



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man
at HMP Liverpool on 21 March 2014**

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 investigation report into the death of a man, who was found hanged in his cell at HMP Liverpool on 21 March 2014. He was 36 years old. I offer my condolences to the man's family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care in prison. The prison cooperated fully with the investigation.

The man had been in prison for three years and had been managed under suicide and self-harm procedures on nine separate occasions. The most recent period began at HMP Lindholme in November 2013, when he had cut himself and nearly died. In January 2014, while the man was still being monitored as at risk of suicide and self-harm, he transferred to HMP Altcourse, to attend a trial and then went to HMP Forest Bank where he spent one night, before finally moving to HMP Liverpool on 13 February. These moves did not help continuity of care. The man continued to be managed under suicide and self-harm prevention procedures at Liverpool. In the early hours of Friday 21 March, an officer was unable to observe the man as he had covered his cell observation panel from the inside and he did not respond. The officer called for help and when staff opened his cell they found the man had hanged himself. Staff found letters in the man's cell indicating his intention to kill himself.

The man was not referred for a mental health assessment when he first arrived at Liverpool as we would have expected. When a referral was eventually made and considered, it did not take into account his risk of suicide and self-harm and only a low level intervention was proposed. A second referral was not actioned, as the team were severely understaffed. There is a complex model for the delivery of mental healthcare at Liverpool, which, in this case, appears to have led to some confusion and blurring of responsibilities for the man's care and I am concerned that this meant that the man never had a mental health assessment at the prison.

Ultimately, it is difficult to prevent someone who makes a determined decision to kill himself from carrying out that plan. It is apparent from the written messages that the man left behind, including to this office, that this was his clear intention. Nevertheless, the investigation found a number of areas for improvement in the operation of suicide and self-harm procedures at Liverpool which the prison needs to address. While in this case it did not lead to a delay, I am also concerned that staff at Liverpool did not follow the correct emergency response procedures.

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

November 2014

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SUMMARY

1. On 27 April 2011, the man was sent to prison for conspiracy to supply class A drugs and possession of a firearm. He was held at HMP Forest Bank before being transferred to HMP Buckley Hall and then to HMP Risley. The man cut himself frequently and was often supported by suicide and self-harm prevention procedures (known as ACCT).
2. In September 2013, the man moved to HMP Lindholme. In November, he cut his arm seriously. Staff began ACCT procedures and he was constantly supervised for the next three weeks. A mental health nurse saw the man regularly and identified three issues: alleged sexual abuse he suffered as a child; a forthcoming trial for an offence he had been charged with while in prison; and loss of contact with his children, who had been adopted.
3. In January 2014, the man transferred to HMP Altcourse for his trial. He had cut himself to try to prevent the transfer but it went ahead. At Altcourse, nurses attended his case reviews but he was not under the care of the mental health team. He then alleged that two officers did not check him when they were supposed to. He moved to Forest Bank on 12 February while managers investigated his claims. (These were ultimately proven.) As the man had previously made allegations about staff at Forest Bank, he was then moved to HMP Liverpool the next day. The man needed to transfer from Lindholme to attend court, but we consider he could have remained at Altcourse while his complaints against staff were investigated.
4. When he arrived at Liverpool, the man was not referred for a mental health assessment. A drug counsellor and an ACCT case manager later referred him on two separate occasions, but the man had not had an assessment before he died. The first referral was not adequately considered and because of staffing shortages the second referral was not progressed. The complex structure of mental health services at Liverpool meant that nobody identified that the man had not been assessed.
5. Staff continued ACCT procedures at Liverpool but only the first review was multidisciplinary. No healthcare staff or staff from other disciplines attended the other five reviews. The risk factors that the man talked about at reviews were not formally recorded in the triggers section of the ACCT document. At three case reviews, including that of 19 March, two days before his death, the case manager reduced the frequency of checks without any evidence that the man's risk of suicide and self-harm had reduced.
6. At 2.40am on 21 March, the night patrol officer was concerned that the man had covered his cell door observation panel and he could not get a response from him. He summoned managers, who unlocked the door and found the man hanging. The emergency response was swift, but staff did not use the correct medical emergency response code. Resuscitation efforts were unsuccessful and at 3.26am paramedics pronounced the man dead.
7. We make seven recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Liverpool about the investigation. No one responded. The investigator visited Liverpool to begin the investigation on 26 March. On 13 and 14 May, the investigator and another investigator interviewed members of staff at the prison. The investigator gave verbal and written feedback to the Governor about the initial findings of the investigation. The investigator subsequently interviewed other members of staff by telephone.
9. A clinical reviewer reviewed the man's clinical care at the prison.
10. We have sent HM Coroner for the City of Liverpool a copy of this report.

The man's family

11. One of our family liaison officers contacted the man's mother and brother to explain the investigation process. They were concerned that the man had transferred between four different prisons in a short period while he was subject to suicide and self-harm procedures. We address this matter in the report.
12. We provided the man's mother and brother with the draft report of our investigation. They did not identify any factual errors and we have replied to their comments by separate correspondence.

HMP LIVERPOOL

13. HMP Liverpool holds approximately 1,400 men. The prison healthcare centre offers 24-hour inpatient care. A doctor is on duty during normal working hours and nurses and healthcare assistants are on duty 24 hours a day. Healthcare is delivered by two different providers. Mersey Care NHS Trust provide:
 - Primary Care Psychological Services, who offer limited time low level therapeutic interventions to deal with psychological distress
 - Community Mental Health In-Reach Team (CMHIRT), who treat patients with severe and enduring mental illnesses
 - Drug Dependency Unit, who provide treatment for prisoners with substance misuse problems
 - Forensic psychiatric team, who work with prisoners who have committed serious offences like arson or murder and have associated mental disorders
 - Criminal Justice Mental Health Liaison Team, who operate from the courts and visit prisoners on remand

14. Liverpool Community Health NHS Trust provide:
 - The Dual Diagnosis Team, who treat prisoners with both substance misuse and mental health problems
 - Mental Health Crisis Intervention Service, who see prisoners with immediate mental health needs; the team is normally staffed by three mental health nurses
 - Primary care nursing staff

15. Any prison or healthcare staff with concerns about a prisoner's mental health can fill in a single point of referral form. All new referral forms are discussed at the weekly single point of referral meeting, where prisoners are allocated to one of the teams depending on their needs.

Assessment, Care in Custody and Teamwork (ACCT)

16. ACCT is the Prison Service process for supporting and procedures prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Her Majesty's Inspectorate of Prisons

17. The last inspection of Liverpool was in October 2013, when inspectors found that too many prisoners felt unsafe. Relationships between prisoners and staff were generally good, but the prison environment required urgent improvement. Living conditions in some cells were unacceptably poor. Complaints were generally dealt with fairly and upheld where appropriate. The quality of ACCT documents was considered reasonable, but inspectors found that some ACCT case managers had not received case management training. (We also found an example of this during our investigation.) Mental health services were extensive and inspectors noted that discussions were underway to try to integrate the different services. Overall, inspectors identified steady if slow progress.

Independent Monitoring Board

18. 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 2012-2013 was very positive about mental health services at the prison, which had been at the forefront of many initiatives. The IMB noted that prison managers had coped well in the face of difficult circumstances and outdated Victorian buildings in need of constant repair. The IMB's main concern was the difficulties associated with mentally disordered prisoners.

Previous deaths

19. We investigated five deaths at Liverpool in 2012, five in 2013 and one in 2014 before the man died. The majority of these deaths were the result of natural causes. When we investigated the self-inflicted death of a man in January 2012, we identified the need to take into account further charges and court appearances as potential triggers for suicide. The man also had a forthcoming trial. In another investigation into the self-inflicted death of a man in August 2012, we noted that staff did not use the correct medical emergency response codes, which was also the case here.
20. In the investigation into the death of a man at HMP Preston in August 2012, who had previously been held at Liverpool, we identified shortcomings in ACCT procedures at Liverpool. We were critical of a lack of continuity of case management and a vague and unhelpful care map. We repeat some of those concerns.

KEY EVENTS

21. The man was remanded into custody at Rochdale Magistrates' Court on 27 April 2011 and taken to HMP Forest Bank. He had a history of heroin and crack cocaine use. On 10 August, he received an eight year prison sentence for possession of a prohibited firearm and conspiracy to supply class A drugs. The man made formal complaints about his treatment by staff at Forest Bank and instructed a solicitor in these matters. While these claims were being examined, he was transferred to HMP Buckley Hall on 28 September.
22. On 2 May 2012, the man cut his wrist with a razor blade. Staff managed the man under Assessment, Care in Custody and Teamwork (ACCT) procedures until 23 July. The man was upset about his children being adopted and the breakdown of his relationship. Staff began ACCT procedures again on 10 August, when the man made further cuts to his wrists.
23. As at Forest Bank, the man made dozens of applications and complaints to various departments at Buckley Hall. He was eventually restricted to making two a week.
24. The man made ten complaints about Buckley Hall to the Prisons and Probation Ombudsman. Four of these were not eligible for investigation, one was rejected, but the other five were partially upheld and resulted in action being taken. The man complained about a range of matters including his mail being opened by staff and the way the prison handled his complaints. The National Offender Management Service (NOMS) accepted our recommendations on behalf of the prison.
25. On 10 October, the man attended a hospital appointment and afterwards transferred to HMP Risley. He had been subject to ACCT procedures since August. Staff at Risley closed the ACCT on 15 October. On 23 October, the man was moved to a different unit after other prisoners became aware that his children were on the child protection register due to the man and his partner's neglect.
26. On 13 November, staff began managing the man under ACCT procedures for a third time when he cut his wrists after receiving a letter from social services about his children's adoption. He moved to a safer cell (designed to reduce the risk of hanging) for constant supervision for the first 24 hours. Staff closed the ACCT on 26 November, but opened a fourth ACCT on 28 November when the man made more cuts to his arms. Staff closed this ACCT on 6 December. A fifth ACCT was opened from 28 December until 6 January 2013 after the man told staff that he had self-harmed again.

2013

27. On 10 January 2013, staff opened another ACCT because the man said he was thinking about harming himself. On 14 January, the man was moved onto the basic level of the Incentives and Earned Privileges (IEP) scheme after submitting a large volume of complaints. Managers had previously

warned him to stop this because it was preventing them from doing their jobs properly. (Prison IEP schemes aim to encourage and reward responsible behaviour through different privilege levels which can be removed if the prisoner's behaviour deteriorates. The move to basic level, the lowest, for this reason appears inappropriate.) The man began to refuse food and asked that 'Do not resuscitate' be put on all of his records. On 23 January, staff moved him back to the standard level of the IEP scheme on the understanding that they would deal with only one complaint form at a time. The case manager closed the ACCT on 11 February.

28. The man had a seventh period of ACCT monitoring from 16 February until 24 April, after he had made superficial cuts to his leg. In May, staff suspected that the man was bullying other prisoners. They began anti-bullying procedures but found no evidence, so no further action was taken. The same month, the man alleged that a prison officer had assaulted him. (The police found this allegation was false and this resulted in a criminal charge of fraud by false representation against the man, which was still being dealt with at Chester Crown Court when he died.) In June, the man had a positive meeting with Rochdale Social Services about his children who had been adopted. Prison staff encouraged him to join offending behaviour programmes to complete his sentence plan, but he refused.
29. On 25 July, the man was placed on the basic regime level because of poor behaviour. He was managed under ACCT procedures for an eighth time from 25 July until 9 August after cutting his arm. He remained on the basic regime during this period. The man was very keen to leave Risley and, on 8 August, staff intercepted a threatening letter he was trying to send to his community offender manager in which he said that he would slit his own throat if he was not transferred. Staff spoke to him about this letter, but he said that he was not having any current suicidal thoughts. On 11 September, staff noted on the man's prison record that he had racist and homophobic attitudes.

HMP Lindholme

30. On 12 September, the man transferred to HMP Lindholme. A mental health nurse reviewed him when he arrived and found no evidence of psychosis or thought disorder. The man said that he had no thoughts of suicide or self-harm. The nurse saw the man again on 4 November and referred him to psychological services to help his low mood and anxiety. The man said he had been on hunger strike since 30 October and had lost several kilograms. However, at the time he was refusing meals only intermittently.
31. On 12 November, an officer found the man bleeding in his cell. He had made deep cuts to his left wrist and had lost five or six pints of blood. Staff called an emergency ambulance. The man was in a critical condition but still conscious. He said that he could not cope anymore and had intended to die. Staff opened another ACCT and the man had a blood transfusion in hospital. He was discharged from hospital the next day, 13 November, and was constantly supervised until 2 December.

32. During an ACCT assessment interview on 13 November, the man said that he had intended to end his own life. He explained that he had become upset after receiving two letters. One was from the police about their investigations into the man's allegations that he had been a victim of sexual abuse as a child. He had also received a letter from social services with an update about his own children, who were now adopted. He was also worried about his own forthcoming trial for false representation.
33. At the first ACCT review, the case manager drew up a care map with the following actions: ask the police to attend an ACCT review and explain the procedure for the prosecution of his alleged abuser; ask social services to provide updates and photographs of his children; and for the man to engage with the sentence planning process.
34. The man received intensive support and intervention in the next few weeks. He was refusing food intermittently and nurses encouraged him to eat properly. A member of staff from the chaplaincy team, held twice weekly sessions with him to help him cope with bereavement and loss.
35. A nurse from the mental health in-reach team regularly reviewed the man. She found no evidence of a psychosis or mood disorder, but considered that the man remained at high risk of serious self-harm and suicide. She wrote in his clinical record that all decisions at ACCT case reviews about the management of his risk and the frequency of observations should involve healthcare staff. At the time, the man was prescribed mirtazapine (an antidepressant), tramadol and gabapentin for pain relief and a reducing dose of methadone (an opiate substitute).
36. The nurse made detailed entries about the man's issues. He was preoccupied with his treatment at previous prisons. He said that he would kill himself if the Crown Prosecution Service decided not to press charges against his alleged abuser. He was unhappy with both his prison offender supervisor and his community offender manager, who he thought had written lies about him in their risk assessments. The man refused to engage with his offender manager and had sent her a threatening letter.
37. A public protection meeting was held at the prison to discuss the man's contact with his now adopted children. Rochdale Social Services agreed that the man could have photographs of his children. They also promised to inform the prison whenever a letter from one of his children was due to arrive. However, no further letters were anticipated for another year.
38. Case managers held six further ACCT case reviews in November. Although not formally recorded as enhanced case reviews, they were chaired by prison managers and staff from different departments attended. The man told the nurse that he might take his life at any time. He was negative and unmotivated and continued to complain about his treatment in prison. The man was referred to the Improving Access to Psychological Therapies (IAPT) team, but was considered unsuitable for treatment because he would not engage with them.

39. At the end of November, the Crown Prosecution Service informed the man that it was reviewing his claims of abuse. The case manager ended constant supervision at the eighth ACCT review on 2 December, and reduced the frequency of observations to five an hour. Staff held 12 further ACCT reviews in December, and reduced the frequency of observations to four observations an hour and then to two every hour during the day and at night and during patrol states when all prisoners are locked in their cells. The man stressed during ACCT reviews that staff needed to check him frequently and irregularly because not knowing when staff would check him was what stopped him from harming himself. He said he planned to harm himself at night when he knew that it took staff longer to respond. The nurse therefore advised against reducing the frequency of observations at night. During December, the man blocked the observation panel in his cell door during ACCT checks and obstructed the night light in his cell. At the end of the month, he made cuts to his arms.
40. The man submitted a formal complaint that the night patrol staff had not completed the required frequency of ACCT checks on 2, 3 and 5 December. The Head of Security began an enquiry on 10 December and interviewed the man on 18 December. At the end of December, the man moved wings after he said that other prisoners had threatened him.

2014

41. Case managers at Lindholme held three further ACCT reviews on 3, 7 and 9 January 2014. On 7 January, the man had asked for the frequency of observations to be reduced, but the nurse advised against this as there was no evidence that his risk had lowered. He was still checked twice an hour. The visiting psychiatrist was due to assess the man on 8 January, but the appointment was cancelled when a meeting overran. Without seeing him, the psychiatrist recommended that the man should be referred to the personality disorder unit at HMP Garth once his court case had concluded.
42. The man was due to transfer to HMP Altcourse for forthcoming court appearances. The nurse wrote in his clinical record that the risk of potential serious self-harm remained because of his poor emotional management skills and anti-social personality traits. She recommended that the same frequency of observations should be continued after he transferred and reassured the man that his treatment plan would continue at the next prison. On 9 January, The man cut his neck with a razor to protest against the move, but the transfer went ahead that day after a brief ACCT review.
43. Staff wrote on the man's prison record that he was not to return to Lindholme under any circumstances because of the allegations which he had made about staff not completing ACCT checks. (On 4 March, the head of security completed his investigation into the man's claims about night patrol staff. He found no evidence to support the man's allegations, but noted that the quality of ACCT documentation was poor. The head of security made recommendations for improvements.)

HMP Altcourse

44. On 9 January, the man transferred to Altcourse and the nurse and a doctor reviewed him in reception. The doctor queried why he was still prescribed methadone after nearly three years in prison. He recorded serious reservations about the mix of drugs prescribed to the man at the time, which taken together potentially acted as depressants to the central nervous system. The doctor agreed to continue the prescriptions for methadone, gabapentin, tramadol and mirtazapine, but only on the condition that these would be reviewed if he remained at Altcourse. The man threatened to disrupt the prison regime if his medication was altered. Healthcare staff did not review his medication again.
45. On 10 January, the man appeared at North Cheshire Magistrates' Court charged with fraud by false representation. His case was committed to Chester Crown Court. When the man returned from court, he refused to return to his normal wing and requested vulnerable prisoner status. He told healthcare staff that he was vulnerable due to the nature of his alleged offence and the forthcoming court case relating to the alleged abuse he had suffered as a child. (It is not apparent how these factors made him vulnerable to other prisoners but the prison accepted this.) Despite his risk of suicide and self-harm, staff moved him to the segregation unit for his own safety until a place became available in the vulnerable prisoner unit. A nurse from the mental health team assessed the man that evening and was satisfied that he was fit to remain segregated. She noted that he was at high risk of self-harm, but found no evidence of a severe and enduring mental illness. The nurse decided to place the man under the care of the mental health team.
46. At the first ACCT case review at Altcourse on 11 January, the case manager set a high frequency of observations (five an hour throughout the day and night and two conversations to be recorded daily) and maintained the level of assessed risk as raised. On 12 January, a nurse saw the man in the segregation unit for a follow up mental health assessment. He told her that he had regular thoughts about harming himself and said that he would not tell the staff if he was planning to do so. Later that day, the man moved to the vulnerable prisoner unit but later said that he was uncomfortable with sex offenders because of his own experiences of abuse. He was offered further counselling and education activities in his cell.
47. Counselling sessions were held with the man on 13 and 21 January. The man asked for a female counsellor because of the sensitive nature of his issues but, in the meantime, the male counsellor planned to carry on seeing him until one could be found. At the next ACCT case review on 13 January, the case manager continued five checks every hour day and night, yet assessed his risk of suicide as low. He updated the ACCT care map with ten new issues:
 - being at Altcourse / counselling
 - settling on the vulnerable prisoner unit

- forthcoming court appearances in the matter of fraud by false representation
 - his ongoing court case as the victim of abuse
 - lost property at Risley
 - anxiety / self-harming / support
 - education and participation in the regime
 - methadone
 - CARATS support
 - eventual transfer back to Lindholme
48. A mental health nurse attended the next ACCT case review on 22 January. The man said he was unhappy with the reduction in his methadone dose and being in close proximity to sex offenders. The case manager added the need for a mental health assessment as an issue to the ACCT care map, maintained the same high frequency of observations and again assessed the man's risk of suicide as low.
49. On 29 January, the man complained that two officers had not carried out checks which they had recorded in the ACCT document. In early February, the man received a letter from the police confirming that his alleged abuser would be charged.
50. At the next ACCT case review on 4 February, the nurse advised that the counselling which the man was receiving was an appropriate level of intervention and there was no urgent need for additional input from the mental health team. The case manager reduced the frequency of observations to three every hour, day and night, and again assessed the man's risk of suicide as low.
51. On 10 February, the man wrote on a complaint form to healthcare staff that he intended to keep the nurses busy while he was subject to ACCT procedures. The same day, a Senior Mental Health Nurse telephoned the other nurse at Lindholme, who said that the man had been treated by their mental health in-reach team because of his suicide attempts rather than for a diagnosed mental illness. The nurse suggested that the man had traits of antisocial personality disorder. The Senior Mental Health Nurse planned to discuss the man at the next referrals meeting and possibly refer him to a psychiatrist for an assessment for personality disorder
52. After the man's allegations on 29 January, the two officers were suspended pending investigation. On 11 February, the Head of Security at Altcourse, asked the Head of Security at Forest Bank, to take the man because he did not feel that it was appropriate for him to remain in the prison while the matter was investigated. They agreed to the transfer.
53. The investigation at Altcourse found that the man was correct and that the officers had not performed the checks they had recorded in the ACCT document. They were dismissed in early March.

HMP Forest Bank

54. On 12 February, the man transferred to Forest Bank. After a GP assessment, he attended an ACCT review in the first night centre with the case manager, and a mental health nurse from the substance misuse team. The case manager and mental health nurse agreed to reduce the frequency of observations to once every hour at night only (night patrol staff work between 8.15pm and 6.30am) and required a quality conversation to be recorded by the day staff in both the morning and afternoon. The case manager assessed his level of risk of suicide as low. The man was located in the first night centre.
55. The Head of Security, immediately recognised the man from his previous stay at the start of his current sentence in 2011. He realised that there were four outstanding claims against the prison dating back to that period in relation to which the man had instructed a solicitor. In turn, the prison had instructed their insurers with a view to court proceedings. The man had claimed that two officers had assaulted him during an incident when force was used. He had also submitted two claims of medical malpractice. Prison managers decided that they could not risk compromising either their own staff or the man while the legal proceedings were still ongoing. (One of the members of staff concerned was an orderly officer sometimes responsible for the whole prison and was therefore likely to encounter the man in the course of his work.)
56. The Head of Security had already agreed to exchange a prisoner with HMP Liverpool the next day as Liverpool wanted to transfer a prisoner to Forest Bank. He therefore agreed to transfer the man to Liverpool, where there were no conflicts of interest with the staff. The next morning, 13 February, before the man transferred, the case manager chaired another ACCT case. The case manager again assessed his risk of suicide as low, but increased the frequency of checks to once an hour, day and night, because of the imminent transfer.

HMP Liverpool

57. Later that day, 13 February, the man transferred to HMP Liverpool. A nurse completed the man's reception health screen and on the healthcare section of his cell sharing risk assessment she noted his mental health issues and that he was being managed under ACCT procedures. However, she did not record either of these issues in his clinical record and did not make a mental health referral. A doctor checked the man's clinical record and prescribed gabapentin, tramadol and mirtazapine. He did not see the man in person.
58. The nurse from the prison's Drug Dependency Unit assessed the man in reception because of his ongoing methadone dependence. She confirmed with Forest Bank that the man had been given his methadone that morning. The man had previously been regarded as a high risk for sharing a cell because of earlier racist and homophobic comments he had made. He continued to be regarded as a high risk and was only ever allocated a single cell.

59. The next morning, 14 February, a specialist doctor in substance misuse saw the man at the Drug Dependency Unit clinic and prescribed 20ml methadone daily for four weeks. The man asked to see the mental health team and said that he was having thoughts of suicide and self-harm. This was the main reason the doctor decided to maintain the man on methadone. The doctor did not refer him to the mental health team because he thought that somebody else would do this and also assumed that mental health services were already aware of the man.
60. Because the man was on a methadone maintenance programme, he was automatically referred to Lifeline, the drug support and counselling service with a recovery coordinator.
61. The custodial manager for the first night centre chaired the man's first ACCT case review at Liverpool that day. The Reverend, a chaplain, Supervising Officer (SO) and a nurse (a mental health trained agency nurse working for the primary healthcare team) attended. The man said that he did not have any thoughts of suicide and self-harm (contrary to what he had earlier told the doctor). The panel kept the ACCT open as a precaution because they did not know enough about him. The panel assessed his risk of suicide as raised but reduced the frequency of observations to five times during the day and five times at night. The review did not request a mental health referral. The custody manager asked the man if he had any new issues that needed to be added to his care map, but he did not. The same day, the man was located in a single cell on H wing, the drug treatment unit.
62. On 17 February, a recovery coordinator from Lifeline, assessed the man, who said that he suffered from anxiety and depression. The next day, the recovery coordinator made a mental health referral indicating that The man suffered from depression and anxiety and that he was subject to ACCT procedures. She did not tick the box to indicate that the man had thoughts of suicide and self-harm as he had told her that he was not having any such thoughts at the time.
63. On 19 February, the man made a complaint that he had not yet seen a doctor about pain relief. An appointment was booked for 3 March.
64. On 22 February, an SO held an interim ACCT case review as there were insufficient staff available to hold the intended full review. The man complained about the prison and asked for a transfer. He said that he was not having any current suicidal thoughts. His risk continued to be assessed as raised and the frequency of observations remained unchanged at five times during the day and five times at night.
65. On 23 February, the man submitted a complaint stating that he had not yet been assessed by the mental health team. He described his mood as similar to when he had tried to take his own life in November. The chronic disease manager, replied and advised him that he should engage with the ACCT process for support.

66. On 24 February, the man was discussed at the weekly single point mental health referral meeting as a result of the recovery coordinator's referral. He was referred to Primary Care Psychological Services (PCPS) for a fixed-term, low intensity therapeutic intervention to address depression and anxiety. He was not referred for a mental health assessment with the crisis intervention team.
67. The same day, the man submitted a complaint stating that he had not been seen by mental health staff since he had left Lindholme. He threatened to harm himself if action was not taken, and wrote that he was slowly going downhill again and nobody was interested. A custodial manager, replied and said that the man had been referred to the psychology team for assessment, that there was a two week waiting list and that he should expect an appointment. She offered to refer him to the crisis intervention team if he felt that he needed help more urgently and she arranged for the man's ACCT review to be brought forward to look at his care plan.
68. The same day, the man complained that nurses at the medication hatch were giving him his whole day's medication at once and not ensuring he swallowed it in front of them. He complained that this was unsafe because he was on an ACCT and could hoard the medication to harm himself.
69. On 25 February, the SO held an interim ACCT review along with the man. The SO noted that a full review was overdue and he scheduled one for the next morning. The man's assessed risk level and existing frequency of observations remained unchanged.
70. The next day, 26 February, the SO held the next proper ACCT case review which the Muslim chaplain also attended. The SO said that he had left a voicemail message for the crisis intervention team inviting one of the nurses to the review, but nobody responded or attended. At the review, the man said that he had intended to kill himself on 12 November and, if he felt like doing it again, he would not inform staff. He said that he was looking forward to giving evidence against his alleged abuser at the court case in October. His assessed risk of suicide and self-harm remained as raised, but the frequency of observations was reduced to three times in the day and five times at night.
71. The SO added mental health issues to the ACCT care map. Under action required, he wrote that the man would be referred to the crisis intervention team. He later noted that he had spoken to the manager of the crisis intervention team at 11.00am that morning, and the manager had said that he would try to prioritise the man. The SO told the investigator that he clearly remembered speaking to the manager about the man on H wing after the case review. He said that he had also completed a written referral and taken it to the healthcare centre the same day, and put it in an in-tray. The manager told the investigator that he had been on H wing that morning but could not remember speaking to the SO. The crisis intervention team have no record of a referral and the man did not have a mental health assessment before he died.

72. On 27 February, a nurse reviewed the man in the substance misuse clinic. He said that he suffered from depression and had submitted numerous requests to see the GP. The nurse advised the man to let staff know if he felt his mental health deteriorating. She said that there was nothing about his appearance which unduly alarmed her. She told the investigator that, because the man was being managed under ACCT procedures, she assumed that he had already been referred to the mental health team.
73. The same day, a Lifeline keyworker saw the man for a 14 day review. The SO spoke to the man about the number of complaints he was submitting (21 in the six weeks he was at Liverpool). A number of these related to food, the heating in his cell and money he was owed for work. Four related to his risk of suicide and his clinical care. The man told the SO that this was simply his way of dealing with things.
74. On 3 March, the nurse saw the man in the substance misuse clinic. She agreed to maintain him on methadone until his mental health improved and to review him four weeks later. The same day, a doctor saw the man to review his neuropathic pain relief and decided to increase his tramadol prescription.
75. The SO chaired another ACCT case review on 5 March which the Muslim chaplain attended. The man said that he was still having thoughts of suicide and self-harm and talked about his trial at the end of the month. The review assessed his risk of suicide as raised and kept the same frequency of observations, three times in the day and five times at night. The next review was scheduled for a fortnight later because the SO thought that the man seemed stable and his issues had not changed. There was no update to the care map.
76. The recovery coordinator from Lifeline was due to assess the man on 6 March, but was unable to see him due to an all day lock down on H wing. On 9 March, the man met his personal officer who told the investigator that the man kept himself to himself, spent a lot of time in his cell and did not really mix with the other prisoners. On 12 March, a doctor renewed the man's prescriptions for gabapentin, tramadol (which had now been increased) and mirtazapine.
77. On 12 March, the man did not attend a primary care psychology assessment. No reason was recorded. Another appointment was planned for early April (The man was due to be informed about this on the day he died). On 17 March, a member of staff from the safer custody team, checked the man's ACCT document and asked wing staff to complete the triggers section, as nothing had been recorded. However, this remained blank.

Wednesday 19 March

78. On the morning of 19 March, the SO planned to hold the man's next ACCT review. He asked the nurse who was working at the treatment hatch if she could attend the review, but she was unavailable as she had to attend some training. It was now too late to hold the review in the morning. The SO the

late shift manager, held it in the afternoon. The Muslim chaplain attended. The SO said he had telephoned for a nurse to attend but nobody answered.

79. The SO told the investigator that the man was forthcoming, calm and composed and talked about his children being adopted. He explained that when he self-harmed, it tended to be a spur of the moment decision. However, he said that he did not have any current thoughts of suicide and self-harm and had not harmed himself since early January. The SO did not therefore think that the risk was imminent but again assessed him as at raised risk of suicide.
80. The SO asked the man what the panel could do to help him stop self-harming. He said that the frequency of ACCT checks at night was disturbing his sleep and it felt like staff were constantly shining a torch in his face and this was causing him stress. The SO offered to reduce the frequency of ACCT checks at night from five to three but he told the man that the frequency of checks would increase if he self-harmed. The man promised to inform staff if his feelings changed. The SO had no significant concerns and scheduled the next review for 2 April, two weeks later. Staff were required to check the man three times during the day and three times at night.
81. Later that day, the recovery coordinator saw the man. He was forthcoming, lucid and polite and said that he was happy with the current level of support. She said that he did not seem distressed and did not report any particular concerns. The recovery coordinator gave him some written exercises to complete in his cell to help him think about his substance misuse and develop strategies to avoid using drugs. She planned to see him again at the end of April.

Thursday 20 March

82. At 9.00am on 20 March, the officer checked the man as part of his ACCT monitoring and spoke to him outside his cell. The officer knew that the man had had his ACCT review the day before and the man told him that the observations had been reduced but he thought that the ACCT should have been closed. He said that he had no thoughts of self-harm. The officer had no particular concerns about the man after their conversation. He checked the man again at midday, and he said that he was still all right.
83. The officer checked the man at 3.15pm, and he said that he was fine. At 5.00pm, the officer checked the man, who said that he was all right. The night patrol officer checked the man at 8.00pm, and he seemed to be asleep. The assistant night orderly officer, checked the man at 9.40pm. The assistant night orderly officer checked the man at about 9.55pm and he was watching television. He said that he was fine.

Friday 21 March

84. At about 12.23am, the night orderly officer checked the man for the third time that night. He appeared to be asleep. At 2.37am, the night orderly officer

went to the man's cell to check him again. The observation panel was covered by a piece of paper with the words 'on the toilet' written on it. He knocked on the door, waited, called the man's name, but got no response. The night orderly officer went further along the fifth landing for about 40 seconds to check another prisoner. He then returned to the man's cell, shouted his name and kicked the door, but still got no response.

85. For security reasons, night patrol officers do not carry a full set of keys, but have a cell key in a sealed pouch for use in emergencies. Normally, the night orderly officer in charge of the prison will attend with keys if a cell needs to be unlocked at night. The night orderly officer did not use his emergency key to go into the man's cell immediately. He said that he knew that the man had been assessed as a high risk for sharing a cell and he could not see inside to assess the risk. Instead, he went downstairs to speak to the night orderly officer, who was walking through the second landing of H wing with a nurse at the time. The night orderly officer told him that he could not get a response from the man and his observation panel was covered. He asked the night orderly officer to open the man's cell. The night orderly officer radioed two officers to join him on H wing as he wanted two other officers present before he opened the cell.
86. The officers went to the cell and arrived at 2.43am, six minutes after the night orderly officer had first tried to check the man. The nurse waited at the bottom of the stairs on the second landing. The night orderly officer unlocked the door and found the man hanging from a sheet tied to the cell window. The night orderly officer waited outside the cell while the night orderly officer and the officer supported the man's weight and the officer cut the sheet from around his neck.
87. Once the officers had laid the man safely on the floor, the night orderly officer left the cell and at 2.44am, he radioed to ask the control room staff to call an ambulance and direct healthcare staff to the cell. He did not use the expected medical emergency response code. The ambulance service agreed to send an emergency ambulance at 2.45am.
88. A nurse came up the stairs to the fifth landing and arrived at the cell at 2.44am. She checked the man and found no signs of life. She began cardiopulmonary resuscitation and asked an officer to bring the emergency medical response bag from the centre treatment room on the second landing. She also asked for another nurse to attend.
89. An officer arrived with the emergency response bag at 2.46am. The nurse asked the officer to take over chest compressions while she prepared a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and inserted an airway. The nurse then arrived and took over from the officer, the nurse giving oxygen and the nurse chest compressions. The defibrillator did not find a shockable heart rhythm and the nurses continued cardiopulmonary resuscitation.

90. An ambulance arrived at the prison at 2.50am and paramedics reached the wing at 2.55am. They took over the resuscitation attempt and gave the man four shots of adrenaline. However, at 3.26am, the paramedics pronounced the man dead.
91. Managers held a debrief meeting for staff involved in the incident before they left the prison at the end of the night shift. Staff involved in the emergency told the investigator that they had been offered a good level of support by prison managers and the care team. Managers arranged for prisoners subject to ACCT monitoring to be checked in case they had been affected by the news of the man's death.
92. Two members of staff from the chaplaincy acted as family liaison officers. At about 10.00am on the morning of 21 March, they visited the man's mother at her home and broke the news to her. They offered to inform other relatives on her behalf, but she wanted to do this herself.
93. The man left a number of letters in his cell. One of these was dated 25 February and addressed to the Prisons and Probation Ombudsman. In the letter, the man explained his reasons for taking his own life. He referred to the number of times he had been transferred and said that since leaving Lindholme, he had not been reviewed by mental health staff despite asking to see them. He said that he had submitted complaint forms, asked for help and had told staff that he planned to take his own life, but no action had been taken and that the frequency of observations and reviews had been insufficient to keep him safe. Although he had previously used razors to harm himself, he said he was surprised that staff continued to issue these to him. The man wrote that although he spent 24 hours a day in his cell and did not associate with other prisoners, officers were not concerned about him. He complained about the poor conditions in his cell and said that he had lost all hope and had given up. He was surprised that his attempt to take his own life at Lindholme had not led to greater ongoing concern from officers and wrote that the prison had not fulfilled its duty of care to him. He wrote that he planned to take his own life 'tonight'.
94. The man's funeral was held on 4 April. The prison contributed towards the cost of the funeral in line with national guidance.
95. The post-mortem examination concluded that the man died as a result of compression of the neck caused by hanging. Toxicology tests found no substances other than the medications he had been prescribed.

ISSUES

Transfers

96. The man transferred between four prisons in January and February 2014 while subject to ACCT procedures. He moved from Lindholme to Altcourse to attend his trial. He then made serious allegations about staff at Altcourse and managers decided to transfer him while the allegations were investigated. At Forest Bank, managers realised that there were outstanding allegations by the man relating to his previous stay which they considered might compromise staff. Therefore he transferred to Liverpool. This was an unusually high number of transfers in a short time for a prisoner identified at risk of suicide and self-harm and unlikely to have contributed to appropriate continuity of care. Transfer between prisons is known to increase the risk of suicide and self-harm and should be avoided if possible. While the reasons were, to an extent, understandable, many prisoners make complaints about prison staff without being moved. We make the following recommendation:

The Directors of Altcourse and Forest Bank should ensure that prisoners at risk of suicide and self-harm should not transfer unless there is an overriding operational need and the move is in the best interest of the prisoner.

Clinical care

97. The man was prescribed mirtazapine, methadone, tramadol and gabapentin. A doctor reviewed him when he arrived at Altcourse in January and was concerned about a combination of drugs which could potentially have a respiratory depressant effect. The doctor was surprised that the man was still prescribed methadone after three years in custody when usually he would have been expected to undertake a detoxification programme so he was no longer dependent on opiates. The doctor agreed to continue to prescribe the medication, but planned to review it if the man stayed at Altcourse. However, he transferred a month later. At Liverpool, the doctor continued the methadone prescription. He told the investigator that he had not been concerned about the combination of medication because the methadone dose was so low.
98. In his clinical review, the clinical reviewer comments that the approach to methadone prescribing and the intended outcome are both unclear from the clinical record. The clinical reviewer thinks that the man's challenging behaviour and pattern of self-harm throughout his prison sentence made the decision to continue his methadone prescription understandable. It avoided destabilising the man (who responded badly when it was suggested that his medication might be altered) and potentially increasing his risk of suicide. The clinical reviewer noted that an appointment with a psychiatrist (which was planned at both Lindholme and Altcourse), including a medication review, would have been an appropriate step. Unfortunately, the man transferred before an appointment could be arranged at either prison.

99. We agree with the clinical reviewer that the man's transfers inevitably disrupted his continuity of care and resulted in an unstructured approach to his treatment. At each prison, his mental healthcare effectively began again with little acknowledgement of the work already done by the nurse at Lindholme. At Altcourse, the Senior Mental Health Nurse contacted the nurse for advice. However, the frequency of transfers after that appears to have led to a breakdown in communication.
100. Because of the length of time the man had been subject to ACCT procedures, his recent attempt to take his own life, the likelihood of a borderline personality disorder (although not diagnosed) and the frequency of transfers, the clinical reviewer thinks that the man should have had a mental health assessment when he arrived at Liverpool. This would have probably resulted in an appointment with a psychiatrist and a medication review.
101. A mental health nurse from the crisis intervention team at Liverpool is expected to carry out an initial assessment after a referral. However, when the man died six weeks after his arrival, he had still not been assessed. The nurse who saw the man in reception on 13 February, made a note about his risk of suicide and self-harm and mental health issues on the cell sharing risk assessment, but she did not note these in his clinical record or make a mental health referral. The doctor saw the man in the Drug Dependency Unit clinic on 14 February and, although he wrote about his mental health issues in the clinical record and the ACCT document, he did not make a referral. The nurse attended the first ACCT case review after the man arrived, where his issues were discussed, and did not make a referral either.
102. Two nurses and the doctor all knew about the man's problems. The nurse overlooked a referral, the doctor assumed somebody else would do it and the nurse presumed it had already been done. We are concerned that all these opportunities to refer the man to mental health services were missed. We make the following recommendation:

The Head of Healthcare at Liverpool should ensure that staff complete a single point of referral form for a prisoner if they have any concerns about his mental health.

103. The recovery coordinator from the Lifeline drug service referred the man to the single point of referral meeting on 18 February and the man's case was discussed at the next weekly meeting on 24 February. However, the man was still not booked in for a mental health assessment. It appears that, because The recovery coordinator ticked only depression and anxiety on the referral form and did not include suicide and self-harm (as the man had told her that he was not having any current thoughts), he was allocated to psychological services for a short term low level psychological intervention. Although the recovery coordinator indicated on the form that the man was subject to ACCT procedures, it appears that the referral meeting relied solely on the ticks on the referral form and did not look at his clinical record.

104. The man was given an appointment with psychological services on 12 March which he did not attend. No reason was recorded. His next appointment was for 2 April. While the recovery coordinator should have ticked to indicate concerns about suicide and self-harm because the man was still subject to ACCT procedures, she had clearly stated on the form that an ACCT document was open. This should have led those present at the meeting to pay closer attention to the need for a mental health assessment, and they should have explored the reasons the man was subject to ACCT procedures and checked his clinical record. We make the following recommendation:

The Head of Healthcare at Liverpool should ensure that single point of referral meetings use all available evidence about a patient when deciding on an appropriate intervention.

105. On 26 February, immediately after another ACCT case review, the SO (the case manager) wrote on the care map that he had just spoken to the crisis intervention team manager who had agreed to prioritise the man. The manager of the intervention team agrees that he was on the wing at the time and therefore accepts that this discussion probably took place. The SO told the investigator that he also handed in a written mental health referral on the same day, but the crisis team have no record of a referral and never assessed the man.

106. Staff shortages undoubtedly affected the treatment the crisis intervention team was able to offer at the time. An average of one staff member was on duty each day during February when there are supposed to be three mental health nurses working for the team. There were six days in February when nobody from the team was on duty. It is apparent that they were not in a position to provide a full service, which might explain why the SO's verbal and written referrals were not dealt with appropriately. We make the following recommendation:

The Head of Healthcare at Liverpool should ensure that the crisis intervention team is adequately staffed to respond to demand.

107. A variety of bespoke mental health services have been developed at Liverpool and the prison has a good range of interventions. However, the investigation found no clear line of accountability. During interviews, managers could not adequately explain the model for service delivery or how a prisoner like the man with a clear history of involvement with mental health services could have been missed. Prison officers said they were confused about who they should refer to. Although the referrals meeting was attended by managers from each team, nobody checked whether a mental health assessment had been arranged for the man. The Governor told the investigator that there are already plans to reconsider the way in which mental health services are delivered. He agreed with the clinical reviewer that mental health services need streamlining. We make the following recommendation:

The Head of Healthcare at Liverpool should integrate mental health services to ensure better communication, oversight and accountability.

Assessment, Care in Custody and Teamwork (ACCT)

108. The man made a serious attempt to take his own life in November 2013. Staff at Lindholme offered immediate and intensive support. The man was constantly supervised for three weeks, which was an unusually long time. PSI 64/2011 requires that, after eight days of constant supervision, enhanced ACCT case reviews are held. Enhanced case management can be very effective in reducing a prisoner's risk of harm to himself. The process requires that a custodial manager or a more senior manager chairs the case reviews. The eight case reviews during the period of constant supervision were attended by a good variety of staff from different departments and were chaired by prison managers. Although not formally identified as enhanced reviews, we consider that they met the spirit of PSI and provided appropriate support at a time of crisis.
109. After the period of constant supervision, the man's frequency of observations remained high until he transferred. At Lindholme, there was a multidisciplinary approach and the mental health team were involved from the start. Case managers explored the man's risk factors, and invited social services to find out more about his adopted children and the CPS to provide an update about his claims of abuse.
110. The frequency of ACCT observations was reduced very gradually over three months at Lindholme and Altcourse. After the man transferred to Forest Bank on 12 February, he had an immediate case review on the first night centre. The case manager reduced the frequency of observations from three every hour day and night to one check every hour at night only (between 8.15pm and 6.30am). (We acknowledge that the case manager sensibly increased the frequency of observations to one check every hour day and night at a further case review before the man transferred again the next day.)
111. We note that the risk of suicide had been assessed as low at the last three case reviews at Altcourse and the frequency of observations set by The case manager appears more appropriate for someone assessed as at a low risk of suicide and self-harm. Three checks every hour day and night (the most recent frequency set at Altcourse) did not indicate a man at a low risk of suicide. However, given the caution exercised during the previous three months, we consider that this initial, sudden reduction in observations at Forest Bank was too soon after the man's transfer.
112. On 14 February at Liverpool, the custody manager chaired the first ACCT review after the man transferred. The review reduced the frequency of observations even further to five checks in the day and five at night, in spite of the man's recent transfers and the fact that the level of assessed risk was now raised. On 26 February, the SO further reduced the frequency of observations to three checks in the day and five at night, even though the man was still talking about taking his own life, he had been referred to the crisis intervention team and his level of risk was assessed at raised. Neither

of these reviews at Liverpool set a frequency of observations which acknowledged the identified level of risk and recent events.

113. A coherent ACCT document is crucial to managing risk and allowing case managers to understand the history of a prisoner at a glance. After more than four months, the man's ACCT document was sprawling and had become progressively more disorganised. The numbering of case reviews inexplicably restarted at one point at Lindholme in late December. A couple of early case reviews are missing and the frequency of observations recorded at the front of the document was not always clear. One of the front covers detailing the required frequency of checks in January and February is missing altogether.
114. The man had explained the three main issues that might increase his risk of suicide at several ACCT reviews at different prisons:
- His children had been adopted and he only had annual contact by letter
 - He had reported being sexually abused as a child and the alleged abuser was due to face trial later in 2014
 - His own trial for a new offence was scheduled for the end of March 2014
115. However, these three risk factors, which all had associated dates when the risk was likely to increase, were not recorded in the triggers section at the front of the ACCT document to assist case managers. Instead, somebody had written, 'See attached cover sheet'. The investigator checked with the investigating police officer, but there is no evidence of any paperwork clearly documenting the triggers attached to the original ACCT document. A member of Liverpool's safer custody team made a quality assurance check on the ACCT document on 17 March and reminded staff to complete the triggers section, but it does not appear that this was ever done.
116. There is a shared database of forthcoming ACCT case reviews at Liverpool, accessed by prison and healthcare staff, to help ensure multidisciplinary attendance. However, with one exception, case managers did not hold multidisciplinary case reviews and some case reviews were held with no other staff but the case manager present. Case managers told the investigator that they tried to involve healthcare staff, who were persistently unavailable. Had healthcare staff attended case reviews, they might have noticed the need for a mental health assessment. The Governor of Liverpool has acknowledged that the absence of healthcare staff at ACCT reviews needs to be addressed. On 26 March, he issued an order instructing that a member of healthcare staff should attend every case review.
117. At the final ACCT case review on 19 March, an SO reduced the frequency of observations at night from five to three at the man's request, as he said his sleep was being disturbed. With the knowledge we now have, that the man appears to have been preparing detailed suicide notes in the preceding weeks, it seems possible that he was trying to ensure that he had more opportunity to take his own life. We appreciate that the SO was trying to take a positive step, and that the decision at the case review made no difference to the outcome, as the night orderly officer actually maintained a higher

frequency of observations on the night the man died and was checking him for the fourth time when he raised the alarm. Nonetheless, the SO's decision was based solely on the request of a prisoner who had previously stated at case reviews that he would harm himself impulsively without first warning the staff. There is no evidence that the decision to reduce the frequency of observations was based on a reduction in the level of risk and, indeed, the case manager maintained the risk level at raised.

118. The investigation also found that at least one ACCT case manager had not completed the appropriate case manager training. This was an issue previously identified by the Inspectorate of Prisons. Although we had some concern about some aspects of ACCT procedures at each of the prisons the man was held in, our principal concern related to the operation of the procedures while he was at HMP Liverpool. We therefore make the following recommendation:

The Governor of Liverpool should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:

- **completing ACCT documents fully and accurately**
- **considering and recording all known risk factors**
- **holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;**
- **setting a frequency of observations which relates directly to risk**
- **providing ACCT training for case managers**

Emergency response

119. Prison Service Instruction (PSI) 03/2013 requires all staff to use emergency codes when they discover an unresponsive prisoner. The correct code should automatically prompt control room staff to call for an emergency ambulance. However, the relevant Governor's order to staff in place in Liverpool at the time the man died, introduced in August 2013, did not accurately reflect the intentions of the PSI and suggested that the member of staff announcing the code was responsible for requesting an ambulance.
120. The Governor issued a new order to staff in April 2014, which accurately reflected the national guidance contained in PSI 03/2013. The new local Order is designed to ensure that control room staff automatically call an ambulance when they receive a simple emergency code across the radio network.
121. During the emergency response, the night orderly officer, did not use the correct medical emergency response code. Instead, he asked the control room staff to call an ambulance. This did not cause a significant delay, but staff should use the correct emergency codes as a matter of routine to ensure the swiftest response possible from control room staff, healthcare colleagues and others responding to the emergency. We make the following recommendation:

The Governor of Liverpool should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies.

RECOMMENDATIONS

1. The Directors of Altcourse and Forest Bank should ensure that prisoners at risk of suicide and self-harm should not transfer unless there is an overriding operational need and the move is in the best interest of the prisoner.
2. The Head of Healthcare at Liverpool should ensure that staff complete a single point of referral form for a prisoner if they have any concerns about his mental health.
3. The Head of Healthcare at Liverpool should ensure that single point of referral meetings use all available evidence about a patient when deciding on an appropriate intervention.
4. The Head of Healthcare at Liverpool should ensure that the crisis intervention team is adequately staffed to respond to demand.
5. The Head of Healthcare at Liverpool should integrate mental health services to ensure better communication, oversight and accountability.
6. The Governor of Liverpool should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including:
 - completing ACCT documents fully and accurately
 - considering and recording all known risk factors
 - holding multidisciplinary case reviews with a consistent case manager and which include all relevant people involved in a prisoner's care;
 - setting a frequency of observations which relates directly to risk
 - providing ACCT training for case managers
7. The Governor of Liverpool should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies.

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Directors of Altcourse and Forest Bank should ensure that prisoners at risk of suicide and self-harm should not transfer unless there is an overriding operational need and the move is in the best interest of the prisoner.	Accepted	The Directors of Altcourse and Forest Bank will ensure that prisoners on an ACCT will only be transferred for operational reasons where this is absolutely necessary. If it does prove necessary, case reviews will take place immediately before and after the transfer - to ensure that relevant risks are managed and that care and support to the individual prisoner continues to be provided - and relevant information will be shared between the sending and receiving prisons in advance of the transfer taking place.	Completed Altcourse: Safer Custody Forest Bank: Head of Residence	
2	The Head of Healthcare at Liverpool should ensure that staff complete a single point of referral form for a prisoner if they have any concerns about his mental health.	Accepted	A notice to all staff will be issued to remind staff of the single point of referral (SPR) process. Advice and information on the SPR will be made a standard agenda item at monthly team briefings. Information about the SPR process will be added to the induction process for all newly appointed staff.	31/1/15 Healthcare (Liverpool Community Health)	
3	The Head of Healthcare at Liverpool should ensure that single point of referral meetings use all available evidence about a patient when deciding on an appropriate intervention.	Accepted.	Healthcare will ensure that the SystmOne clinical notes will be used to inform the SPRI meeting about appropriate intervention.	completed. Healthcare (Merseycare)	
4	The Head of Healthcare at Liverpool should ensure that the crisis intervention team is	Accepted.	Management of the crisis intervention team is now the responsibility of Merseycare who	completed.	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	adequately staffed to respond to demand.		have the responsibility for all mental health services at HMP Liverpool. Performance and staffing of Crisis Intervention are monitored by the Prison Health Operational Group which meets with commissioners monthly. A weekly mental health steering group meeting, introduced in order to improve mental health services, also monitors the performance of Crisis Intervention. The work of this group feeds into a weekly meeting with senior staff within MerseyCare and HMP Liverpool, which monitors staffing within mental health services at HMP Liverpool.	Safer Custody MerseyCare	
5	The Head of Healthcare at Liverpool should integrate mental health services to ensure better communication, oversight and accountability.	Accepted.	Since The man's death, management of the crisis intervention team is now the responsibility of MerseyCare who have the responsibility for all mental health services at HMP Liverpool.	completed Healthcare MerseyCare	
6	The Governor of Liverpool should ensure that prison staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including: <ul style="list-style-type: none"> · completing ACCT documents fully and accurately · considering and recording all known risk factors · holding multidisciplinary case reviews with a consistent case manager and which 	Accepted.	A number of changes have taken place locally since The man's death: <ul style="list-style-type: none"> - case management of all ACCTs that have been open for one month or more is undertaken by Custodial Managers in order to provide improved consistency; - the wing Custodial Manager is responsible for an additional management check of any open ACCTs, in addition to those conducted by Safer Custody staff and senior managers; 	completed	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	<ul style="list-style-type: none"> include all relevant people involved in a prisoner's care; · setting a frequency of observations which relates directly to risk · providing ACCT training for case managers 		<ul style="list-style-type: none"> - the SystemOne screening tool used in Reception is being developed to include an assessment of risks and triggers. This will be accompanied by local training for reception staff on known potential risks and triggers; - ACCT case manager training forms part of the establishment training plan and further ACCT training will be provided for case managers. 	31/1/15 31/1/15 Safer Custody Healthcare Training.	
7	The Governor of Liverpool should ensure that all prison staff are reminded of and understand PSI 03/2013 and their responsibilities during medical emergencies	Accepted.	Advice and guidance on emergency response codes will continue to form part of 6 monthly reminders to staff via Governor's notices to staff. This information is also included in Introduction to Safer Custody training.	31/1/15 Safer Custody.	