

**Independent investigation report by the  
Prisons and Probation Ombudsman  
Nigel Newcomen CBE  
into the death of  
a prisoner at HMP Liverpool  
in December 2014**

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## ***Our Vision***

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

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.

The man was found hanged in his cell at HMP Liverpool on 16 December 2014. He was 34 years old. I offer my condolences to the man's family and friends.

My investigation found a number of procedural failings in the management of suicide and self-harm prevention procedures at Liverpool. I am also concerned that reception staff did not appropriately assess the man's risk of suicide and self-harm, despite clear risk factors and warnings from external agencies. While staff did not identify any significant concerns that would have alerted them to the man's intentions on 16 December, I am concerned that there was an underestimation of his risk of suicide throughout his time at the prison. This resulted in observations that were too infrequent and in the man being left alone in a cell he normally shared, on the morning of his 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**

**August 2015**

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## SUMMARY

### Events

1. On 4 November 2014, the man arrived at HMP Liverpool, charged with assaulting his partner. The man was managed under Prison Service suicide and self-harm prevention procedures (known as ACCT) as he was depressed, had recently taken an overdose and had alcohol misuse problems. The man continued to be considered at risk of suicide and self-harm until he was released from Liverpool on 2 December, after he received a suspended sentence.
2. Two days later, on 4 December, the man was sentenced to 30 weeks in prison after he breached a restraining order. Court custody and probation staff were worried about the man and communicated their concerns to the prison but reception staff at Liverpool did not identify the man as at risk of suicide or self-harm. The next day, prison staff began ACCT procedures, when his risk was recognised. These remained in place until his death.
3. On 7 December, the man cut his arm. The next day, he discussed his problems, including recent suicide attempts, with a mental health nurse and a doctor. The man got a prison job and attended education classes. He continued to be monitored as at risk of suicide and self-harm, but prison staff did not record any particular concerns about him. Although he was assessed as at raised risk of suicide, he was required to be checked only four times during the day. An ACCT case review, scheduled for 15 December, was cancelled because there were no healthcare staff available.
4. On the morning of Tuesday 16 December, the man's cellmate moved out, leaving him alone in the cell. Staff noted no concerns about the man that morning, but, when an officer unlocked his cell at 11.31am, he found the man had hanged himself. After ambulance staff arrived at the prison, it took nine minutes for them to reach the man's cell. Resuscitation efforts were unsuccessful and, at 12.20pm, paramedics pronounced the man dead.

### Findings

5. The man was subject to suicide and self-harm prevention procedures for almost the whole time he was at Liverpool. We have some concerns about how effectively they operated to support and safeguard the man, including the management of case reviews and the level of observations set.
6. When the man returned to the prison on 4 December, we are concerned that, reception staff did not appropriately assess his risk of suicide and self-harm. They did not give sufficient weight to the man's known risk factors or to warnings from external agencies. Although the man had left the prison only two days previously, staff did not follow local policy and automatically begin ACCT procedures for someone who had been released while on an ACCT. The level of observations was too low to reflect his risk and we are concerned

that he was left alone in his cell on the morning of his death, without any consideration of the risk.

7. We consider that the man received a good standard of mental healthcare at the prison, but no one referred him to the prison's substance misuse service when he returned on 4 December. He had previously received support from the service but healthcare staff were unaware of this because this was not recorded in the man's medical records, to which substance misuse workers had no access.
8. It took too long for paramedics to reach the man's cell once they had arrived at the prison.

## **Recommendations**

- The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:
  - Have a clear understanding of their responsibilities and the need to record relevant information about risk.
  - Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and suicide risk warnings from external organisations.
  - Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.
- The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including:
  - Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care.
  - Having consistent case management and attendance where possible.
  - Considering all known risk factors when determining the level of risk of suicide and self-harm.
  - Setting appropriate levels of observations to reflect identified risk.
  - Ensuring that all staff record interactions in the ACCT record.
  - Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them.
- The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells, are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.

- The Head of Healthcare should review the management of health records to ensure all relevant staff, including the Lifeline team, have appropriate access to prisoners' medical records and that they are used as the primary record for all medical care.
- The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

## THE INVESTIGATION PROCESS

9. 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.
10. The investigator visited the prison on 22 December 2014 and obtained copies of relevant extracts from the man's prison and medical records.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison. The investigator and investigator interviewed 13 members of staff, some jointly. At the initial report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included below the recommendations at the end of this report.
12. We informed HM Coroner for Liverpool of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
13. One of the Ombudsman's family liaison officers contacted the man's brother, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. The man's brother said that when the man was arrested he threatened to kill himself. He wanted to know if the police had passed this information to the prison. He also asked how the prison had assessed the man's health needs. The man's brother received a copy of this report. He did not make any comments.

## **BACKGROUND INFORMATION**

### **HMP Liverpool**

14. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. Healthcare is delivered by Lancashire Care NHS Foundation Trust and Mersey Care NHS Trust. The Lifeline team provides interventions and services for prisoners with drug and alcohol problems.

### **Her Majesty's Inspectorate of Prisons**

15. The most recent inspection of HMP Liverpool in May 2015 has yet to be published. In preliminary inspection feedback, inspectors reported that all new prisoners underwent a private interview in reception and there was a good focus on vulnerabilities. Levels of self-harm and the subsequent use of suicide and self-harm prevention procedures (ACCT) were lower than in comparator prisons. The quality of ACCT documents varied and too many lacked consistent case management, were insufficiently multidisciplinary and had inadequately completed caremaps.

### **Independent Monitoring Board**

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The IMB annual report for 2014 noted that the healthcare providers had changed, which had led to some improvements, including better healthcare involvement in ACCT procedures. The Board reported that the prison had a positive suicide prevention policy. Overall, the Board concluded that staff at Liverpool provided a high standard of professional care, despite difficult circumstances.

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

17. Since 2013, we have investigated nine deaths at Liverpool, three of which were self-inflicted. We identified shortcomings in ACCT procedures in investigations into the deaths of two men in March and April 2014. In one of the investigations, we were concerned that reception staff did not effectively identify risk of suicide and self-harm. This investigation found that the prison had failed to deliver the actions they had identified in response to previous recommendations.

### **Assessment, Care in Custody and Teamwork**

18. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

19. 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. 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.
20. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011

## KEY EVENTS

21. On 4 November 2014, the man was remanded to HMP Liverpool charged with assaulting his partner and criminal damage. This was not his first time in prison. Police custody staff recorded on the man's person escort record (PER), which went with him from the police station to court and on to the prison, that he suffered from depression and had taken an overdose two years earlier.
22. A Supervising Officer (SO) was in charge of the prison reception when the man arrived. The SO recorded that the man was not happy at being in prison and said he had substance misuse problems.
23. The nurse recorded in the man's medical record that the man was tearful and emotional. He noted that the man had taken an overdose in the past week, but said that he had no concrete plans to harm himself. The nurse referred the man to the prison doctor.
24. The nurse was concerned about the man's recent overdose, low mood, depressive illness and alcohol withdrawal. At around 5.00pm, the nurse began Prison Service suicide and self-harm prevention procedures, known as ACCT.
25. The SO saw the man again and completed an ACCT immediate action plan and instructed staff to check the man once an hour. The SO recorded that the man had been offered access to Listeners (prisoners trained by the Samaritans to support other prisoners in distress) a telephone call to his family and the Samaritans.
26. A substance misuse nurse, recorded that the man drank a bottle of vodka every day. He was sweating, had a tremor and was mildly anxious, which are signs of alcohol withdrawal. The nurse referred the man to the prison doctor.
27. The doctor saw the man at around 6.00pm and recorded that the man was feeling low and suicidal. The man's community GP had previously prescribed sertraline (an antidepressant) but had stopped the prescription because of the man's alcohol abuse and attempted overdose the previous week. The doctor noted that the man had attempted suicide several times (although he did not record any further details). He diagnosed the man with depression and prescribed 50mg sertraline daily. The doctor started the man on an alcohol detoxification programme and prescribed chlordiazepoxide. He referred the man to the mental health team for an assessment. The doctor did not make an entry in the ACCT record.
28. The man shared a cell on A Wing, the prison's induction wing, rather than H Wing, the drug detoxification wing, where new prisoners undergoing alcohol detoxification usually go if there is space. As part of his alcohol detoxification programme, a member of healthcare staff checked him for symptoms of

alcohol withdrawal twice a day, until 7 November. After receipt of the initial report, NOMS commented that all new receptions including those on alcohol detoxification reside on A wing while being inducted. They are transferred to H wing after induction.

29. At around 11.55am on 5 November, the officer assessed the man as part of the ACCT procedures. The man said that he had committed the offences because of problems in his personal life. He said he felt low, tearful and depressed and was withdrawing from alcohol. He told the officer that he had taken an overdose of antidepressants a fortnight before his arrest, because of the stress of his charges, problems at work and family issues. (Both the nurse and doctor had recorded that the man had taken an overdose one week earlier.) The man said he had previously attempted suicide by hanging, taking an overdose and cutting his wrist, but did not say when. The man said he drank excessively, which contributed to his low mood. He said he had no current thoughts of suicide or self-harm.
30. The man said that he had children, but he was not allowed to see them. He said he realised that his actions would have an impact on them, and that this would stop him from taking his life. He said he was arranging to get support in the community for his alcohol and family issues.
31. At around 3.10pm, a prison's substance misuse worker assessed the man. She recorded that the man was feeling depressed and was tearful throughout their meeting. Although the man said he felt low, he said he had no current thoughts of suicide or self-harm. The substance misuse worker completed an initial assessment, and she and the man agreed that he needed to be referred to the prison's mental health service and, on release, to community-based drug and alcohol misuse services. They agreed that the man needed ongoing support from Lifeline while he was in prison.
32. At 4.30pm, a custodial manager, chaired the man's first ACCT case review with the SO. The custodial manager recorded that no one from the healthcare team was available to attend (a mandatory requirement for the first ACCT case review). The custodial manager noted that the man was still quite low and undergoing alcohol detoxification. The man said he had no thoughts of self-harm. The man was not allowed to contact his partner due to the nature of the charges against him, but the custodial manager said that staff could contact his stepfather on his behalf, the next day, if he needed support.
33. The staff assessed the man's risk of harm to himself and likelihood of further risk behaviours as raised (on a scale of low, raised or high). They agreed that staff should record one meaningful interaction with the man during the morning, afternoon and evening. Night staff were required to record a meaningful interaction with him at the beginning of the night duty, then check the man once an hour. The custodial manager recorded that staff should hold a second case review the next day, which healthcare staff should attend. The custodial manager did not record any actions on the ACCT caremap (the plan of care, support and intervention) to help reduce his risk.

34. On the afternoon of 6 November, the substance misuse worker saw the man again. She recorded in the ACCT record that the man was still low in mood and withdrawing from alcohol, but he reported no thoughts of self-harm.
35. The SO chaired the man's second case review that afternoon, which the substance misuse worker and the nurse attended. The SO recorded that the man was withdrawing from alcohol. He said that he had thoughts of harming himself when he was intoxicated, but had not had any such thoughts since he had been in prison. The SO recorded that the man was working closely with Lifeline. The man said that he was still anxious, but felt more settled as each day passed. The review now assessed the man's level of risk of suicide as low and reduced the required frequency of checks to four times during the day and four times at night. The nurse noted in the man's medical record that he felt better now he was not drinking.
36. On 7 November, the SO wrote two actions in the ACCT caremap. He noted that the man was suffering alcohol withdrawal and that the substance misuse worker would refer him to Addaction (a community substance misuse service) for support when he was released. The SO also noted that the man was having trouble sleeping and needed to discuss this with the doctor. That day, the man moved to a shared cell on H Wing, the detoxification wing.
37. On 14 November, a mental health nurse, assessed the man. She recorded that he had had numerous issues in the past, including child abuse and bereavements. The man said he had attempted suicide three times between 2010-14, including two overdoses and an attempted hanging. He said he had no current thoughts of suicide or self-harm, as he could not be bothered. The man told the mental health nurse that he was not sleeping well and did not think the sertraline was working. He said that he was due to appear in court by video-link on 18 November. The mental health nurse noted that the prison's crisis intervention mental health team would continue to offer the man support.
38. Later on 14 November, an SO chaired the third ACCT case review with the mental health nurse. The man said he still felt very low, but had no immediate thoughts of self-harm. The SO and the mental health nurse concluded that the man's risk remained low. The SO updated the caremap and noted that the substance misuse worker had referred the man to Addaction in case he was released after the video-link court appearance. She also noted that the man was waiting for a doctor's appointment. (The man did not see a doctor before he was released on 2 December.)
39. On 18 November, the mental health nurse tried to see the man but he was appearing at court by video-link at the time. (The court adjourned the man's case that day.) The next day, 19 November, the substance misuse worker reviewed his progress with him. She recorded that the man had no thoughts of suicide or self-harm, but he was frustrated that his court case had been adjourned. This was the last time the substance misuse worker saw the man. On 20 November, the man moved to F Wing, a standard prison wing.

40. On 27 November, another SO chaired the fourth ACCT case review, with a nurse. The SO recorded that the man had talked about his recent overdose, his offences and his drinking habits. He said that he was not happy with his medication. The review assessed the man as low risk. The SO did not update the caremap.
41. On 2 December, the man appeared at court by video-link. The court sentenced him to 18 weeks in prison, suspended for two years, and imposed a restraining order, ordering him not to contact his partner, the victim of his offences. He was released from prison that day.
42. On 3 December, the man was arrested for breaching the restraining order. The man's brother told us that the man's partner had originally told him that, when he was arrested, the man had threatened to kill himself. The Detective Sergeant from Merseyside Police told the investigator that the police who arrested the man were wearing body cameras. She said that the footage of the arrest did not record the man threatening to kill himself. In her statement to the police, the man's partner said she did not hear him threaten to kill himself.

#### **4 December 2014**

43. On 4 December, the man was sentenced to 30 weeks (210 days) in prison. Court custody staff completed a suicide and self-harm warning form noting that the man had taken an overdose five weeks earlier. The man told court custody staff that he felt okay, but they noted that he was very upset about going to prison again. At 12.33pm, Merseyside Probation Trust faxed a suicide risk form to the police and the prison. The probation officer wrote that the man had depression but was not taking any medication and had 'poor emotional wellbeing'. The probation officer said that court custody staff were keeping an eye on the man because of his demeanour since being sentenced to prison. The probation officer recorded that the man was a perpetrator of domestic violence, with mental health and alcohol misuse problems and posed a high suicide risk. The prison told the investigator that reception staff would have received the fax but there is no evidence that anyone in reception read the fax and no one referred to it in their assessments.
44. An SO was in charge of reception that day. He told the investigator that he remembered seeing the suicide and self-harm warning form, which court staff had completed, but could not specifically recall dealing with the man. He signed the warning form to record that he had seen it. The SO said he did not check the man's prison record on the computer when he first saw him, which would have shown that the man had been managed under ACCT procedures when he was released from Liverpool two days earlier. The SO said he did not consider opening an ACCT because he only saw the man for a couple of minutes and said that other officers working in reception would be better placed to access his risk of suicide and self-harm.
45. A nurse signed to say that she had seen the suicide and self-harm warning form. She wrote in the man's medical record that he was a heavy drinker, and

was prescribed sertraline, which he did not think was working. The man said that he had taken an overdose five weeks earlier. He said that he had issues with his family, was not able to see his children and had suffered bereavements. The nurse wrote that the man was tearful but said he would not try to harm himself, because of his children. The nurse noted that the man needed a mental health assessment and to see a doctor to review his medication. The nurse told the investigator that she did not think that she needed to open an ACCT. She said that she did not know that the man had been released from Liverpool two days earlier or that he had been on an ACCT until his release.

46. Lifeline staff do not have access to SystmOne, the computerised prison medical record, and are unable to record their interactions with prisoners on SystmOne. This meant the nurse, had she checked, would not easily have been able to identify the man's previous engagement with Lifeline and advise Lifeline staff that the man was in the prison again. Although the nurse knew that the man was a heavy drinker, she did not refer him to Lifeline for support. The substance misuse worker told us that she did not know the man had come back to the prison.
47. The officer completed some reception processes and documents with the man. The officer said that he saw the suicide and self-harm warning form but said that the man did not come across as low or depressed. He therefore did not open an ACCT. The officer said that he usually looked at the prisoners' records before seeing them, but he did not know the man had been on an ACCT until his release, which was clearly noted. He assessed the man as suitable to share a cell, and the man went to a shared cell on A Wing.
48. On 13 October 2014, the Governor had issued a Notice to Staff (GNTS 202/2014 ACCT Procedures - Reception). The notice instructed staff to begin ACCT monitoring again if a prisoner who had been released when he was on an ACCT, returned to prison. The officer said that, on 4 December, he was unaware of this instruction. No one in reception assessed the man as at risk of suicide or self-harm and no one opened an ACCT.

## **5 December 2014**

49. On the morning of 5 December, a safer custody officer, discovered that the man had returned to Liverpool. The safer custody officer knew that the man had been released on 2 December, still subject to ACCT procedures. The safer custody officer noted that reception staff had asked the man about his history of self-harm and considered his risk, but had not opened an ACCT, contrary to local instructions. The safer custody officer obtained the man's previous ACCT record and gave it to an SO, on A Wing.
50. The custodial manager responsible for reception, emailed reception staff that morning to remind them that if a prisoner was released on an open ACCT, the ACCT must be re-opened as soon they return to custody regardless of the amount of time they had been released.

51. At 2.40pm, the SO held an ACCT case review with the man with no one else present. The SO recorded that healthcare staff were unable to attend, due to staffing levels. The SO recorded that she had spoken at length to the man about the ACCT being re-opened. He told her he had no current thoughts of suicide or self-harm and was disappointed that he was being monitored under ACCT procedures again. The SO assessed the man's level of risk as raised. She instructed staff to check the man four times during the day and four times through the night until a full review, attended by healthcare staff, was held the next day. The SO did not add any new caremap actions.
52. At around 10.00am on 6 December, the man moved to I Wing (a standard residential wing). At 11.15am, another SO held another case review with a nurse. Neither the SO nor the nurse had met the man before. The man said that his primary concerns were having contact with his children, depression and problems sleeping. The SO noted that the man was due to see a doctor the following week to discuss his medication. He recorded that he had advised the man to contact his solicitor about access to his children. The man said that he had no thoughts of ending his life. The review assessed the man as at raised risk of suicide and self-harm and concluded that the ACCT should remain open. The SO added one action to caremap, noting that the man had depression and that the nurse would refer him to the mental health team and for a medication review. The next case review was scheduled for 15 December. The level of observations remained at four times during the day and four times at night.
53. At around 7.30pm on 7 December, the officer answered the man's cell bell and found him in a distressed state. The man had made superficial cuts to his arm and tied a small noose to the bed. The assistant night orderly officer, Officer, attended with a nurse who examined the man. The nurse recorded that the man did not need any treatment as the cuts were not serious. The nurse did not make an entry in the ACCT document. Staff moved the man to a care suite, with two Listeners, for the rest of the night.
54. At around 9.00am on 8 December, another mental health nurse, assessed the man. The nurse made a detailed entry in the man's medical record and a brief note of their conversation in the ACCT record.
55. The man told the nurse that, for the past two years, he had been treated for depression. The man said he believed his low mood dated back to his childhood when he had been bullied. More recently, deaths of family members and friends had left him unable to resolve his feelings of grief. The man said he was currently feeling really down and had never felt like this before. He said he was anxious and tired, and sometimes cried for no reason. The man said he had taken an overdose around nine years ago and had recently overdosed on medication and vodka, and had tried to hang himself. The man said he had cut his wrists about six months previously, and again during the night of 7 December. He said that he had had enough and could see no way out of his predicament.

56. The man told the nurse that he had been violent towards two partners and that, as a result, he had no contact with four of his children. He was worried that his most recent offences meant that his current relationship was over, which would make contact with his other two children difficult. The nurse recorded that he and the man had agreed that the man should see a prison doctor to review his medication; engage in talking therapy (although the man said that he preferred his condition to be managed by medication); and that he would continue to be supported by the mental health team.
57. The SO and nurse held an interim ACCT review with the man at around 10.00am, after his self-harm the previous night. The man said that he felt better, but wanted to be out of his cell as much as possible and asked for any available work. The SO did not update the man's caremap or record what action staff should take to find the man work. The SO and nurse assessed the man as at raised risk of suicide and self-harm but did not alter the frequency of checks, which remained four times during the day, and four at night. The next case review was still scheduled for 15 December.
58. That afternoon, the man saw the doctor who prescribed zopiclone (sleeping tablets) because the man said he had trouble sleeping. The doctor recorded that the man was on an ACCT, maintained good eye contact but appeared low and said he felt distressed. He said he had had suicidal thoughts. The doctor prescribed sertraline again and wrote that a doctor should review the man within two weeks. The doctor did not make an entry in the man's ACCT record.
59. There were very few entries in the man's prison record. The man did not make any telephone calls and did not receive any mail. On 11 December, the officer noted that the man had started work that day in the leather workshop. The officer recorded that the man had been keen to work full time, but could not as he was also attending education sessions. This was the last entry in the man's prison record.
60. At 10.30am on 15 December, the SO recorded that he was unable to hold the planned ACCT case review because there were no healthcare staff available to attend. The SO noted that the case review would be held the next day, although there is no record that he had arranged with any member of healthcare staff that they would be able to attend. The SO recorded that the man was okay and coping.
61. The SO told the investigator that senior managers had told supervising officers that there were staff shortages in the healthcare department that day. He left a note for another supervising officer to hold the case review the next day.
62. At 12.25pm, an officer recorded in the ACCT document that the man had collected his meal and reported no problems. At 6.00pm, the SO recorded that the man had collected his evening meal and had spent time out of his cell during the association period (when prisoners are free to mix with each other).

When the SO asked how he was, the man said he was fine. In her entry at 8.15pm, the officer recorded that the man was okay.

#### **16 December 2014**

63. The officer recorded in the ACCT document that she had checked the man at midnight, 3.00am and 6.00am on 16 December. The officer checked him again at 7.40am. Each time, the man seemed to be asleep.
64. At about 10.40am, another officer spoke to the man and his cellmate. In a statement she made after the man's death, the officer said that the man was lying on his bed and said that he was okay, when she asked him how he was. Officer Stevenson left their cell door open as the man's cellmate was moving out to share a cell with his son.
65. At 10.50am, the officer noted in the ACCT record that the man was outside his cell while the man's cellmate moved out and that he had said he was okay. The officer noted that a prisoner from another wing would be moving in with the man that afternoon.
66. The man's cellmate told the investigator that, as he was moving out of the cell, he told the man that he would be getting a new cellmate. The man had told him that he would prefer to be on his own. The man's cellmate said that the man had always seemed very stressed. He found him difficult to talk to, said the man chain-smoked, paced up and down their cell, kept trying the door handle and peeled paint off the cell walls. The man's cellmate said he did not think the man had changed his clothes or had a shower in over a week. Sometimes he wore all his clothes and his shoes to bed at night. Prisoners in the nearby cells told the investigator that the man kept to himself and did not talk to them. The man's cellmate said the man's behaviour on the day he died was no different from previous days.
67. At about 11.00am, the officer started locking prisoners back into their cells. The man had not gone to work that morning because many prison staff were attending a colleague's funeral. The man's was the first prisoner he locked up. The officer said that before he locked the door, he asked the man how he was feeling. The man said he was okay.
68. At around 11.30am, two officers started unlocking prisoners on I Wing for lunch. One officer unlocked the man's cell and found he had hanged himself by a ligature made from bedding attached to the toilet door. The officer called the other officer for help. When the officer reached the cell, he found the other officer supporting the man's body. The officer, who was not carrying a radio shouted to other staff and the officer and SO, who were both on I Wing, responded.
69. At 11.31am, someone radioed a code blue emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing). Control room staff immediately called an ambulance.

70. Two officers helped support the man's body, while the other officer cut the ligature. The officers lowered the man to the cell floor and the officer and the SO started cardiopulmonary resuscitation. Two nurses arrived and attached a defibrillator (a life saving device that gives the heart an electric shock to restart the heart rhythm in some cases of cardiac arrest). The defibrillator found no shockable rhythm and the staff continued the resuscitation attempt.
71. An ambulance arrived at the prison gates at 11.36am. Paramedics reached the man's cell at 11.45am, and took over emergency treatment. (The paramedics reported that they had been delayed by the number of gates they had to pass through once inside the prison.) At 12.20pm, the paramedics pronounced that the man had died.
72. After the man's death, officers found a letter in his cell addressed to his partner. In the letter, the man said how much he wanted to change, and asked for forgiveness. He said that he had tried to kill himself several times and could see no point in carrying on without her and their children.

### **Contact with the man's family**

73. The man had named his stepfather as his next of kin. After the man's death, one of the prison's family liaison officers, a chaplain and the Governor went to the man's stepfather's house during the day but he was not at home. They went back at 4.30pm, and informed him that the man had died and offered their condolences. The family liaison officer saw the man's brother and stepfather again on 17 December. The prison contributed to the costs of the funeral, in line with Prison Service guidance.

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

74. After the man's death, the governor debriefed the staff involved in the emergency response, and the prison's care team offered support. He issued notices to staff and prisoners informing them of the man's death. Officers and members of the chaplaincy team supported prisoners. Staff reviewed all prisoners who had been assessed as at risk of suicide and self-harm, in case they had been adversely affected by the man's death.

### **Post-mortem report**

75. A post-mortem examination recorded the man's cause of death as hanging. Toxicology tests found no trace of alcohol or any commonly misused drugs in the man's bloodstream.

## FINDINGS

### Assessing the man's risk of suicide and self-harm on arrival

76. Prison Service Instruction (PSI) 64/2011, covering safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. The man had a number of these risks. He was in the early days of custody, had previously attempted suicide, was charged with a violent offence against his partner, and had a history of mental health and substance misuse problems. All staff should be alert to the increased risk of suicide and self-harm posed by prisoners with these risk factors and appropriately address any concerns, including beginning suicide and self-harm prevention procedures if necessary.
77. When the man first arrived at Liverpool on 4 November, the nurse who saw him in reception, rightly identified him as at risk of suicide and self-harm and opened an ACCT. The ACCT remained open until the man was released on 2 December.
78. The man returned to Liverpool on 4 December. Court custody officers had completed a suicide and self-harm warning form because of the man's demeanour at court, and because he had taken an overdose five weeks earlier. In addition, a member of probation staff had faxed a suicide risk form to the prison, before the man arrived, noting that he was at high risk of suicide. Despite these warnings, and the man's existing risk factors, reception staff concluded that the man was not at risk of suicide or self-harm.
79. Prison Service Instruction (PSI) 74/2011 (the relevant instruction at the time) about early days in custody, sets out mandatory reception procedures. It says 'The PER and any other available documentation including Suicide & Self Harm Warning Forms, ACCT documents and CSRA assessments, must be examined, and the prisoner interviewed in reception, to assess the risk of self-harm or harm to others by the prisoner, or harm from others.' PSI 64/2011, specifically states as a mandatory action that, "Any member of staff who receives information, including that from family members or external agencies, or observes behaviour which may indicate a risk of suicide/self-harm must open an ACCT by completing the Concern and Keep Safe form."
80. As reception staff did not act on the suicide and self-harm warning form, or the faxed warning from probation highlighting the man's risks, we do not consider that the prison complied with these instructions. We also note that reception staff did not follow Liverpool's own local procedures and open an ACCT, as the man had been released while he was being monitored under ACCT procedures. Reception staff said that they were not aware of the local instruction at the time.
81. In response to a previous recommendation about failures to identify risk in reception, the prison said they had introduced a pro forma to ensure suicide warnings are logged on receipt by the reception SO and then signed for on handover to healthcare staff. At the end of the shift, the SO and healthcare

staff would conduct a cross reference check of warnings to confirm what actions were taken in each case and it would be documented on the prisoner's record if they had made a decision not to open an ACCT. There is no record this was done. The deficiencies in assessing the man's risk in reception demonstrate a need for improved procedures, which all staff understand and follow. We make the following recommendation:

**The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:**

- **Have a clear understanding of their responsibilities and the need to record relevant information about risk.**
- **Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and suicide risk warnings from external organisations.**
- **Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.**

### **Management of the ACCT process**

82. The man was monitored under ACCT procedures for almost the whole time he was at Liverpool. We have some concerns about how effectively the prison managed the ACCT process.

#### *Frequency of observations*

83. On 5 November, the man's first full day at Liverpool, staff assessed his risk of suicide and self-harm as raised. The custodial manager, who chaired the first case review, instructed staff to record one meaningful interaction with the man in the morning, afternoon, evening and at the beginning of the night duty. Night staff were instructed to check the man once an hour. The next day, at a second case review, staff decided that the man's risk was now low and reduced the frequency of checks to four times during the day and four times at night. When staff began ACCT monitoring again on 5 December, they assessed the man as at raised risk, yet the frequency of checks remained four during the day and four at night.
84. We do not consider that staff appropriately assessed the man's level of risk, or that the level of observations reflected that risk. On 6 November, a review reduced his risk to low, yet there had been no real change in his risk factors since the day before, when the ACCT was opened, and his risk was assessed as raised. The frequency of checks set on 5 November, or on 5 December when staff regarded his risk of suicide and self-harm as raised, was too low to reflect that risk. The level of observations set on 5 December, was identical to the level when his risk was assessed as low. We are also concerned that

there is little evidence from the ACCT records that staff actively attempted to engage with the man. Most of the entries were observational and did not indicate much attempt to engage with the man and try to understand what he was thinking or feeling.

### *ACCT reviews*

85. PSI 64/2011 requires that a member of the healthcare team attends the first ACCT case review, and that, thereafter, case reviews are multidisciplinary whenever possible. The custodial manager noted that no one from the healthcare team could attend the first case review on 5 November. The SO noted the same on 5 December and the SO decided not to hold a case review on 15 December, because no one from the healthcare team could attend.
86. As the ACCT case managers did not record the steps they had taken to ensure healthcare representation at reviews, it is difficult to know if this was a general problem at Liverpool at the time. However, on 15 January 2015, the Governor issued a Notice to Staff (8/2015) informing staff that Mersey Care (one of the healthcare providers) was introducing a diary booking system to co-ordinate healthcare staff attendance at case reviews.
87. The substance misuse worker, a substance misuse worker with Lifeline, attended one review during the man's first stay at Liverpool. The substance misuse worker did not know that the man had returned to prison on 4 December and was not involved in any other case reviews before his death. It is unfortunate that, although the man linked his thoughts of suicide with his problematic use of alcohol, no one thought to invite the substance misuse worker to the later case reviews. PSI 64/2011 suggests that multidisciplinary case reviews include "any other member of staff who has or will have contact with the at-risk prisoner and who can contribute to their support and care" and includes substance misuse workers
88. The SO postponed a scheduled case review on 15 December because no one from the healthcare team could attend. He said that he left a note for the supervising officer on duty the next day, asking her to hold one but he did not make an entry in the wing observation book. There is no evidence that he had arranged that a member of healthcare staff would attend an ACCT case review on 16 December, and no evidence that anyone had arranged one before 11.31am, when an officer found the man hanged. We do not consider that ACCT case reviews were effectively planned to ensure appropriate multidisciplinary attendance of those involved in the man's care.

### *Caremap*

89. PSI 64/2011 requires caremaps to reflect the prisoner's needs, level of risk and the triggers of their distress. Caremaps should aim to address issues identified in the ACCT assessment interview and consider a range of factors including health interventions, family contact, peer support, location, provision of diversionary activities, including occupations in cell and access to gym and other activities. Each action on the caremap must be tailored to meet the

individual needs of the prisoner, be aimed at reducing risk to themselves and be time bound.

90. Although the man was monitored under ACCT procedures for a month, and had five case reviews, his caremap contained only three entries. The actions were broad and focussed only on health interventions for alcohol detoxification, depression and sleep problems. There were no actions about helping the man address his family problems, which he indicated were a major source of anxiety, or reflecting that he wanted to work in prison. (Although the latter issue appears to have been addressed without a caremap action.)
91. Guidance in the ACCT document notes that effective case reviews have the same case manager present, wherever possible. We are concerned that the man had five different case managers in a month, and there was no consistency in the staff who attended to provide continuity of care. We are also concerned that the healthcare staff who had contact with the man did not usually record details of their interactions with him in the ACCT document. . We make the following recommendation:

**The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including:**

- **Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care;**
- **Having consistent case management and attendance where possible;**
- **Considering all known risk factors when determining the level of risk of suicide and self-harm;**
- **Setting appropriate levels of observations to reflect identified risk;**
- **Ensuring that all staff record interactions in the ACCT record;**
- **Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which identify who is responsible for them.**

#### **Decision to move the man's cellmate**

92. On the morning of 16 December, the man's cellmate moved out of the cell leaving him in the cell on his own. Staff intended that this would be for a short time and that another prisoner would move into the cell, later that afternoon.
93. However, the man was being managed under ACCT procedures and regarded as at raised risk of suicide and self-harm. There is no evidence in his ACCT document that anyone noted that the man was now the sole occupant of the cell or considered that this was a change in circumstances, which might affect the level of risk. Staff decided it was reasonable to leave the man alone in the cell until he got a new cellmate later that afternoon.

94. We accept that there will inevitably be occasions when prisoners at risk of suicide and self-harm, who usually share a cell, are left alone in their cells. However, where possible, this should be avoided. The man's cellmate could have moved his possessions to his new cell but stayed in the cell with the man until a new cellmate arrived. Staff should also have considered whether the man's risk needed to be re-assessed or whether the level of observations needed to be increased while he was alone in the cell. We make the following recommendations:

**The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells, are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.**

### **Clinical care**

95. The clinical reviewer concluded that, overall the clinical care the man received at Liverpool was comparable to that he might have received as a patient in the community. He identified some areas for improvement in the delivery of healthcare services, which the Head of Healthcare will need to address. As they are not directly related to the man's death, we do not repeat them in this report.
96. The clinical reviewer considered that the care provided by the mental health team at Liverpool was of a good standard and Lifeline's drug and alcohol services were delivered in a responsive and professional manner. However, the substance misuse worker, the man's primary contact with Lifeline, said that she did not know that the man had returned to the prison on 4 December. The clinical reviewer considered this was a missed opportunity to engage the man in further support for his alcohol use.
97. Lifeline staff do not have access to prisoners' electronic medical records and cannot make entries in them. This meant that general healthcare staff had no information about the support the substance misuse worker had given the man. Had healthcare staff who saw the man after 4 December realised that he had previously worked with Lifeline, they might have referred him back to them. However, entries from November 2014, detailed the man's alcohol misuse and subsequent detoxification. We are surprised that no healthcare staff thought to re-refer the man to Lifeline in December.
98. According to the NHS Code of Practice, the primary function of medical records is to support patient care. The medical record should be the primary record of care for a prisoner and should have all available medical information including any history, observations, interventions and medication to ensure a comprehensive record. Medical records should be available to all healthcare and related staff regardless of whether they are primary or secondary care. We recommend:

**The Head of Healthcare should ensure that all relevant staff, including the Lifeline team, have appropriate access to prisoners' medical records and that they are used as the primary record for all medical care.**

### **Emergency response**

99. The control room logged that they received an emergency code blue at 11.31am, and immediately called an ambulance. The control room made a second call at 11.32am to confirm the ambulance was on its way.
100. The ambulance arrived at the prison gates at 11.36am, but the paramedics did not reach the man's cell until 11.45am, nine minutes later. PSI 3/2013 sets out how a prison should respond to a medical emergency. It requires that every prison should develop a protocol with the local ambulance service, which ensures, among other things, that there is no unnecessary delay in escorting ambulances and paramedics to the patient and discharging them from the prison. Liverpool's related Governor's Order reminds the control room to inform the prison gate to ensure fast entry into the prison.
101. We consider that nine minutes is too long to get paramedics from the prison gate to a cell in a medical emergency. We understand that the delay in this case would not have affected the outcome for the man, but in other emergencies such as delay could be critical. Paramedics said that they were delayed by the number of gates and the prison needs to ensure there are effective contingency arrangements to get paramedics to a prisoner without delay in a life-threatening situation. We make the following recommendation:

**The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.**

**Action Plan**

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	<p>The Governor should ensure that there are effective operating procedures in reception and that all staff understand the procedures for identifying prisoners at risk of suicide and self-harm and for managing and supporting them. In particular, staff should:</p> <ul style="list-style-type: none"> <li>▪ Have a clear understanding of their responsibilities and the need to record relevant information about risk.</li> <li>▪ Consider and record all the known risk factors of newly arrived prisoners when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms, PERs and suicide risk warnings from external organisations.</li> <li>▪ Open an ACCT whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors, irrespective of their stated intentions.</li> </ul>	Accepted	<p>A pro forma has been introduced to ensure suicide warnings are logged on receipt by the reception supervisory officer and then signed for on handover to healthcare staff. At the end of the shift the supervisory officer and healthcare staff conduct a final cross reference check of warnings to confirm what actions were taken in each case.</p> <p>The Governor will commission a project to review and implement improvement to reception procedures in partnership with Lancashire Care Foundation Trust (LCFT) to address this concern. We will focus on ensuring that there is a defined pathway for the handling of suicide and self-harm markers. We will implement a role brief for supervisory officers to ensure that there is consistency in the management of risk.</p> <p>We will liaise with other establishments to identify best practice in the reception interview process in order to determine where the healthcare assessment fits best in the process and to reduce reliance on it.</p> <p>All staff working in reception and first night have received written advice on being alert to the presence of risks and triggers and to open an ACCT in all cases in</p>	<p>Completed</p> <p>1/12/15 Operations Completed May 15</p> <p>Completed 25/7/15</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>which there are concerns.</p> <p>A Governor's Notice to Staff (GNTS) will be issued bi-annually to raise awareness of risks and triggers amongst staff.</p>		
2	<p>The Governor and Head of Healthcare should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national instructions, including:</p> <ul style="list-style-type: none"> <li>▪ Holding multidisciplinary case reviews which include all relevant people involved in a prisoner's care.</li> <li>▪ Having consistent case management and attendance where possible.</li> <li>▪ Considering all known risk factors when determining the level of risk of suicide and self-harm.</li> <li>▪ Setting appropriate levels of observations to reflect identified risk.</li> <li>▪ Ensuring that all staff record interactions in the ACCT record.</li> <li>▪ Setting effective ACCT caremap objectives which are specific and meaningful, aimed at reducing a prisoner's risk, include issues of family contact where relevant and which</li> </ul>	Accepted	<p>The Governor will commission a project to review our case management process and to introduce an allocated case manager for each ACCT. The project will determine how we can best deliver this change to our practices within the resources available. This will deliver consistency and improve the quality of the ACCT process. We will also seek a solution to improve the delivery of high levels of observations when prisoners are located on residential units.</p> <p>We now have a mental health team who are responsible for attending all ACCT reviews.</p> <p>HCC follow pathways to ensure the process for booking appointments are adhered to and participate in the MDT approach to the review process.</p> <p>A quality assurance process has been implemented to review care map actions. A daily briefing sheet which is issued to all staff includes guidance on what constitutes a quality entry.</p>	<p>1/12/15 Residence Safer Custody</p> <p>Completed Feb 15</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	identify who is responsible for them.				
3	The Governor should ensure that, where possible, prisoners assessed as at risk of suicide and self-harm, who usually share cells, are not left alone for extended periods without a documented review of the risk and a consideration of other options to help protect the prisoner.	Accepted	A GNTS will be published to remind staff of this requirement. Where prisoners on an ACCT are in single accommodation the ACCT will acknowledge that the risk has been assessed.	30/9/15	
4	The Head of Healthcare should review the management of health records to ensure all relevant staff, including the Lifeline team, have appropriate access to prisoners' medical records and that they are used as the primary record for all medical care.	Accepted	Since June 15 LCFT have moved to an integrated model of healthcare provision, and now provide all healthcare services. Lifeline staff have access to System One, ensuring that all patient records are being stored on one system.	Completed June 15 LCFT	
5	The Governor should ensure that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.	Accepted	It is recognised that 9 minutes was too long for the paramedics to get from the gate to the cell in this case. A protocol is in place with the North West Ambulance Service (NWS) which includes the security measures that must be followed. The protocol has been reviewed recently to ensure that all necessary steps are taken to ensure a speedy passage through the gate and into the prison.		