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A Report by the  
Prisons and  
Probation  
Ombudsman  
Nigel Newcomen CBE

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**Investigation into the death of a man at HMP  
Liverpool in January 2012**

## ***Our Vision***

*'To be a leading, independent investigatory body,  
a model to others, that makes a significant contribution to  
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man at HMP Liverpool in January 2012. He was found hanging in his cell. He was 53 years old. I offer my condolences to his family.

The investigation was carried out. The local Primary Care Trust (PCT) appointed a clinical reviewer to conduct a review into the clinical care the man received at HMP Liverpool. The prison cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man was first remanded to Liverpool in 2008. In August 2010, he took an overdose and suicide prevention measures were put in place to support him for a short time. He moved to HMP Wymott in November 2010. In October 2011, he successfully appealed his conviction, but remained in prison on remand pending a retrial and returned to Liverpool. On 12 January, he was questioned by police about further serious potential charges. A few days later an officer discovered that he had blocked entry to his cell and, when the door was opened, he was found hanging. Resuscitation was attempted and an ambulance was called, but his death was pronounced by paramedics at 12.42pm.

The man was facing a number of pressures at the time of his death. His regime privileges level had been incorrectly reduced; he had no allocated activity and a consequent lack of prison pay. The prison had denied him contact with his children, although this had been agreed with the Social Services for some years. Just a few days before his death, he faced questioning from the police about further serious charges. There is no indication that anyone spoke to him of the impact all this had on him and there was no consideration of opening suicide and self-harm prevention measures. When he was found barricaded and unresponsive in his cell the emergency response was slow.

The man made a very determined effort to kill himself and it would have been difficult for staff to prevent his death. Nevertheless, there are a number of lessons for the prison to learn from his tragic death.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**July 2013**

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## SUMMARY

1. The man was remanded to Liverpool in January 2008 and in February 2008; he was convicted of serious sexual offences. He maintained his innocence of these offences and appealed his convictions.
2. In August 2010, the man took an overdose of drugs and prison staff found plastic bags, string and a suicide note in his cell. He was monitored under the ACCT procedures (the Prison Service process for supporting and monitoring prisoners at risk of harming themselves) for only two weeks. The monitoring process was poor. There was no care and management plan with substantive actions to support him and observations were not always recorded.
3. During the monitoring, prison staff identified and noted the trigger factors that were likely to cause the man to self-harm. In 2011 and early 2012, when he was remanded and questioned about further offences, prison staff did not take account of these identified triggers or other guidance on risk factors.
4. The man had a number of other worries and concerns. Contrary to Prison Service instructions, his status under the prison's incentives and earned privileges system had been reduced from the highest level, to standard when he moved. He had no allocated activity and little prison pay. The prison had also prevented him contacting his children, because he had refused to sign a public protection compact, although his contact with his children had been approved by Social Services for some years.
5. Although it seems unlikely that the man could have been saved, the emergency response was not as swift as we would have expected. He had barricaded himself in his cell and there were significant delays in getting specialist equipment to open the door and in calling an ambulance.
6. We make recommendations about improving suicide and self-harm prevention arrangements, emergency response, IEP and public protection arrangements.

## THE INVESTIGATION PROCESS

7. An investigator carried out the investigation. He visited Liverpool on 19 January, where he met the Governor and other key staff, as well as representatives from the Independent Monitoring Board (IMB) and Prison Officers' Association (POA). He collected the man's prison and health records and spoke to his cell mate during the visit.
8. Notices announcing the investigation and its terms of reference were issued to staff and prisoners at Liverpool, inviting them to give the investigator any relevant information. No one came forward.
9. The investigator reviewed the man's records and interviewed several members of prison staff. The local Primary Care Trust (PCT) appointed a clinical reviewer to review the clinical care that the man received at Liverpool and he jointly interviewed healthcare staff with the investigator. The investigator wrote to the Governor with preliminary feedback on 1 May.
10. The delay in issuing this report is regretted. It was caused by a backlog of cases in the office which we are striving to clear, compounded by staffing changes during the course of the investigation.
11. One of the Ombudsman's family liaison officers contacted the man's wife to explain the investigation. She had the following questions which she wished the investigation to consider:
  - Why did her husband have a plastic bag in his cell, when he had spoken about his intention to use such a bag to kill himself in the past?
  - Was he subject to suicide prevention monitoring after he took an overdose of tablets in August 2010, and why did he have access to a plastic bag on that occasion?

## **HMP LIVERPOOL**

12. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,184 prisoners. Healthcare is delivered by a Community Health Trust. There is a primary mental health team, in-reach team (for those with a diagnosed severe and enduring mental illness), and a clinical psychology service, which delivers specialist therapy and counselling.

### **Her Majesty's Inspectorate of Prisons (HMIP)**

13. Her Majesty's Inspectorate of Prisons (HMIP) carried out a full unannounced inspection in December 2011. The inspection found some progress had been made at the prison since the last inspection, but it was very slow. One of the Inspectorate's main concerns was the treatment of vulnerable prisoners, who were held separately from the main prison population for their own protection, either because of the nature of their offence or for other reasons. Inspectors found that vulnerable prisoners had a more limited experience at Liverpool compared to other prisoners, including access to work and learning and skills opportunities in the prison. The man was a vulnerable prisoner and was unemployed at the time of his death.
14. The Inspectorate considered that safer custody policies were reasonable, but they were not effectively implemented on the wings and a worrying number of officers were not trained in the suicide and self-harm prevention procedures. Complaints were mainly answered quickly, politely and relevantly. The Inspectorate was concerned that prisoners had to be at the prison for three months before they could be considered for enhanced status (which entitles them to increased privileges, including time out of cell and additional visits).

### **Independent Monitoring Board (IMB)**

15. Each prison has an Independent Monitoring Board (IMB), of unpaid volunteers from the local community, to help ensure that proper standards of decency are maintained. In its annual report for 2010/11, the IMB expressed concern about staffing shortages and the impact of further budget cuts on the delivery of the regime. The IMB was satisfied that staff were vigilant and professional about safer custody procedures.

### **Previous deaths at HMP Liverpool**

16. There were four deaths at Liverpool in 2011, two of which were self-inflicted. The man's death was the first of five in 2012, one of which was also self-inflicted. There are no apparent similarities between the findings of this and the other investigations.

## **KEY EVENTS**

### **HMP Liverpool**

17. The man was remanded to HMP Liverpool on 22 January 2008. When he arrived at the prison, he told a nurse during a health screen that he was prescribed citalopram (an antidepressant) for depression. He said he had never self-harmed. At that stage he was not referred to the mental health team for assessment. On 11 February, he was convicted of serious sexual offences, some involving children. He was given an indeterminate sentence for public protection with a minimum term of seven years in prison before he could be considered for release on parole.
18. On 9 April 2008, a doctor examined the man. The doctor wrote, "a very angry man ... very upset with the justice system". The doctor noted that he suffered from depression and suggested that he might benefit from a psychiatric or psychological assessment.
19. On 30 April, a social worker wrote to the prison's Public Protection Department to say that Children's Services supported contact between the man and his sons. Despite the nature of his offences, she noted that his sons missed him a great deal. He was permitted visits, telephone calls and correspondence with his sons.
20. On 4 September, a member of the primary care mental health assessed the man five months after the doctor suggested a psychiatric or psychological assessment. He said that he was struggling with the appeal process, and she suggested coping strategies. Two weeks later, another member of the primary care mental health team discussed his mild depression. He told him that he was angry about the appeal process, and felt low as a result, but he was not thinking about harming himself. He was referred to a counsellor.
21. The man had his first counselling session on 28 October 2008, with senior counsellor. He received weekly counselling over the next five months and engaged well. In March 2009, his counselling sessions stopped and he continued to take citalopram. The appeal process continued.
22. In March 2010, the man told a doctor that his antidepressant was no longer effective and he wanted to take seroxat (another antidepressant). The doctor agreed and changed his prescription.
23. The senior counsellor saw the man on 12 August 2010, because he was anxious about his appeal and concerned about health issues.

### **Attempted overdose in August 2010**

24. On 25 August, the man slipped on his way to collect his dinner. When officers asked him if he was all right, he said that he had taken too much seroquel. Seroquel is an antipsychotic medication, which he had not been prescribed. He was taken to hospital for urgent treatment. Officers found string, plastic bags and a long suicide note in his cell. A doctor arranged for him to be admitted to

the inpatient unit when he got back from hospital and suggested that he needed a psychiatric evaluation and psychological review.

25. The next day, the man returned to prison and was admitted to the healthcare centre inpatient unit. A nurse assessed his mental health and concluded that he was not mentally ill. He told the nurse that it was an impulsive act and he felt better for expressing his anger in writing. The senior counsellor went to visit him, but he was asleep.
26. Suicide and self-harm monitoring procedures were started. A Senior Officer (SO) chaired an Assessment Care in Custody and Teamwork review. (ACCT – the prison process to identify and support prisoners at risk of suicide or self-harm.) The man repeated that his suicide attempt was impulsive, but the SO recorded that it seemed like a well thought through plan. Officers wrote that triggers for him to self-harm might be bad news about his relationship or problems with his appeal, which was scheduled for 3 September. Staff were instructed to observe him four times daily and nightly. His risk was assessed as 'raised'. After the review, his prescription for antidepressants was increased.
27. A caremap (a list of actions designed to defuse a crisis and address a prisoner's problems) should be drawn up for every prisoner subject to suicide and self-harm monitoring. There was no caremap in the copy of the man's ACCT given to the investigator. (The Prison Service subsequently stated that such a caremap exists.)
28. The man was discharged from the healthcare centre back to the wing on 27 August. At an ACCT case review, chaired by an SO on 28 August, the SO recorded that he was more positive and looking forward to his appeal hearing, scheduled for 3 September. His risk was considered to be 'low'. The SO agreed with a Healthcare Assistant (HCA), an officer and the man that his ACCT should remain open for another week. The level of observations remained the same.
29. During a counselling session on 1 September, the man told the senior counsellor that he was angry because his appeal hearing had been cancelled. A nurse spoke to him on 3 September, and described him as bright and chatty. He told the nurse that he would not try to kill himself again.
30. Three days later, an SO chaired an ACCT case review, attended by a member of the chaplaincy team and a nurse. The man was much more positive about the future and, although his appeal had been deferred, he told staff that he would deal with it when it happened. The senior officer closed his ACCT less than two weeks after it was opened. At a post-closure review on 9 September, he told an officer that he was still waiting for new dates for his appeal, but he did not think that he would hurt himself again. The ACCT remained closed.

## **Transfer to HMP Wymott – November 2010**

31. The man transferred to Wymott on 1 November 2010. His attempted overdose was noted by reception staff, and he was referred for a mental health assessment because he was taking antidepressants. He also had to reapply for contact with his children.
32. The senior counsellor from Liverpool prison wrote to the prison doctor at Wymott on 10 November. He explained that he had counselled the man over the previous year and supported him through problems with his relationship and the appeal process. He had been due to see him on 4 November and it was only when he did not turn up for his appointment that he learned that he had transferred. He offered to speak to someone at Wymott to ensure continuity of care, but there is no record of further contact between Wymott and the senior counsellor.
33. The man received notice of his appeal on 17 November. It was scheduled for 20 December 2010, at the Court of Appeal in London.
34. On 23 November, a primary mental health practitioner carried out a mental health assessment. She wrote that the man had been transferred to take part in the sex offender treatment programme, but he refused to do it because he maintained his innocence of the offences. He told the primary health practitioner that he had found counselling beneficial, but he no longer had relationship problems and did not feel like he needed support any more. She agreed that he did not need mental health support, but explained how he should access mental health services if he needed to. She wrote the following entry, in capital letters, in his medical record:

“FEELS RISK OF SELF HARM/SUICIDE ATTEMPT MAY INCREASE IN RESPONSE TO FUTURE STRESSORS ESPECIALLY MARITAL DIFFICULTIES, APPEAL PROCESS”
35. On 17 December, the man transferred to HMP Pentonville in preparation for his appeal. He was taken to the Court of Appeal on 20 December, when his appeal hearing was adjourned while more evidence was gathered. The next day, he returned to Wymott prison, where he remained for the next few months.
36. The man was admitted to hospital after a heart attack on 14 March 2011. The Criminal Appeal Office wrote to Wymott on 1 April, to ask whether his physical health would prevent him from instructing his legal team about his appeal. A nurse practitioner replied on 12 April, advising that he had been discharged from hospital and he was working again. Although he was still being monitored by healthcare staff, there was no reason to delay the appeal process. He continued to work at Wymott and received follow-up care for his heart condition.

## **Appeal hearing**

37. The man's appeal hearing was eventually listed for 28 October 2011, but he opted not to attend. The day before the hearing, he told his personal officer that he had spoken to his solicitor, who said that there might be a retrial.
38. The man's case was heard on 28 October and all his convictions were quashed. However, the court ordered that he should remain in custody pending the Crown Prosecution Service's application for a retrial. The court considered he was at risk of fleeing the jurisdiction as he had been extradited from Spain when he was originally taken into custody. He was also regarded as a risk to his alleged victims because he had made threats about them in monitored correspondence with his wife.

## **Return to HMP Liverpool – October 2011**

39. Wymott holds convicted and sentenced prisoners and, as the man's conviction had been overturned, he returned to Liverpool prison on 29 October. Reception staff noted that he had self-harmed when he was first sentenced (which was inaccurate) and that he had had a heart attack in March 2011. Although he had been on the enhanced level of privileges at Wymott, he reverted to being on the standard level of privileges at Liverpool.
40. The man was asked to sign a Public Protection Unit compact to allow staff to monitor his telephone calls and correspondence. He refused to sign the document, which he believed was unnecessary, as contact with his two sons had been approved since he came into prison in 2008. He had received visits from his sons and spoken to them on the telephone throughout his time in custody.
41. A nurse carried out a routine health screen on 2 November 2011, and recorded that the man had tried to take an overdose in August 2010, but that he no longer had thoughts of suicide. He told the nurse that his court case was proceeding, but that he had lost interest and thinking about it made him anxious. The nurse referred him to a clinic to monitor his heart condition.
42. On 7 January 2012, the man submitted a complaint about being reduced to the standard level of privileges on his return to Liverpool, despite being an enhanced prisoner at Wymott. He was also concerned that his approved telephone numbers had been blocked, so that he could not contact his wife and children. He was worried that he no longer had any prison pay and considered he should not have to work as a remand prisoner who was spending a lot of time preparing for his retrial.
43. The Business Support Manager replied to the man's complaint on 12 January. She agreed that he had been on the standard regime since his return to Liverpool and encouraged him to raise this with the wing manager if he did not believe it to be correct. She wrote that his telephone numbers would be blocked for as long as he refused to sign the Public Protection Unit compact. She said that his pay had been stopped because he was refusing to work, rather than being unable to work. Prisoners on remand only received pay to remain in their

cell when they were unable to work. Although she agreed that prisoners on remand did not have to work, she suggested that he speak to officers about arranging employment.

44. That day, 12 January 2012, the man was taken to a police station for questioning. On the letter requesting that the prison facilitate this, the police noted that he had had a successful appeal and a retrial was set for March 2012. In addition they had further allegations of a sexual nature against him, which they wished to question him about. Despite the seriousness of the new allegations, there was no reference to them on his Prisoner Escort Record (PER), his case history notes or in his medical record. There is no record of him being assessed in reception when he returned from the police station after questioning.
45. A doctor reviewed the man's heart condition on 13 January and changed his medication. This is the only recorded staff contact with him after his questioning by police and there is no evidence that any staff spoke to him to check how he might be affected.

### **Day of the incident**

46. At 11.30am, Officer A tried to open the man's door, but could not do so. He looked through the observation panel but the cell was completely dark. He reported this to the SO in the wing office. The SO and three officers then went to the cell with Officer A. The SO pushed the door, but could only open it an inch. He asked if anyone was in the cell, but there was no response. Officer A said that only the man was in the cell, because his cell mate had gone to work.
47. Two nurses were dispensing medication in the wing's treatment room at about 11.35am, when the SO told them that there was a possible barricade on the third landing, so treatments might be delayed.
48. At 11.45am, the SO asked the two nurses to be on standby outside the cell, because officers were not sure what had happened to the man. Officer B told the orderly officer that there was a possible barricade and brought the inundation key in attempt to gain a better view of the inside of the cell (cell doors have a small opening in the door to allow a fire hose to be connected in the event of a fire). Officer A used the key but could still not see into the cell and told the orderly officer that he needed a barricade device to get into the cell.
49. At about 11.55am, two Control and Restraint (C&R) Instructors received a call to open a cell that a prisoner had barricaded on K wing. At 12.00 noon, Nurse A called the healthcare centre and told the Nurse Manager that there was a possible code blue (which means a serious emergency with a prisoner with breathing difficulties) on K wing. The Nurse Manager remembered Nurse A saying that officers thought a prisoner might have hanged himself.
50. The C&R Instructors collected a special barricade device, and, at 12.10pm, opened the cell door and discovered the man hanging from the television plug socket by a bed sheet. The SO radioed a code blue and asked the control room

to call an ambulance. Officers cut the bed sheet and Nurse B followed them into the cell. She checked him and found no signs of life.

51. Nurse A applied the defibrillator pads, which advised that resuscitation should continue. Nurse B inserted an airway and Nurse A attached the oxygen. The nurses then did chest compressions and administered oxygen for about 18 minutes, until the paramedics took over. When the paramedics arrived at 12.27pm, the nurses left the cell and the wing to give them space to work. The paramedics continued to try and resuscitate the man, but pronounced him dead at 12.42pm.

### **Prisoner support**

52. The Governor issued a notice to all prisoners informing them that the man had died. The notice indicated the support available, including Listeners (prisoners trained by the Samaritans to offer confidential support to other prisoners). The care team and other relevant staff were also notified. An officer told the investigator that all prisoners subject to self-harm monitoring had case reviews.

### **Post-mortem examination**

53. The post-mortem examination concluded that the man died of compression of the neck with occlusion (obstruction) of the external airways by plastic bag. The toxicology analysis discovered more paroxetine (seroxat) than would have been expected in his blood, although the results might have been affected by post-mortem changes in the body.

### **Family Liaison**

54. At 1.30pm, the prison's family liaison officer and one of the chaplains went to the address held for the man's wife to break the news of his death. The house was unoccupied so they returned to the prison to try to find an alternative address. Around an hour later they visited her at another address, where they informed her of her husband's death. In line with national guidance they offered financial assistance with the funeral costs. The family liaison officer kept in touch with her to deal with matters such as her husband's property. The chaplain attended the funeral with an operational manager at the prison.

### **Letter written on 15 January 2012**

55. After the man's death, a letter dated 15 January was discovered in the outgoing mail on the wing written by him and addressed to The Guardian national newspaper. In the letter, he described his frustration with the British criminal justice system, which he said did not protect the innocent and allowed prosecution in the absence of physical evidence.

## ISSUES

### Clinical care

56. A clinical reviewer considered the care that the man received at HMP Wymott and HMP Liverpool. In his review, he outlines the healthcare interventions that he received during his two and a half years in custody, including his mental health treatment, migraine, and the response to his heart attack. He concludes that there were no significant shortcomings, and that his care was more than satisfactory. We agree with the clinical reviewer that his clinical care was equivalent to the care that he could have expected in the community.

### Suicide prevention monitoring

#### *The man's ACCT monitoring*

57. It appears that the man planned to kill himself in August 2010. He took a drug overdose and officers subsequently found items in his cell which suggested he had been intending to hang himself. Suicide prevention monitoring lasted for only two weeks and identified no actions designed to support him. The case reviews were chaired by different senior officers for the short time it was open. Observations were not recorded and there is a period of 24 hours when no entry was made in his ongoing record, despite being required four times a day and overnight.

58. The Inspectorate found that ACCT processes needed tightening in their most recent inspection in December 2011. We are similarly concerned about the quality of the man's ACCT monitoring and agree with the Inspectorate's recommendation:

**The Governor should ensure that staff comply with the requirements for ACCT monitoring.**

#### *Assessment of risk after the man's return from police questioning*

59. The major trigger for the man's attempted suicide in 2010 was the appeal process, for which he received counselling. He was questioned about his forthcoming retrial and further serious charges four days before he died. The primary mental health practitioner at Wymott highlighted in capital letters issues that would cause him additional stress, which included the appeal process. There is no record that any member of staff spoke to him about the added pressure of his new trial.

60. At the time of the man's death, PSO 2700, "Suicide Prevention and Self-harm Management", governed the management of prisoners at risk of suicide or self-harm and listed a number of potential triggers of self-harm. The PSO has been superseded by Prison Service Instruction (PSI) 64/2011, which like the previous guidance, recognises that further charges and court appearances may increase the risk of a prisoner's self-harm.

61. Chapter three of PSI 64/2011, highlights that a prisoner's risk (or likelihood) of violence, self-harm and/or suicide may increase in certain circumstances and notes that a prisoner facing further charges is a known trigger which may increase risk of self-harm, suicide or violence.

62. This is further supported by PSO 3050 "Significant Life Events Affecting Prisoner's Health" which states that,

"Events that require a prisoner to leave the prison and pass back through prison reception (as the man did), can have significant impact on the health of a prisoner."

63. The PSO includes events such as attending court, sentencing at court and being questioned by the police and notes that prisons must have protocols in place for screening such prisoners for any potential healthcare, or suicide/self-harm issues. There was no evidence that the man received a healthcare screening when he arrived back at Liverpool after being questioned by the police to see how this had affected his state of mind.

**The Governor and Head of Healthcare should ensure that all prisoners passing through the prison reception following events which may involve a change in their status, including attending court, sentencing at court and being questioned by the police, should receive a screening for any potential healthcare or suicide/self-harm issues.**

**The Governor should ensure that staff are aware of the impact of further charges on a prisoner's risk of self-harm and give active support to those who require it.**

#### *Plastic bags*

64. The post-mortem report concluded that the man died from hanging, and also that his airways were obstructed by a plastic bag. His wife was concerned that he had access to plastic bags in prison, especially as he had planned to use a plastic bag to harm himself previously.

65. The plastic bag that the man used is for the distribution of items bought by prisoners, known as canteen, an arrangement that is in place in all public sector prisons. As he had not been assessed as at risk of self-harm, removing items from his possession had not been considered.

66. PSI 64/2011 says that removal of items should be kept to a minimum and must never be automatic. The man might have been considered at heightened risk of self-harm if staff had considered his retrial and further charges and the stress this was causing him. Even if he had been assessed as at risk of suicide and self-harm at the time, we do not consider that the prison staff would have been likely to conclude, in the absence of other evidence, that he was at such significant risk that any item, including plastic bags, should have been removed from his possession.

## **Incentives and Earned Privileges (IEP)**

67. Prison Service Instruction (PSI) 11/2011 governs the operation of the IEP scheme in prisons. The scheme aims to reward responsible behaviour by prisoners and has three levels – basic, standard and enhanced. The man transferred from Wymott to Liverpool after his status changed from sentenced to remand. In relation to transferred prisoners, the PSI requires:

“When a prisoner is transferred P-NOMIS will automatically default a prisoner’s privilege level to standard regardless of previous status. To ensure prisoners’ retain the privilege level they were on at the sending establishment staff should check previous history and amend the status field accordingly. This will apply to prisoners who were on the basic or enhanced level. Transferred prisoners should be assessed within two weeks (wherever possible) after arrival to ensure they have been placed on the appropriate privilege level.”

68. The man had been on the enhanced level of privileges throughout his time at Wymott. There is no documented reason why his privilege level was reduced and no review of his privilege level after a fortnight. There is no recorded attempt to explain to him why he was considered a standard level prisoner. When he made a formal complaint about this, the response just passed the matter back to him and suggested that he should speak to his wing manager about it rather than seeking to resolve the complaint. This was not a satisfactory response.

69. The Inspectorate criticised HMP Liverpool for the blanket approach to insisting all new prisoners are considered standard level for three months before their IEP status is reviewed. The man was not a new prisoner, and had earned his enhanced status. To remove his privileges because of unrelated legal proceedings, without explanation, is contrary to the provisions of the PSI.

**The Governor should ensure that prisoners transferred from other establishments retain their IEP status.**

## **Public Protection measures**

70. In April 2008, the local authority wrote to support the man’s contact with his children, having taken into account the offences for which he was convicted. The local authority children’s services had no objection to him speaking to his sons on the telephone, writing to them and having visits with them. He maintained contact with his children over the next three and a half years. When he transferred to Wymott, he had to apply for contact with his children again, and expressed his frustration about this. However, once his status changed from sentenced to remand, he transferred back to Liverpool prison and his contact was stopped.

71. The man refused to sign the compact because contact with his children had already been approved. Rather than recognising that approval had been granted once before at Liverpool, the prison stopped contact with his family without any substantive ground on which to do so. At this stage, his potential risk to his

children remained the same as when permission was granted at Liverpool in 2008 and Wymott in 2010, except that now he was unconvicted of any offences. While we consider he could have been more cooperative in this matter, we consider that the prison should not have stopped his contact with his children automatically simply because he refused to sign a document that he had already signed on two previous occasions.

**The Governor should ensure that public protection measures correspond with risk and, wherever possible, a prisoner's contact with his family is maintained.**

## **Emergency response**

### *Barricade*

72. Half an hour elapsed between an officer being unable to open the man's door and staff gaining entry to the cell. Nurses said that they were asked to wait outside the cell at 11.45am, but trained officers with barricade equipment were not contacted for a further fifteen minutes. If the senior officer considered that medical assistance might be required, efforts to open the door should have been more urgent and trained officers called sooner.

**The Governor should ensure that entry is gained to a barricaded cell without avoidable delay.**

### *Ambulance*

73. An ambulance was not called until staff had got into the man's cell, more than half an hour after the alarm was first raised. One of the nurses remembered officers talking about the possibility that he had hanged himself behind the door. If there was a suspicion that the barricade was caused by such a life-threatening situation, we consider an ambulance should have been called sooner.
74. The Director of Offender Health and the Chief Executive Officer, National Offender Management Service, wrote to all prison Governors and prison healthcare managers on 17 February 2011, to reiterate previous guidance about the importance of calling an ambulance as soon as possible in an emergency. Any delay can have a significant impact on the prisoner's chance of survival.
75. While it is unlikely to have changed the outcome for the man, an ambulance should have been called as soon as officers suspected that he was hanging in his cell.

**The Governor should ensure that an ambulance is called immediately in an emergency.**

## CONCLUSION

71. After an attempted overdose in 2010, the man was monitored for a short time under the suicide and self-harm procedures and likely triggers for further attempts were listed in his medical records. One of his concerns was his appeal against his convictions. Although these were quashed towards the end of 2011, he was remanded pending a retrial. Two and a half months later, he hanged himself.
72. The investigation found a number of deficiencies in the suicide prevention process. In spite of a serious attempt to kill himself in 2010, the man was monitored for only a short time, no specific actions were put in place to support him, case managers varied and observations were not recorded. Significantly, although his risk factors were known, staff failed to take account of them and offer support when he was subject to further criminal charges. However, he appears to have made a determined attempt to kill himself which would have been very difficult to prevent. When he was found, there were delays in gaining entry to his barricaded cell and calling an ambulance.

## RECOMMENDATIONS

The Prison Service accepted all the recommendations. Their response is listed below each recommendation.

1. The Governor should ensure that staff comply with the requirements for ACCT monitoring.

*“ACCTs are subject to daily monitoring through daily wing management checks and safer custody checks. They are also subject to weekly senior management checks.”*

2. The Governor and Head of Healthcare should ensure that all prisoners passing through the prison reception following events which may involve a change in their status, including attending court, sentencing at court and being questioned by the police, should receive a screening for any potential healthcare or suicide/self-harm issues.

*“A Governors order will be produced to notify this change in procedure. All Prisoners returning from court or Police production where a change of circumstances exist will be screened for vulnerability.”*

3. The Governor should ensure that staff are aware of the impact of further charges on a prisoner’s risk of self-harm and give active support to those who require it.

*“A Governors order will advise staff accordingly.”*

4. The Governor should ensure that prisoners transferred from other establishments retain their IEP status.

*“CNOMIS automatically resets IEP levels to standard on transfer. A Notice to staff will be produced reminding staff that Prisoners should retain their IEP status on transfer. This will be notified to prisoners via Induction/Sign Posting.”*

5. The Governor should ensure that public protection measures correspond with risk and, wherever possible, a prisoner’s contact with his family is maintained.

*“The Governor will ensure that public protection measures correspond with risk and, wherever possible, a prisoner’s contact with his family is maintained.”*

6. The Governor should ensure that entry is gained to a barricaded cell without avoidable delay.

*“HMP Liverpool will ensure that contingency plans eliminate avoidable delays for staff attempting to gain access to a barricaded cell.”*

7. The Governor should ensure that an ambulance is called immediately in an emergency.

*“A Gov order was published Nov 2012 concerning emergency codes and priority access for emergency vehicles.”*