with a judgement about whether to visit his grandmother in person or speak to his mother over the telephone. While we understand Mr Hayden's mother's concerns, we do not think it is unreasonable that they chose to visit his grandmother first.

Inquest

83. The inquest into Mr Hayden's death concluded on 30 June 2023. The jury concluded that Mr Hayden died as a result of a self-applied ligature, but that it cannot be said whether he intended the act to be fatal.

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