

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Liverpool, in February 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 dead in his cell at HMP Liverpool in February 2015. He was 49 years old. A post-mortem examination was unable to establish the cause of death. I offer my condolences to his family and friends.

The man had a number of health problems, including a long history of mental ill health. He had been at the prison less than two weeks when he died. There is no evidence that he took his own life, but I am concerned that staff did not consider all his risk factors when assessing his level of risk.

The investigation also found a lack of coordination in assessing and managing the man's health needs. A full mental health assessment took too long and there were also some deficiencies in his physical health care. There was some suggestion that he had been using illicit drugs, including new psychoactive substances, but the investigation was unable to find evidence of this.

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

March 2016

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Summary

Events

1. On 17 February 2015, the man arrived at HMP Liverpool after being sentenced to 28 days in prison for shoplifting. It was not his first time in prison. He had history of substance misuse, mental ill health and had attempted suicide several times in the previous year. When he arrived at Liverpool, staff began suicide and self-harm prevention procedures (known as ACCT), which remained in place until his death.
2. The man began a supervised alcohol withdrawal programme and was prescribed methadone (a heroin substitute). He was also prescribed antidepressants, anti-anxiety medication and an antipsychotic. Several different members of staff referred him for a mental health assessment.
3. A week before his sentence, the man had received hospital treatment for cellulitis, caused by a burn on his right wrist. On 24 February, a prison GP prescribed antibiotics as his wrist was infected. He received one dose that day but it does not appear he received any further doses the next day.
4. On 25 February, a nurse assessed the man's mental health. He said that he was hearing voices telling him to hurt himself and others. The nurse did not find any evidence of psychosis and referred him for further assessment and treatment.
5. During the evening the man spent time with other prisoners on the wing. No one reported any concerns about him. Later that evening, he complained that he had not received his antibiotics that day. The night officer said that a nurse told him that she was not allowed to dispense the tablets at his cell door and that he would have to wait until the next morning. A night officer checked him during the night. At 5.12am, the officer noticed vomit on his sheet and alerted the night manager, who called a nurse. He was unresponsive and staff attempted to resuscitate him. Paramedics arrived quickly, but shortly afterwards, recorded that he had died. The cause of his death has not been established.

Findings

6. The man had contact with several healthcare services and received varying levels of care. He had longstanding mental health problems. Staff made a number of referrals to the mental health team, but he did not have a full mental health assessment until the day before he died, eight days after he had arrived at the prison. The clinical reviewer considered that he did not receive a standard of mental health care equivalent to that he could have expected to receive in the community.
7. We are also concerned that a dressing the man had for a wound on his wrist was not examined and changed as frequently as it should have been. The wound became infected and, two days before he died, a doctor prescribed antibiotics, but he received only one dose.

8. The man received appropriate clinical treatment for substance misuse problems. Some staff had suspicions that he had used new psychoactive substances in the prison, but there is no firm evidence of this.
9. Although there is no evidence that the man took his own life, we have some concerns that staff did not take into account all his risk factors when assessing his risk. It does not appear that the appropriate medical emergency code was used when he was found unresponsive.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.
- The Head of Healthcare should ensure that prisoners with wounds that need dressing have these reviewed frequently and the dressings replaced as necessary.
- The Head of Healthcare should ensure that prisoners receive medication as prescribed and that there are no unnecessary breaks in treatment.
- The Governor should ensure that prison staff consider all known risk factors when determining the level of risk of suicide and self-harm, and set appropriate levels of observation to reflect identified risk.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Liverpool informing them of the investigation and asking anyone with relevant information to contact her. No one responded. She wrote to prisoners who had signed a joint complaint about the man's treatment. Two prisoners responded.
11. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.
12. The investigator visited the prison in March 2015. She obtained copies of the man's prison and medical records and interviewed 16 members of staff and two prisoners.
13. We informed HM Coroner for Merseyside of the investigation and have sent the coroner a copy of this report. We suspended our investigation pending the result of the toxicology and post-mortem examination.
14. One of the Ombudsman's family liaison officers contacted the man's sisters to explain the investigation and to ask if they had any matters they wanted the investigation to take into account. His sisters asked about the events of the evening of 25 February, and whether he had received adequate care that night. They wanted to know about the circumstances in which he was found on 26 February and they were unhappy that the police had informed them of his death but had little information of the details.
15. The man's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Liverpool

16. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 1,247 men. From January 2015 to June 2015, Lancashire Care NHS Foundation Trust provided primary care services and Mersey care NHS Trust provided mental health and substance misuse services as an interim arrangement when NHS England ended its contract with the previous provider after significant concerns about the safety of the service. Lancashire Care NHS Foundation Trust now provides all healthcare services. Lifeline provides substance misuse services.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Liverpool was in May 2015. Inspectors reported that, since the previous inspection, primary healthcare services had deteriorated dramatically. In late 2014, elements of the service had been judged unsafe and the new provider had inherited a failing service. Inspectors reported that governance was improving, but severe staff shortages restricted provision. Waiting times for most primary care services were too long and medicines management was poor. However, they reported that the management of prisoners with substance misuse problems was sound, although prisoners withdrawing from alcohol were not monitored overnight. Primary mental health provision had improved considerably.
18. The Inspectorate reported that the quality of ACCT documents was variable. Too many lacked consistent case management and caremaps were often inadequate.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2014, the IMB noted that Lancashire Care NHS Foundation Trust had made a number of improvements after taking over provision of healthcare services at the prison.

Previous deaths at HMP Liverpool

20. The man was the ninth of twelve deaths at Liverpool since January 2014. In the investigation report into the death of a man who had died at the prison in January 2015, we were concerned about his mental health treatment and the assessment of his risk of suicide. In an investigation into a death of a man in April 2015, we noted that he did not receive all his prescribed medication.

Assessment, Care in Custody and Teamwork (ACCT)

21. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support and monitor prisoners assessed as being at risk of suicide and self-harm. The purpose of the ACCT process 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. Levels of supervision and interactions are set according to the perceived risk of

harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

22. New Psychoactive Substances (NPS) are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
23. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.
24. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

25. On 9 February 2015, the man visited his GP surgery complaining of severe pain in his right wrist. The GP found that his hand was swollen, blistered and foul smelling. He was immediately admitted to hospital and was diagnosed with cellulitis, an infection of the deep skin tissue, which was treated with antibiotics. On 13 February, the hospital discharged him with instructions for his GP and the district nurse.
26. On 16 February, the man was arrested and charged with shoplifting. He spent the night in police custody. The next day, 17 February, he was sentenced to 28 days in prison and sent to HMP Liverpool. It was not his first time in prison.
27. The man told a court probation officer, that he had attempted suicide seven times in the previous 12 months, following his wife's death in December 2013. His escort record, which accompanied him from the police station to court and then to the prison, noted that he had attempted suicide two months previously. It also noted that he was a heroin user and had schizophrenia. The probation officer completed a suicide and self-harm warning form.
28. When the man arrived at Liverpool, a Supervising Officer (SO) read the warning form. He told the SO he felt like harming himself. The SO began ACCT procedures and initially required staff to have three conversations with him during the day and one during the evening, and to observe him six times during the night. He said he had no next of kin.
29. The man said that, 15 years earlier, he had taken three prisoners hostage. As a result, staff initially assessed him as unsuitable to share a cell.
30. The man told a nurse that he had recently fallen asleep in front of a fire and had burnt his right wrist, which had required hospital treatment. She recorded that the wound looked clean and dry. He said he had no concerns about his physical health. She recorded that he had a long history of drug and alcohol dependency. He drank heavily and used heroin daily. He had been prescribed methadone (a heroin substitute) in the community.
31. The man said that he suffered from asthma, depression and other mental health problems. He said he had attempted suicide several times by overdose and hanging. He said he had been admitted to mental hospitals several times, and had seen the community mental health team a week earlier for his depression. He said that he was prescribed pregabalin (prescribed to treat anxiety, seizures or neuropathic pain), diazepam (used to treat anxiety disorders) sertraline (an antidepressant) and olanzapine (an antipsychotic).
32. The nurse noted that she had read the suicide and self-harm warning form and that reception staff had opened an ACCT. The man told her that he felt like killing himself. She referred him to the drug dependency unit and radioed the mental health crisis team. She also referred him to the mental health team, using a single point of referral procedure, where all routine referrals were allocated at a weekly meeting.

33. At about 6.00pm, a substance misuse nurse reviewed the man, who had tested positive for opiates, methadone, benzodiazepine and cannabinoids. He told her he had last taken drugs on the 16 February. He said he had used heroin and cannabis and had drunk three litres of cider each day for the last 11 months. She referred him to the drug dependency unit GP for further assessment
34. The man told the specialist substance misuse GP that he smoked heroin and crack daily, had toothache and was feeling rough. He said he heard voices telling him to hurt himself or others, but the GP did not detect any signs of thought disorder. The doctor prescribed chlordiazepoxide (to help control the symptoms of alcohol withdrawal) and a starting dose of 10mg of methadone. He arranged for another substance misuse specialist GP to see him the next day. (On 19 February, after confirmation from his community GP, he was prescribed two inhalers for asthma, diazepam, olanzapine, pregabalin and sertraline.)
35. At about 7.30pm, a nurse from the mental health crisis team saw the man for an initial mental health screen. He said he had been diagnosed with anxiety, depression, and schizophrenia and personality disorder. He said that, in the community, he had taken illicit drugs on top of his prescribed methadone. He said he was hearing voices telling him to hurt staff and had thoughts of self-harm, but no active plans or intention to harm himself. The nurse identified no other psychotic symptoms and recorded that the man was coherent and lucid and seemed calm and settled. The nurse wrote in his clinical record that the man's ACCT should remain open and that a full mental health assessment should be conducted the next day. This mental health assessment did not take place.
36. The man was given a single cell on A Wing, the First Night Centre for new prisoners. An officer interviewed him as part of first night procedures. He said he had thoughts of self-harm but had the support of family and friends. He said he had been seen by staff from the drug dependency unit and did not feel vulnerable.
37. On the morning of 18 February, a substance misuse recovery worker saw the man and assessed his alcohol and drug withdrawal symptoms. He scored relatively highly on a clinical assessment tool for alcohol withdrawal symptoms. The recovery worker was concerned about his general physical condition and referred him to a substance misuse specialist GP.
38. At 9.17am, a substance misuse specialist GP examined the man and concluded that he was experiencing moderate alcohol withdrawal symptoms, including tremors and anxiety. He told the GP that each day he smoked four bags of heroin, up to three bags of crack, sniffed cocaine, smoked five cannabis joints and took 40mls a day of prescribed methadone, which he had not collected since his hospital admission on 9 February. He said that he drank heavily and had a history of fits. The GP checked his pulse and blood pressure. His blood pressure was slightly raised.
39. The GP increased the man's daily dose of methadone to 40mls, in line with his community prescription, to continue until he was released. He noted that the man needed to continue the alcohol detoxification, continue taking vitamin B1 and B12, and take diazepam as needed, if he experienced fits. The GP advised him to engage with Lifeline, the prison's substance misuse service. The GP

noted that the man's hand wound needed immediate attention, as the dressing had not been changed for five days and the wound smelt offensive.

40. That afternoon, a substance misuse recovery worker saw the man again in the substance misuse clinic. He recorded that the man appeared unwell and that wing officers were concerned about him. He noted that the man's alcohol withdrawal score had reduced to 27 but was still high. His blood pressure was still raised. He asked a healthcare manager to arrange for a nurse to examine the man as soon as possible. He reported that the man had received his morning dose of chlordiazepoxide late and had not yet received his afternoon dose.
41. Around an hour later, a nurse re-dressed the wound on the man's wrist and recorded that it was clean and dry. She did not record any checks of his blood pressure or general physical health.
42. On 18 February, an officer went to see the man twice to assess him as part of the ACCT procedures, but the man said he felt unwell and asked if he could assess him the next day. He said he had no current thoughts of suicide or self-harm. An SO agreed that the assessment could be postponed until the next day. In the meantime, she noted in his ACCT document that he posed a raised risk of suicide and self-harm. She noted in the ACCT caremap, that he had mental health problems and that she had referred him to the mental health team. She considered that the level of observations another SO had set was appropriate and made no changes.
43. At 10.50am on 19 February, an officer assessed the man, who said he was finding it difficult to come to terms with his wife's death, and had used drugs to help him cope. He said that he had attempted suicide a few times; by overdose, attempted hanging and trying to get himself knocked over on a busy road. He said that, although he had had some thoughts of suicide when he had first arrived at the prison, he felt more settled and had had no further suicidal thoughts. He said that he heard voices and was prescribed medication. He said that he had three children and knew his actions would impact on them. The officer did not record whether he was in contact with his children, or any other family or friends.
44. A substance misuse recovery worker saw the man in the substance misuse clinic that afternoon. She was concerned that his blood pressure was low, his alcohol withdrawal symptoms score was still high and he did not look well. She wrote that his orientation and memory seemed poor. He said he had not received any of his mental health medication since he had arrived at the prison. She spoke to a nurse, who said that a nurse see him as soon as possible.
45. At 5.00pm, an SO and an agency nurse from the crisis intervention team met the man for his first ACCT case review. In the record of the case review, the SO wrote that he said he felt much better and had no current thoughts of self-harm. He said that he was still hearing voices. He said that his prescribed medication helped his mental health problems and the SO noted that his medications were being confirmed. The review assessed his risk to himself as low, but that the ACCT would remain open until healthcare staff had confirmed his medications. The level of observations and conversations remained at three conversations

during the day, one in the evening and six observations during the night. The SO scheduled the next ACCT case review for 26 February.

46. The nurse wrote in the man's clinical record that he was tearful, visibly low in mood and did not make eye contact during the review. When she had asked him how he was feeling, he said that he was all right and thankful for the support he was getting. He said that he did not have any thoughts of suicide or self-harm and was looking forward to being released on 23 February. (In fact, his expected release date was 2 March.)
47. On 19 February, the man's community GP faxed his community medical records to the prison, which indicated that his GP had not prescribed olanzapine for several months. He told a nurse that he was feeling angry and agitated and was having suicidal thoughts because he had not been prescribed his usual medication.
48. At about 7.30pm, a GP reviewed the man's community medical record and noted that he had a possible diagnosis of hepatitis C (a virus that affects the liver and, untreated, can cause serious and life-threatening damage). He did not record whether any action needed to be taken. The GP prescribed him inhalers for asthma, pregabalin, olanzapine, sertraline and diazepam. A nurse booked a GP appointment for 24 February to review all his prescribed medication.
49. On the morning of 20 February, the man's alcohol withdrawal symptoms score had dropped to seven and his blood pressure was within normal limits. At 2.48pm, a nurse checked him again. His alcohol withdrawal score had risen to 15, but the nurse recorded no particular concerns. In line with his prescribed alcohol withdrawal management plan, this was the last time that his withdrawal symptoms were assessed.
50. At 7.15pm on 21 February, an officer checked the man, who was writing something at the time. He said that he was okay, but when the officer walked away became abusive and threatening. The officer warned him about his behaviour.
51. At 4.35pm on 22 February, an officer recorded in the ACCT record that the man said he felt he had been forgotten. The officer assured him that this was not the case. At 7.25pm, an officer checked him, who said he was okay, but was again verbally abusive when the officer walked away. At 8.15pm, the officer checked him again and wrote that he had smelt burning coming from his cell. When he challenged him, he was verbally abusive. By 9.00pm, he was asleep.
52. On 23 February, the man was discussed at the mental health team referral meeting. A nurse recorded that he was still waiting for a full mental health assessment by the crisis team.
53. On 24 February, a prison GP saw the man. He said he was unhappy about his wrist wound and she noted that the wound was covered with a clear film dressing with no absorbent pad. He said this had been applied earlier that day. The doctor described the wound as infected with a slightly offensive smell. He told her that he had spent a week in hospital because of the burn and had been discharged on antibiotics.

54. The man said that no one had examined or treated the burn since 18 February, despite him collecting medication at the treatment hatch every day. The GP arranged for the wound to be redressed and noted that it needed redressing every two days. (The next day a nurse dressed his wound and noted that the day before he had asked her for a dressing to protect it in the shower. She had given him one but told him it was only for short-term use while he showered. He had left it on and the wound had deteriorated.)
55. The man also told the GP that he had not yet received his asthma inhalers. She arranged for the prescription to be faxed to the pharmacy and prescribed an antibiotic, flucoxacillin, to be taken four times a day.
56. Later that day, the man received one dose of antibiotics. He then moved from A Wing to a single cell on H Wing (the drug dependency unit) as a cell had become available. His prescription record remained on A Wing, which meant that he did not receive any further doses of the antibiotics and was not given the asthma inhalers the GP had prescribed.
57. At 10.30am the next day, a nurse saw the man for a mental health assessment. He said he was not sleeping well and was hearing voices. He said he could hear two voices he did not recognise - one telling him to hurt himself and the other commanding him to hurt others. He said he did not have any tobacco as someone had stolen his from his cell, and asked the nurse to get him some cigarettes, and that if he did not get any tobacco, he would harm himself. The nurse considered that his mood was low and he was suffering from panic attacks and anxiety. He thought that threatening to self-harm if he did not get any tobacco was manipulative behaviour and that there was no evidence of psychosis.
58. The man told the nurse about his suicide attempt three months earlier, but said that he had no current thoughts of suicide or self-harm, or of hurting anyone else. The nurse wrote that he needed to be referred to the psychology department for bereavement counselling, for housing advice because he did not know where he would live when he was released, and to Lifeline for substance misuse support. The nurse discussed him with the crisis team manager, who recommended that the nurse also use the single point of referral to refer him back to mental health team. The nurse told the investigator that he did not understand why the manager had advised this.
59. At 1.55pm, an officer wrote in the ACCT record that he had unlocked the man to have his dressing changed at the treatment room. The officer recorded that, later, the man said another unidentified officer had stopped him from going to the treatment hatch. At 4.05pm, the officer wrote that he had unlocked him again to see the nurse. A nurse recorded in his medical record that she had examined his wound, which looked clean and normal, and changed the dressing.
60. At 6.00pm, the officer recorded that the man was mixing with other prisoners on the wing during an association period (when prisoners can mix with each other on the wing) and seemed in good spirits. CCTV showed that he was chatting with other prisoners until he was locked in his cell at about 7.00pm.

61. At 7.40pm, the night patrol officer on H Wing recorded in the ACCT record that he had spoken to the man, who had said he was okay, but did not sound very coherent. In a statement for the police, the officer said the man told him he had not received his antibiotics, but did not say he had any pain. He went on to ask for a new television aerial. He said the man appeared exhausted and medicated, but that was not unusual as a lot of prisoners on H Wing were prescribed methadone and presented in this way.
62. In the same entry, the officer wrote that he spoken to the duty nurse about the man. In his police statement, he said that the nurse told him she would not give him antibiotics that night, and he would have to wait until the morning. (He was on long-term sick leave after the man's death and we were unable to interview him. He has since left the Prison Service.)
63. The nurse told the investigator that no one had spoken to her about the man during that night. She said that, in any case, she would not have been able give him his antibiotic tablet at his cell door as this would be secondary dispensing and not allowed under healthcare policy. CCTV shows that the night patrol officer observed the man in his cell at 10.00pm, 11.15pm, 12.43am, 2.26am, and 3.47am. He did not ring his cell bell that night. At each check, the officer recorded in the ACCT that he appeared asleep, but that he had seen him move.
64. At about 5.12am, the night patrol officer checked the man and noticed vomit on his bedding. He called to him, but he did not respond. He then radioed the assistant night orderly officer and asked him to come to the man's cell. The assistant night orderly officer arrived quickly and also tried to rouse the man, but he did not respond. He told the police that he unlocked the door and radioed for the designated emergency response nurse. He tapped the man's shoulder but he did not respond. He said that he then radioed a code blue (which indicates circumstances such as when a prisoner is unconscious and should alert other staff to attend with emergency equipment and the control room to call an ambulance immediately.)
65. The nurse arrived at the man's cell at 5.13am. She told the investigator that she did not hear a code blue message and only had with her the basic medical response kit, not the emergency bag with a defibrillator, oxygen, airways and face mask. She said that she saw brown vomit around his mouth and on his sheet. She rolled him on to his back and checked for a pulse, but could not find one. She said he was limp but not cold. The assistant night orderly officer collected an emergency bag from the nearby nurses' office and they tried to resuscitate him. The nurse attached the defibrillator but it detected no shockable heart rhythm.
66. According to the control room incident log, the assistant night orderly officer asked for a 'blue light ambulance'. We were unable to verify whether or not he radioed a code blue emergency.
67. At 5.16am, the officer in the control room requested an emergency ambulance. An ambulance and a first response vehicle arrived at 5.25am. At 5.32am, a paramedic recorded that the man had died.

68. At 6.00am, Merseyside Police officers arrived and examined the man's cell. They did not find anything to indicate that he had taken his own life, or overdosed on prescribed medication or illicit drugs. The police found an undated note in his cell, in which he complained that he was angry he had not had adequate treatment for his burn, and that he was worried about having an asthma attack and not having any inhalers. He wrote that the only way he could think to express himself was through self-harm, that he was in a great deal of pain and he felt that no one was listening. In the cell, there was also an unaddressed letter, complaining about his medical treatment.

Complaint by prisoners after the man's death

69. After the man's death, a prisoner complaint form signed by 30 prisoners was handed to an H Wing manager. The prisoners complained that he had been asking for a nurse for several hours before his death. The police contacted 12 of the 30 prisoners to ask them about the complaint. (One prisoner was interviewed at his home after he had been released; the other 11 were still at the prison. The remaining 18 had been released or were not contacted for other reasons.) When asked for more details, none of the prisoners still at Liverpool said that they had heard him ask for help on the night of the incident. Some said that another prisoner had encouraged them to sign the complaint, but they had not understood what they were signing. The prisoner who other prisoners said had instigated the complaint denied this but said that he had heard the man call for help, so he had signed the complaint.
70. A friend of the man's, who was on the same landing, wrote to the police that the man did not kick his door or shout out on the night of the incident. He said that the night before he died, the man told him he had taken some pills. He said the man was often under the influence of illicit substances but did not specify what.
71. The investigator contacted all of the prisoners, whose names were on the complaint and were still in prison. She asked whether they wanted to explain why they had signed the complaint form. Two prisoners responded. One said that he had spoken to the man the evening before his death as they waited in the queue for medication. He said the man looked pale and said he was having problems with his stomach. He told the prisoner that 'they' would not give him his medication. Later, when they were locked in their nearby cells, the prisoner shouted out to him that he should complain. He said that he had heard him shout out of his cell door that he wanted to see a nurse. After his death, the prisoner said that he looked through the observation window in his door and saw his body on the landing floor. He was angry about this and told a female supervising officer how he felt about this. She had suggested that he make a complaint, and he said that he and a few prisoners did.
72. Another prisoner wrote that he had heard shouting and banging in the early hours. He said that after staff found the man unresponsive, prisoners had concluded that the noise they had heard had been the man banging on his door to get the night officer's attention.

Contact with the man's family

73. When he arrived at the prison, the man said he did not have any next of kin and did not give any emergency contact details. After he died, staff checked his telephone records from previous periods in prison and found a telephone number for one of his sisters. The Governor asked the police if they could match an address to the telephone number as he intended to visit the man's sister to inform her of his death. However, at 9.20am, the police went to see her themselves and explained her brother had died. The police gave no further details and his family were under the impression he had taken his own life in police custody.
74. Shortly after, a friend visited the man's sister to sympathise and told her that he had died in prison. The friend had learned of his death through another prisoner. At 11.25am, the Governor and a family liaison officer went to see the man's sister and offered condolences and gave her more details about what had happened. In line with national instructions, the prison offered a contribution towards funeral expenses.

Support for prisoners and staff

75. Although he did not hold a formal debrief, the Governor checked that all the staff involved in the emergency response were all right. The prison's care team offered support to staff.
76. The Governor 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 identified as at risk of suicide and self-harm in case they had been adversely affected by his death.

Post-mortem report

77. Toxicological tests confirmed the presence of benzodiazepines, methadone, an antidepressant, an antipsychotic and pregabalin in the man's blood, at therapeutic levels, in line with his prescribed medication. The toxicologist did not test for the presence of antibiotics or new psychoactive substances (synthetic cannabinoids).
78. The pathologist was unable to establish the cause of the man's death.

Findings

Clinical care

79. The clinical reviewer noted that in his short time at Liverpool the man had contact with several areas of healthcare services at the prison. He considered that the man received variable levels of care.

Substance misuse

80. The man had a long history of heavy alcohol and drug misuse. When he arrived at Liverpool, he was quickly identified as at risk of drug and alcohol withdrawal and was prescribed medication. His withdrawal symptoms were monitored over the following days and the methadone dose was increased in line with his community prescription. The clinical reviewer concluded that his treatment for dependency on drugs and alcohol was of a good standard and equivalent to that he could have expected to receive in the community.

Mental health care

81. When he arrived at Liverpool, the man told healthcare staff that he had a history of mental ill health, including a personality disorder, depression and schizophrenia, for which he was prescribed a variety of medications. He had been admitted to mental hospitals in the past and said he had seen the community mental health team the week before he came to prison because of his depression.
82. A nurse from the mental health crisis team briefly assessed the man in reception on 17 February and concluded that he needed a full assessment the next day. However, he did not have a full assessment until 25 February - eight days later. The clinical reviewer considered that this was too long.
83. The man was referred to the mental health team, using the single point of referral process several times by different staff, even after he had had a full mental health assessment. We do not consider that his mental health was given sufficient priority for someone who had been identified as at risk of suicide and self-harm, with a history suicide attempts, mental illness and psychiatric admissions.
84. At the time of the man's death, the mental health provision at Liverpool was under considerable pressure. In December 2014, NHS England ended its contract with Liverpool Community Health Trust for primary care physical and mental health services owing to significant concerns about the safety of the service. Lancashire Care NHS Foundation Trust (LCFT) became the interim primary care provider and Mersey Care NHS Trust took over primary mental health provision from January 2015 to June 2015. Lancashire Care NHS Foundation Trust won the contract to provide all health from June 2015.
85. We recognise that there had been significant changes since the time of the man's death. At an inspection of Liverpool in May 2015, HM Inspectorate of Prisons noted that mental health services had improved. Primary provision had enhanced significantly and the overall range of mental health provision was good.

However, inspectors noted that referrals to the mental health team were not reviewed to assess whether prisoners had urgent needs.

86. We were concerned that the weekly referral meeting led to an inherent delay in the system. There was confusion about the operation of the referral system and the man's mental health was not given sufficient priority for someone with his psychiatric history. We had similar concerns in the investigation of the death of a man at Liverpool in January 2015. We repeat the recommendation we made in that investigation report:

The Governor and Head of Healthcare should ensure that there is a clear pathway for mental health services, which ensures that prisoners identified as at risk of suicide and self-harm have an urgent mental health assessment within three days.

Wound management

87. In the fortnight before the man arrived at Liverpool, he had received hospital treatment for cellulitis, caused by a wound on his right wrist. The wound continued to cause him problems in prison.
88. The clinical reviewer found that the management of the man's wrist wound was inconsistent. On 18 February, a GP was concerned about the wound, and on 24 February, another GP noted that it had deteriorated. The wound dressing had not been changed in the interim.
89. A GP prescribed antibiotics (four tablets a day) to treat an infection in the wound but there were delays administering them. It seems that the man received only one dose on 24 February, while he was still on A Wing. He did not receive any more doses after he moved to H Wing later that day.
90. On the evening of 25 February, the man told the night patrol officer that he had not received that evening's antibiotic tablet. The nurse on duty said that no one contacted her about him that night. But in any case, she said that she would not have been able to dispense the antibiotics to him that evening, at his cell door, as this would have been regarded as secondary dispensing. The Healthcare Manager accepted that there was some confusion about the policy at the time and has since clarified with healthcare staff that nurses can administer medication in such circumstances. We make the following recommendations:

The Head of Healthcare should ensure that prisoners with wounds that need dressing have these reviewed frequently and the dressings replaced as necessary.

The Head of Healthcare should ensure that prisoners receive medication as prescribed and that there are no unnecessary breaks in treatment.

Prisoners' complaint

91. After the man's death, 30 prisoners signed a complaint that on 25 February, he had been asking for help during the night and did not receive any. When the prisoners were questioned further by the police, and approached by the investigator, most said that they had not heard him call out during the night. The CCTV footage shows that the night patrol officer checked him five times between 10.00pm and 5.10am. He said that the man did not ask for further help that night and we are satisfied that there is no evidence to support the prisoners' claims.

New psychoactive substances

92. As in many prisons, the use of "Spice", a synthetic cannabinoid, known as a new psychoactive substance (NPS) is a problem at Liverpool. Such substances are currently not detectable by prison drug tests and it does not have the characteristic smell associated with cannabis. Its use can produce a wide range of reactions including bizarre, aggressive behaviour and hallucinations.
93. During the investigation, some staff said that they had heard that the man might have been using "Spice", a new psychoactive substance. His ACCT document records on the 21st February 2015 that he was verbally aggressive and threatening to officers for no reason. On 22nd February 2015, there was a strong smell of burning coming from the toilet area in his cell and he became verbally abusive when an officer challenged him. It is possible that these were indicators of use of NPS. A friend of his said he was often under the influence of illicit substances.
94. At the inspection of the prison in May 2015, inspectors noted that there had been increasingly large finds of NPS, coupled with several reported incidents of prisoners suffering from the effects of taking NPS. Inspectors considered that the prison was dealing with the issue robustly through a specific strategy, which included educating prisoners and staff about the risks and a clear protocol for dealing with prisoners suspected of taking NPS.
95. There is no clear evidence that the man was using NPS and it is not possible to say that it played any part in his death. However, given the extent of the problem and the reported concerns of staff, this cannot be ruled out as a possible factor. Unfortunately, toxicology tests as part of the post-mortem did not test for NPS. HM Inspectorate of Prisons noted that Liverpool had identified the scale of the problem, and was taking steps to deal with it. We therefore make no recommendation.

Management of risk of suicide and self-harm

96. Prison Service Instruction 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self harm. The man had a number of these risks. A court probation officer completed a suicide warning form detailing some of his risks and when he arrived at Liverpool, a SO rightly began ACCT procedures.
97. The man said he had attempted to take his life seven times in the previous 12 months, since his wife's death and he said that he had thoughts of suicide every day. He was withdrawing from alcohol and had mental health problems. Despite

these factors, a SO set an initial frequency of observation as three times during the day, once in the evening and six times during the night, until he had been assessed. We consider that the frequency of observations was low, particularly during the day, and did not reflect his level of risk.

98. On 19 February, at the first ACCT case review, the man said that he was no longer having suicidal thoughts and the review panel assessed him as low risk and left the frequency of checks unchanged. However, the agency nurse who attended the review noted in his medical record that he was tearful, visibly low in mood and did not make eye contact. While there is no evidence that he took his own life, we consider that, based on all of the evidence known about him, including a number of recent suicide attempts, he should not have been considered low risk. We make the following recommendation:

The Governor should ensure that prison staff consider all known risk factors when determining the level of risk of suicide and self-harm, and set appropriate levels of observation to reflect identified risk.

Emergency response

99. At 5.12am, the night patrol officer could not rouse the man and radioed for help from the night managers. The assistant night orderly officer arrived quickly, radioed for the emergency response nurse and asked the control room to call for a 'blue light ambulance'. We have not been able to establish whether he radioed a code blue emergency but there is no record of one. The nurse said that she did not hear a code blue call and so did not take the emergency response medical bag with her.
100. In another recent investigation into a death at Liverpool in April 2015, we were concerned that staff did not have a good knowledge of emergency medical code procedures and made a recommendation that the prison will need to implement. We do not repeat the recommendation as we are satisfied that the man received timely treatment and the possible failure to use a recognised emergency code did not affect the outcome.

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