

**Investigation into the circumstances surrounding the
death of a man
at HMP Liverpool**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

December 2006

The man upon whom this report focuses was 57 years old when he died, after hanging himself in his cell at HMP Liverpool. My colleagues and I offer our sincere condolences to his family and friends.

Two members of my office carried out the investigation. I wish to thank the Governor for making the necessary facilities and information available to these investigators, and for the assistance of the prison's Liaison Officer.

In the course of the investigation, I asked for a clinical review to be carried out into the care and treatment received by this man whilst in custody. I am grateful to the Lead Commissioner for Prison Health at North Liverpool Primary Care Trust (PCT) for her assistance.

I conclude that the man kept his intentions very close to himself and gave no indication of what he was planning to do. All the evidence is of a man who had settled in well to the prison regime and was making plans for his future release. He was however aware of further police investigations, and the seriousness of the allegations against him. Had he been charged and found guilty of these offences, he could have expected a lengthy prison sentence.

I am very pleased to record the investigators' positive comments about prisoner and staff relationships at Liverpool. Additionally, where other matters were identified, not all of which related to the man's death, during the investigation, the Governor has already confirmed that he will deal with the majority. (For example, my investigation revealed flaws in the system for handling legally confidential letters.) I do make two recommendations, and the clinical review makes another.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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CONTENTS

Summary	4
Conduct of the investigation	6
HMP Liverpool	8
Key events	12
Issues considered in the investigation	18
Recommendations	22

SUMMARY

On 12 January 2006, the man at the centre of my investigation was sentenced to 28 days imprisonment for failing to supply a specimen, and obstructing a police officer. Fourteen days later, he was convicted of burglary and sentenced to a further 33 months imprisonment. The man was also being investigated by police in relation to offences of possession with intent to supply, for which he expected a custodial sentence of up to eight years if convicted. He was also aware that the police were investigating other matters, which at the time of his death, had not been concluded. These were again of a serious nature and could have resulted in a lengthy prison sentence.

Once the man completed Liverpool prison's induction programme, he joined a computer course based in the prison learning centre, and began to engage in full time education. He appeared to settle well into the prison regime and was considered by officers to be a "model prisoner", always polite and keeping himself to himself. Prisoners too respected the man and said that he would help them with their education course work. He had enquired about training to become an alcohol, drugs and solvents abuse counsellor, in preparation for future employment when released from prison.

In April, at the request of the police, he was taken to a local police station, to be interviewed regarding the alleged offences of possession with intent to supply. He was told that the charges were unlikely to be proceeded with, and could be reduced to individual lesser charges, which he believed would not lead to additional time in prison.

In the same month, the man submitted an application to be assessed for the Enhanced Thinking Skills programme. However, at the time of his death the assessment had not taken place.

At the end of the month, the man wrote letters to two different solicitors, asking for assistance in recovering property taken by police during a search of his home. His marriage had broken down and, at the time of his death, divorce proceedings had started. He also asked them to advise his son whether the Prison Service had any legal liabilities as to his welfare. The man said in the letters that no-one cared about him, and that he was hearing voices telling him one thing and then another. He ended by saying that he could not stand it much longer. Regrettably, the letters were not received by the solicitors until after his death, and the prison was unaware of their content.

At about 5.00am on 2 May, the man's cell mate went to use the in-cell toilet. When he opened the door, the man fell to the floor. He summoned assistance from the Night Patrol Officer, who responded quickly to his shouts and banging on the door. The officer looked through the observation panel in the door and saw the man lying there. He called for assistance from the Night Orderly Officer. When the door was unlocked, officers entered and removed a ligature from around the man's neck. They checked for signs of life, but found none. A nurse attended very soon afterwards, found that rigor mortis had set in and decided that it was inappropriate to

attempt resuscitation. Paramedics arrived at 5.37am and, after carrying out their own checks, confirmed the man's death at 5.46am.

The man's bed was made up to look as if he was in it. He had placed a pillow and bedding in the bed and covered it with a blanket, giving the impression that the bed was occupied. The ligature was a length of plastic coated wire washing line, which was manufactured in one of the prison's workshops until 12 months earlier. It had since remained undetected within the prison.

Following the man's death, my investigators met members of his family. His mother-in-law said that, about eight weeks prior to his death, he began to tell her what he wanted should anything happen to him whilst in prison. He repeated the conversation again six weeks later, but also talked about being released early in 2007. Additionally, during his final telephone call the Sunday prior to his death, she overheard him tell his young daughter not to forget that he loved her, which was apparently an unusual statement. However, neither she nor his family had any concerns for his safety or welfare, or suspected what he was intending to do. They confirmed that they had no reason to inform the prison of the conversations.

THE INVESTIGATION PROCESS

1. Once my office had been notified of the man's death, the investigation was allocated to a senior member of my office. He was assisted by another colleague, and they opened the investigation at the prison on 5 May 2006 by meeting the Governor. Also at the meeting was the prison's Liaison Officer, an officer representing the Prison Officers' Association, a gentleman representing the Independent Monitoring Board, and the prison's Head of Healthcare.
2. The Governor provided a number of documents relating to the man's death, enabling the investigators to identify the people they would wish to interview. On 1 June, my investigators returned to commence their interviews with prison staff, a prisoner and two staff employed by Mercia Partnership and teaching in the prison's Learning Centre.
3. One of my family liaison officers (FLOs) and the investigators met the man's son and his mother on 13 June, and the next day met his parents-in-law. Both families made my investigators welcome and contributed towards the investigation by asking a number of questions. These have been considered as part of the investigation, and I hope this report will provide them with answers.
4. The man's mother-in-law told the investigators that, approximately eight weeks prior to his death, the man started talking about what he wanted in the event of anything happening to him while in prison. She had asked him what he meant but he brushed over it and said that you never know what happens in such places.
5. His mother-in-law also said that about two weeks prior to his death, the man repeated the comment and told her what he wanted. Again she asked him what he meant, but he did not go into any detail. He also told her that the charges he was facing were being reduced to a lesser charge, which would not affect the length of his sentence and he would be eligible for release on tagging in January 2007.
6. Furthermore she said that on the Sunday before his death, the man telephoned her as usual to speak to his daughter. She said that he kept repeating his sentences and appeared to be a little confused. She added that normally when he had finished speaking to his daughter he would send her a kiss, and say that he would speak to her next week. However, on this occasion she heard him say something different, that his daughter should not forget that he loved her, which she thought was unusual.
7. The man's mother-in-law made my investigators aware of a letter written by him, and sent from prison to his former partner. The letter, which was not received until after his death, gave specific instructions for what he wanted to happen to his property.

8. Finally, she confirmed that the man had never discussed any difficulty in accessing medical care in the prison with her, or that he had given her any cause for concern about his own safety.
9. My investigators met the police officer investigating the man's death. He said that the police were carrying out further investigations into potentially serious criminal activities. He confirmed that the man was aware of the nature of the enquiries, and the seriousness of those investigations. If convicted, the man would have been facing a lengthy prison sentence.
10. The man's prison medical record was forwarded to the Lead Commissioner for Prison Health at North Liverpool PCT, who was asked to provide a clinical review of his medical care and treatment. Three specific issues were identified for comment. These are considered at the end of the report.
11. On 2 June, the investigators met the Governor to feedback their initial findings which were largely accepted. Further feedback was given four days later. The remaining staff interviews were completed on 27 June. On this latter occasion, my senior investigator was assisted by one of my Assistant Ombudsmen.
12. Due to the prison having an incorrect address for the man's wife, my FLO was unable to contact her and invite her to meet with the investigators. However, I am pleased to say that following a telephone call from the solicitor acting for her that my investigator and FLO were able to meet with her and her solicitor at her home on 28 September. She raised her own concerns, which we have done our best to address in the report.
13. Following this visit my investigators arranged for the man's wife and her solicitor to visit the prison and to see where the man had died. The visit was agreed by the governor and facilitated by the prison's liaison officer. It is regrettable that following the visit my investigator received a call from the wife's solicitor in relation to their observations in the cell. The solicitor reported that when they entered the cell, a piece of washing line, similar to that used by the man, was hanging from the window bars. This is of concern to me and I have commented on it later in my report.

HMP LIVERPOOL

14. Liverpool prison was constructed in 1855 and replaced a much older prison situated in the centre of Liverpool. There are eight wings, all of which have been refurbished and provided with integral sanitation. The prison serves the courts of the Merseyside area and provides an operational capacity of 1,377 beds.
15. Throughout the investigation, the investigators made a number of unannounced visits to the wings and workshops. They saw good evidence of officers and prisoners interacting with each other and officers ready and willing to talk to prisoners. The atmosphere was relaxed and positive. Prisoners spoke well of the relationships and said they felt safe and able to approach officers if they required anything. I very much welcome this.

Cell

16. The cell accommodation is mainly dual occupancy with bunk beds and integral sanitation, separated from the cell by a door, which opens inwardly into the cell. All cells are fitted with internal lights which can be switched on or off by the occupant. Additionally, the lights can be operated by a member of staff from outside the cell. Each cell door has an observation panel, which allows a member of staff to open the panel and look into the cell and check on the whereabouts of the prisoner.

Wing patrol and observations

17. At certain periods during the day, the prison is in patrol state. Prisoners are locked into their cells and wing staffing levels are at a minimum, with one officer to patrol the wing until the night staff take over at approximately 9.00pm.
18. Roll checks take place at least five times per day and are normally carried out prior to first unlock, lunchtime, evening meal, final lock up and by the night staff when taking over responsibility for the prison. To confirm the wing roll, the officer is required to look into each cell via the door observation glass and be satisfied that the prisoner is in the cell and that the cell is securely locked.
19. During the night, staffing levels are also reduced to one officer on each wing. The night patrol officer is responsible for ensuring that cells and prisoners are secure, and to respond to any cell call bells activated by prisoners who require assistance.
20. Unlike officers on duty during the day, night patrol officers are not issued with security keys. Instead, they are issued with a cell key, in a sealed leather pouch, which is secured to the officer and is only to be opened for urgent reasons to enter a cell. The officer must be satisfied that it is safe to unlock the door and enter the cell. If they judge that it is unsafe, they must wait for assistance to arrive.

21. During Bank Holidays, the regime is restricted to wing association, exercise in the open air and access to the gymnasium. At about 5.00pm, the prisoners are locked into their cells for the evening, and no further evening activity takes place. The learning centre, workshops and offending behaviour courses do not operate on Bank Holidays.

Healthcare

22. With the exception of the Healthcare Manager, all nursing staff are employed by the prison, with the service commissioned from North Liverpool Primary Care Trust.
23. The prison has an 18 bed in patient facility which is staffed by four nurses and one manager during the day, reducing to two nurses and a manager between 5.00pm and 7.30pm, and a further reduction to one nurse between 7.30pm and 9.00pm. Between the hours of 9.00pm and 7.30am, there is one nurse and one Operational Support Grade on duty.
24. Primary care is provided between 7.30am and 5.00pm by five nurses and one manager. From 5.00pm through to 9.00pm, the service is provided by three nurses and one manager. During the night, one nurse is on duty from 9.00pm to 7.30am.
25. The outpatients department is staffed by two nurses from 7.30am to 4.30pm. The department administers prescribed and non prescribed medication. The administration of any drug should be noted on the prisoner's medical record.

Prisoners' education and employment

26. The prison's regime includes a number of courses aimed at addressing offending behaviour, including a variety of education and social skills courses provided by Mercia Partnership. Training courses in industrial cleaning and metal fabrication are also on offer. There are workshops offering employment skills in textiles, leather goods, wood assembly, and wheelchair repair and contract services. Contract services work is usually unskilled, non accredited employment, but providing valuable basic skills.
27. One of the workshops, Workshop 7, manufactures plastic coated washing lines and fishing lines from raw material provided by the contractor. Washing lines and fishing lines are cut to a specific length and then wrapped in preparation for delivery to the contractor and eventual sale to the public.
28. The psychology department offers offending behaviour courses designed to help reduce the risk of re-offending. The Enhanced Thinking Skills course is designed to help the participant to recognise the consequences of their actions and look at alternative decisions.
29. An accredited alcohol, drugs and solvent counselling course is also available as a distance learning course. It provides a recognised qualification for those assessed as suitable to offer counselling to anyone abusing alcohol, drugs or

solvents. It is intended to provide employment opportunities in counselling following release from prison.

30. As counsellors work with mainly vulnerable people, all applications are subject to a risk assessment and further police checks. Prisoners wanting to join the course must apply in writing in the first instance and no-one is allowed to join the course until the necessary clearance has been obtained.

The prison radio network

31. The prison radio communication system is normally on “closed net”. This means that the radio operator in the control room can hear all radio transmissions, but the individual staff with handsets cannot. The only transmission they can hear is anything transmitted by the control room radio operator. However, the system allows for the radio net to be placed on “talk through”. Under talk through conditions, every person with a radio can hear the full transmissions and not simply the transmission made by the control room radio operator.
32. Talk through is often used during an emergency as it allows everyone with a radio to be aware of what is happening. Additionally, talk through is often used during the night time, as it allows the night staff to remain in communication.
33. “Urgent message” is a specific radio transmission used in emergency situations, usually associated with a potential or actual breach of security. If used, it should attract a pre-determined response from the control room. Under normal circumstances, where assistance is required, it would not be usual to announce urgent message.
34. “Black spot” is the term used to describe an area where prison radio signals are either not being received or radios are incapable of transmitting signals. It is a problem which the Governor is aware of, but has been unable to rectify.
35. In the event of urgent medical assistance being required, the prison uses a radio code system to alert medical staff to the emergency. Code red informs them that the patient is bleeding, and code blue alerts them that the patient has difficulty breathing. The system ensures that they take the correct emergency equipment, and can provide the necessary medical care as quickly as possible.

Prison Service Orders (PSOs)

36. Prison Service Orders are long term mandatory instructions. Any instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.
37. PSO 4400 sets out the Incentives and Earned Privileges Scheme (IEP), which is operated by all prisons. It is designed to encourage responsible behaviour, participation in constructive activity and progress through the prison system.

There are three levels to the scheme: Basic, Standard and Enhanced. Prisoners assessed as Basic have the minimum regime and facilities. Standard and Enhanced prisoners are allowed access to more money, additional visits, in cell television and other facilities, dependent upon the resources available.

38. Following any serious incident in prison, PSO 8150 Post Incident Care for Staff section 1.2 allows the Governor the facility to arrange for a "Critical Incident De-brief" to be offered to those staff involved. Critical incident de-briefs should be arranged within seven days of any serious incident and all staff involved invited to attend. They offer a valuable service and allow staff the opportunity to comment in a safe environment on what went well and what could be improved. However, I recognise that it is not mandatory that they take place, and individual governors can choose to use the facility or not.

Prison Rule 39

39. Prisoners and legal advisers are allowed to correspond with each other confidentially and not have the mail read by anyone from the prison unless there is reasonable suspicion that there is illicit content and /or enclosure. Letters arriving or being sent out should have Prison Rule 39 written on the front, which indicates that it should not be opened or read by anyone other than the recipient. Liverpool prison records incoming mail marked in this way, but does not record outgoing mail.

KEY EVENTS

Events prior to 2 May 2006

40. On 12 January 2006, the man was sentenced to 28 days imprisonment for failing to supply a specimen and obstructing a police officer. Additionally, he was remanded for further charges in connection with burglary. When he arrived at Liverpool prison, a member of the healthcare staff interviewed him and completed a first reception health screen document. He did not raise any concerns about his physical or mental health, and declined to see a doctor.
41. The man was allocated to the First Night Centre, where he was assessed in accordance with the first night procedures. He joined the prison's induction programme, where he remained for five days, after which he moved to I wing. On 18 January, he joined a computer course in the learning centre. The same day, a secondary health assessment was completed. As with the first assessment, the man did not raise any concerns regarding his health. He agreed to be immunised against Hepatitis B, and had the first injection on 24 January.
42. On 26 January, the man attended court and was convicted of burglary and sentenced to a further 33 months imprisonment. A further reception health screening check was carried out when he returned to the prison, and the nurse noted that the man had expected to receive a longer sentence. The nurse also noted that he had no thoughts of harming himself, and again declined to see the doctor. He had the second Hepatitis injection on 31 January.
43. The solicitor dealing with the man's divorce visited him at the prison on 6 March, after which a number of legal papers were sent to his wife. Later that month, on 22 March, the man expressed an interest in applying to the learning centre for a place on the alcohol, drugs and solvent counselling course. Although he spoke to an assessor about the course, he did not follow it up by making a formal application.
44. As a result of the man's continued good behaviour and compliance with the prison regime, he was placed onto the enhanced level of the Incentives and Earned Privileges Scheme.
45. On 7 April, at the request of the police, the man was taken to Copy Lane Police Station, regarding additional charges of possession with intent to supply drugs. However, the charge was not expected to proceed due to insufficient evidence, and was likely to be reduced to individual lesser charges. The man had told his cellmate that he expected to receive up to eight years if found guilty of the original charge, but if the charges were reduced he did not expect any further custodial time. The cellmate said that, after returning from the police station, the man appeared relaxed, happy and was not worried about the charges.

46. Three days later the man went to the evening medical treatment room and asked for medication which had not been prescribed to him. The nurse on duty refused his request, as none was prescribed. The investigators have been unable to establish what medication was requested, as no record was made. Unusually, the man became aggressive towards the nurse and, although the nurse did not report his actions, it was recorded on his wing file. The man's cellmate said that the man complained of back pain and he believed he had applied to see a doctor. The investigators were unable to find any record of the request within his medical record.
47. On 23 April, the man submitted a written request to be assessed for the ETS programme, but by the time of his death the assessment had not taken place. The following day, 24 April, he wrote a letter to his wife expressing his views about their relationship. Four days later, he took part in a court video link, when he and his co-accused were remanded until 19 May in relation to the lesser drug charges.
48. Two days later, the man wrote two letters to two firms of solicitors under Prison Rule 39. Each was asked to assist him recover items taken by police officers during a search of his property. He also asked them to contact his son and advise him whether the Prison Service had any legal liabilities for his welfare. The letters continued by saying that, despite asking to see a doctor, he had not had an appointment and no-one cared for him. Finally, he wrote that his head was full of voices telling one thing and then another. He said that he could not stand the voices much longer, and hoped that the doctor would see him on Tuesday. As the letters were probably posted under Prison Rule 39, the prison staff were not permitted to read them. Sadly, they arrived at the solicitors' offices after his death.
49. The investigators found that, contrary to Prison Rules, the man had been typing and printing letters using the computers in the learning centre, one of which was the letter to his wife dated 24 April 2006. Additionally, he wrote a second letter to his wife on 25 April, which was an amended version of the letter written 24 April. It is believed that they were smuggled out of the learning centre, as at least one was found in his possessions. It is not known whether any were posted out of the prison using Prison Rule 39. The investigators raised the matter with the Education Manager who had already identified and corrected the flaw by ensuring that all printers were removed from the classroom and only accessible to tutors. A tutor examined the computer the man had been using and could find no personal letters stored on the hard drive.
50. The prison computer log of telephone calls shows that on 30 April the man made a telephone call to his mother-in-law at 10:31am. The call lasted for 19 minutes 45 seconds and was the last he made which was answered. He tried to call his son's telephone number at 10:52am, but the call was not answered.
51. 1 May was a Bank Holiday, and so the man and others could not go to the learning centre. Prisoners were allowed out of their cells to associate on the wing. The man's cellmate told my investigators that during the afternoon the

man spent some time with another prisoner from the same part of Merseyside, and that he appeared to be acting normally and did not give any cause for concern. He said that the man was due to return to Copy Lane Police Station the following day and that he appeared confident that the police did not have enough evidence to charge him with possession with intent to supply; the man expected the charges to be reduced to lesser individual charges.

52. My investigators spoke informally to an officer familiar with the man, who explained the wing routine for the day. He said that at 4.00pm the tea meal was served, then prisoners returned to their cells to eat. He said the wing roll check started at 4:45pm and, once the roll had been confirmed as correct, the prison was placed into patrol state. At 5:00pm, the officers who were not on duty during the evening left the prison. This officer knew the man well and described him as a model prisoner, who did not make any demands on prison staff. He said that the man and his cellmate were more mature prisoners, who kept themselves to themselves.
53. At about 9.00pm, an officer came on duty as the night patrol officer for I wing. He said at interview that he carried out a roll check of I wing and confirmed the wing roll as correct. He also said that the night was quiet and he had had no reason to check on the man or his cellmate. He said that, when he looked into the man's cell during the roll check, he remembered seeing him and his cellmate watching a film.

2 May

54. The officer who was on night patrol for I wing started the morning roll check at about 5.00am. At interview, the man's cellmate said that at about 5.00am he woke up to go to the in-cell toilet. When he tried to open the toilet door, he found it heavy and difficult to open. He said that as he opened the door fully, the man's body fell to the floor. The cellmate said that he immediately raised the alarm by banging on the cell door and shouting for assistance. He said that the night patrol officer responded very quickly to his call.
55. The officer on night patrol said that he was still carrying out the roll check when, at about 5.20am, he heard loud banging and shouting and saw a cell call light illuminated. He ran immediately to the cell and looked in through the door observation panel. He saw the man's cellmate standing at the door, where he blocked the view into the cell, and asked what the problem was. He said that the cellmate did not reply, but stepped to one side allowing the officer to see the man lying on the floor. In his written statement, the officer said that he could immediately see that the man was dead.
56. The officer on night patrol immediately used his radio to request assistance. His call sign was Alpha Six, which is the call sign allocated to I wing. The radio system was on "talk through" at the time and everyone in the prison in possession of a prison radio heard the officer announce that it was an Urgent Message, and request medical assistance. Unfortunately, the radio transmission was breaking up, as the officer was in a black spot. The

investigators asked whether he used the code blue message, and it was evident that he was unclear as to the meaning of the two codes and so unable to explain which to use in a given situation. Although it would not be normal to transmit an Urgent message in these circumstances, I make no criticism of the officer as his actions prompted an immediate response from his colleagues. However, the finding was brought to the attention of the deputy governor who said that all staff would be reminded of the meaning of codes blue and red.

57. Although the officer was in possession of a cell key held in a sealed pouch, he did not use it to enter the cell. When interviewed, he believed that he was not actually allowed to use the key. My investigators discussed this with the Governor, who said that he would also remind staff of the correct procedure for using the sealed cell key.
58. Two senior officers (SOs) were the night managers and, at the time, were working in an office situated just outside the entrance to I wing. The first SO said that, at approximately 5.30am, they heard the radio message from the night patrol officer and ran immediately to the cell. He said that the radio transmission was intermittent and breaking up, but they realised that the call-sign requesting assistance was alpha six from I wing. As the cell was only a short distance, they arrived very soon after receiving the radio message. When he and the second SO arrived at the cell, the officer told them that the man was dead.
59. At interview, the officer said that the first SO opened the cell door and entered first, followed by the second SO and then himself. However, the first SO said that it was the second SO who unlocked the cell door, and was the first person to enter the cell, followed by the officer and the first SO. He said that the second SO removed the ligature from around the man's neck and began to check for signs of life. He said the ligature was made from plastic coated washing line, which had been secured to the door handle on the cell side of the toilet and then passed over the top of the door into the toilet area.
60. Very soon after they entered the cell, a nurse arrived in response to the radio message. This nurse, a Registered General Nurse, checked for signs of life but could not find any. He said that the man's body was cold to the touch and, when he tried to open his mouth, he found that rigor mortis had begun. He said that the man's jaw was so stiff that he was unable to move it. He appropriately decided that it was not sensible or seemly to attempt resuscitation. The officer left the cell with the man's cellmate. He took the cellmate to a rest room used by the officers where he gave him a drink of tea.
61. Using his prison radio, the first SO asked the control room staff to call an emergency ambulance, and also asked for the duty governor to be contacted at home. He left the cell and returned to the office in order to refer to the prison's contingency plans for dealing with a death in custody. Whilst checking the plans, the duty governor telephoned and the first SO briefed him about what had occurred. The first SO did not return to the cell again, but remained in the office managing the contingency plans.

62. At 5.37am, paramedics arrived and carried out their own medical checks, which included attaching an electrocardiograph machine (ECG) to the man's chest. There was no sign of life and at 5.46am the man was pronounced dead.

After the man's death

63. An examination of the cell showed that the man's bed was the bottom bunk. The bed was made up, with pillows underneath the blankets, placed to look as if it was occupied.
64. As the cell was potentially a crime scene, the door was locked and sealed pending the arrival of the police who had been called by the first SO. The police officers attended and carried out their own enquiries. They were satisfied that the man had not died in suspicious circumstances. The ligature mark on the neck did not extend all the way around and was only evident where the weight of his body caused pressure on the neck.
65. Additionally, the investigators saw that the in-cell light fitting, which should be white, had been painted over at some time with red paint. They spoke to the first SO and asked him if painting the cell lights caused the night staff difficulty in accounting for prisoners. He said, "It has got to pose a problem in as much as it happens, but when the night staff are going around counting, they are checking, as long as they can see them and identify them, then that is fine." He also suggested that it would not be unusual to find lights painted over anywhere in the prison.
66. The investigators also spoke to the night patrol officer about the observation into the cells at night time. He said that it was a problem due to the low light level and suggested that it would help the night staff if they were to be issued with a torch. He said that it had been raised with prison management, but that nothing had been done. At a meeting with the Governor on 2 June, the investigators made him aware of the difficulties with observation into the cells. The Governor accepted the finding and I understand is dealing with the problem, along with his management team.
67. The investigators could find no evidence to show that a Critical Incident De-brief had taken place, or was going to be arranged. They discussed this with the Governor and he said that in his opinion it was not necessary to hold a Critical Incident De-brief in such circumstances.
68. The Governor offered a contribution towards the funeral costs in line with PSO 2710. Additionally, with the family's agreement, the prison was represented at the man's funeral. This is good practice. Unfortunately, one member of staff who attended was wearing clothes marked with HMP Liverpool and had a key chain in full view.
69. My investigators found that not all of the man's private cash had been identified when his property was returned, and £40.49 had been withheld.

When the deputy governor was informed, he instructed that it should be returned immediately. I welcome his intervention.

70. The investigators examined the prison contingency plans for dealing with a death in custody. They found the plans had worked well and the relevant action points had been dealt with appropriately. However, they did find two action sheets, one dated 2002 and the other dated 2005, in the same folder and that the two sheets had not been updated to reflect the latest contingency plan. The investigators informed the Governor of the finding, and he said that the error would be corrected.

ISSUES

Clinical issues

71. Following the man's death, North Liverpool PCT undertook a clinical review into the care and treatment he received whilst in prison. The report, written by the Lead Commissioner for Prison Health acting as clinical reviewer, addressed three specific areas that the investigators wished to clarify on behalf of the man's family.

Should the man have seen a doctor in relation to his back pain?

72. The medical records show that the man received three healthcare screen assessments during his first month at the prison. There is no record to show that he raised any concern about back pain or a slipped disc, and he refused more than one offer to see a doctor. The clinical reviewer said that a doctor's appointment was available, had either he or the nurse requested one.
73. The medical records show that the man was given Ibuprofen, but that it was not prescribed by a doctor. Nursing staff are permitted to issue medicines such as Ibuprofen from an approved list agreed by the Drugs and Therapeutics Committee. The practice is in line with primary care services delivered outside the prison setting. The medication was noted in the Special Treatment Record, which is the wing's record of treatment, but it was not recorded in his individual record. The information should have been entered in both the wing record and his individual record, thus providing a comprehensive record of all his medication, whether prescribed or once only. The wing record also shows that the man had refused Ibuprofen on one occasion, but this information had not been transferred to his individual record.
74. On one occasion, the man became unusually aggressive when the nurse refused to give him any medication. The clinical reviewer said that, if the behaviour was related to a clinical condition, it should have been recorded in the medical record. However, if it was deemed to be a discipline issue, it should have been reported to prison staff and not recorded there. She concluded that it was acceptable that his behaviour was not recorded in his medical records, and that it was an individual clinical judgement as to whether the matter resulted from a clinical condition.

Whether there were any identified mental health issues?

75. The clinical reviewer identified no reported issues relating to mental health problems.

Whether the man asked to see a doctor?

76. There are no records in the man's medical records of any doctor's appointments, nor of any requests to see a doctor.

Administration of stock medicines

77. Although the man had no appointments with the prison's healthcare services, other than routine reception screening and Hepatitis B injections, the investigators became aware that he regularly received pain relief as a one off dose, rather than on prescription. His consumption of the medication was not monitored, and his use was not identified, so no specialist advice was sought. The drugs were only recorded on the wing record, and not in his individual records, though I doubt that full records would have meant that his healthcare needs were properly addressed. It is recognised that the recent introduction of a clinical information system at HMP Liverpool will improve comprehensive record keeping in line with general practice in the community. Nevertheless, the reviewer recommends that full records are maintained.

A review of clinical records should be undertaken to ensure that all appropriate information is contained in the Inmate Medical Record.

Rule 39 letters

78. The investigators examined the system for Prison Rule 39 letters, and were told that prisoners are required to place the letter in an envelope in the presence of an officer, after which it is sealed. The officer is required to sign and print their name on the back of the envelope, and either put it in the wing post box, or take it to the correspondence office. The correspondence officer said that any letter sent out under Prison Rule 39 which does not have an officers' name should be returned to the wing for identification and not posted.
79. However, when a sample of letters were checked, my investigators found that the procedures were not always followed. The sample contained three letters marked Prison Rule 39, one with an illegible signature on the back and the others with no signature or identification. It was questionable whether the name and address of one intended recipient was actually a legitimate legal adviser. It is clear that the system for dealing with letters under the heading of Prison Rule 39 was flawed. Correspondence officers would accept any letter as confidential, providing it had Prison Rule 39 on the front of the envelope.
80. Additionally, only letters arriving at the prison marked as Prison Rule 39 were recorded in the correspondence record, and there was no such system for recording outgoing mail. Had there been so, the investigators could have identified when the letters written by the man to his solicitors were posted. The logic of the recording systems could not be explained by the correspondence officers, and neither could the apparent failure to deal with the outgoing letters marked as Prison Rule 39. The investigators made the deputy governor aware of what had been found. He said that the system would be corrected and staff reminded of what was expected.

Access to the ligature

81. The ligature the man used was made from plastic coated washing line with a wire insert, very much like an electrical cable. The investigators examined the washing line, and asked the instructor responsible for Workshop 7 if it was from his workshop. The instructor confirmed that the line was from the workshop. However, that type of line had not been in use for more than 12 months, as the contract had changed and it had been replaced with plastic coated line without wire.
82. My investigators asked how the line was accounted for and what happened to any off-cuts. They were told by the instructor that the line is cut to a pre determined length by a machine and any off-cuts disposed of in a skip which is kept locked. Although they found no evidence of long pieces of discarded washing line or fishing line around the workshop, they did see large amounts of shorter lengths of fishing line on the floor and in boxes awaiting disposal. It would be possible for a prisoner to join these to form one long line. The investigators have confirmed that the man did not work in Workshop 7, and so could not have taken the line himself. He must have obtained it from some other unidentified source.
83. As part of the investigation, the investigators watched the end of work searching procedures in Workshop 7. They saw the instructor carry out a rub down search of each prisoner, but no check was made of their pockets. That level of search would be unlikely to identify small amounts of line, and it would be relatively easy for prisoners to remove it from the workshop undetected. Although this was not the type of line the man used to hang himself, it is important that the prison is certain that all line is accounted for and any risk of self harm or risks to security are minimised.

The Governor should satisfy himself that the system for accounting for washing line and fishing line is sufficiently robust to allow the detection of any prisoner trying to remove it from Workshop 7.

84. The investigators attempted to identify how the washing line could have remained undetected for so long, and whether it could have been used to hang curtains in a cell. According to the prison, this was not possible as prisoners were not allowed to hang curtains at the cell windows. However, contrary to what they had been told, the investigators found curtains were hanging at a number of windows on I wing, though none of those examined was held up by the same sort of line. There appeared to be a general acceptance amongst officers that, although curtains were not allowed, the custom continued and was not challenged. The investigators discussed the finding with the Governor and he gave immediate instructions to his managers for them to remind all staff of his policy.
85. When the investigators spoke to the man's cellmate, he said that the line was in the cell toilet about one month previously, and used for drying washing. The line was in full view to anyone entering the toilet until one Saturday morning when the man told him that an officer had been into the cell to carry

out a routine security check. The cellmate said the man explained that the officer told him to take it down, as washing lines were not allowed. He did not know whether the officer removed the line or simply told the man to take it down.

86. Routine security checks of cells require the officers to enter the cell and physically examine the condition of the cell, including the toilet area. Additionally, the officer checks that the lights and cell call bell system work satisfactorily. Officers finding any unauthorised item are expected to remove it and, if necessary, report the discovery to the security department. The investigators have found no evidence to suggest that an officer either removed the line or reported it to security. It is possible that the man made up the story of the officer so as not to arouse any suspicion about what he was planning.
87. As I have previously mentioned, the man's mother and her solicitor reported seeing a plastic washing line in the man's cell when they visited the prison following the meeting with the investigation team at the end of September. I am concerned that this situation does not appear to have improved almost five months after the man's death. This has clearly caused distress to the man's mother. I strongly urge the prison to be more rigorous in their security checks of cells.

Attendance at the funeral

88. I welcome the fact that the prison was represented at the man's funeral. Given the family's consent, this is an example of good practice. Sadly, on this occasion one member of staff wore a prison issue fleece jacket with HMP Liverpool written on the front. The family also reported to my investigators that the member of staff had a key chain in full view. This was insensitive and caused unnecessary upset to the man's family.

The Governor should remind all staff of the dress code when attending funerals.

RECOMMENDATIONS

- 1. A review of clinical records should be undertaken to ensure that all appropriate information is contained in the Inmate Medical Record.**
- 2. The Governor should satisfy himself that the system for accounting for washing line and fishing line is sufficiently robust to allow the detection of any prisoner trying to remove it from Workshop 7.**
- 3. The Governor should remind all staff of the dress code when attending funerals.**