Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Fielding, a prisoner at HMP Liverpool, on 19 January 2024

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Daniel Fielding died on 19 January 2024, having been found hanged in his cell at HMP Liverpool. He was 38 years old. I offer my condolences to Mr Fielding's family and friends.

Mr Fielding was assessed as a risk to himself for two short periods in December 2023 and was managed under prison suicide and self-harm support measures. I have identified deficiencies in the way Mr Fielding was supported but am satisfied that Liverpool is taking action to improve the management of prisoners at risk. I have concluded that it was reasonable that staff had not assessed Mr Fielding as a risk to himself when he died.

However, Mr Fielding's assertions that he was in debt were not appropriately investigated and he had used illicit substances while at Liverpool. Staff were unaware of this at the time and the prison is now appropriately reviewing their drug strategy.

An inadequate welfare check by a staff member on the morning of 19 January, meant that a prisoner discovered Mr Fielding hanging less than five minutes later. This was completely unacceptable.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2024**

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Summary

Events

1. Mr Daniel Fielding had a history of suicide attempts, self-harm and substance misuse in custody and the community. On 13 October 2023, Mr Fielding was remanded to custody for an offence of theft. He was taken to HMP Liverpool.

2. Mr Fielding told staff when he arrived that he was prescribed quetiapine (an antipsychotic) as he was diagnosed with personality disorder, depression and anxiety. Mr Fielding received his first dose of quetiapine on the 10 November 2023. Mr Fielding was also prescribed methadone and other medication to lessen his withdrawal symptoms from drugs. He told staff he had last self-harmed around three weeks earlier. Mr Fielding regularly engaged with a substance misuse worker over the following months.

3. On 12 December, Mr Fielding cut himself and staff started Prison Service suicide and self-harm monitoring procedures, known as ACCT, checking Mr Fielding hourly. The next day, during an ACCT assessment, Mr Fielding disclosed being in debt for vapes. He said he missed his family and self-harmed to relieve pressure. Later that day, staff reduced Mr Fielding's observations to four in the day and four at night. Mr Fielding again told a member of staff that he was in debt.

4. On 18 December, staff closed Mr Fielding's ACCT with no healthcare staff present.

5. On 30 December, staff re-opened Mr Fielding's ACCT after he (superficially) cut his neck. The next day staff closed Mr Fielding's ACCT, as they felt he was no longer in crisis.

6. On 17 and 18 January, Mr Fielding did not attend work. He phoned a friend and said that he was struggling with his mental health and had been smoking Spice. Staff were unaware of the content of this call. Those we interviewed had no concerns that he was a risk to himself.

7. On 19 January at 4.55am, staff checked Mr Fielding as part of routine checks on all prisoners. They told us that he was asleep in bed. Another member of staff looked through his observation panel at 7.55am before moving onto the next cell. Shortly after this, another prison looked through Mr Fielding's observation panel, saw that he was hanging and raised the alarm. Two officers went straight into Mr Fielding's cell, radioed an emergency medical code and supported his weight. Staff cut him down and started CPR. Healthcare staff and subsequently paramedics took over Mr Fielding's care. At 9.01am, paramedics pronounced that he had died.

8. After Mr Fielding's death, prison staff found a pipe in his cell. It tested positive for Spice.

Findings

9. There were issues with the implementation of ACCT procedures at Liverpool. Mr Fielding's care plan did not contain any support actions, and healthcare staff did not attend, nor provide an update, on the case review on 18 December 2023 when the

ACCT was closed. Staff closed Mr Fielding's subsequent ACCT prematurely. Liverpool has since taken steps to improve ACCT management for prisoners.

10. There is no debt policy at Liverpool. Staff did not investigate Mr Fielding's assertion that he was in debt or support him appropriately. Unknown to staff at the time, Mr Fielding used Spice while he was at Liverpool. We are satisfied that Liverpool is now reviewing their drug strategy to reduce the demand for and supply of illicit substances.

11. Staff completed an inadequate welfare check five minutes before a prisoner found Mr Fielding hanging.

Recommendations

- The Governor should introduce a standalone comprehensive debt strategy which is communicated to and understood by all staff, including providing appropriate support and intervention to prisoners where there are any concerns about debt.

- The Governor should ensure that welfare checks are clearly defined in Liverpool's Safer Strategy, that staff complete welfare checks in line with this strategy and that there is a robust quality assurance process in place to ensure these checks are done correctly.

The Investigation Process

12. HMPPS notified us of Mr Daniel Fielding's death on 19 January 2024.

13. 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.

14. The investigator visited Liverpool on 23 January. She obtained copies of relevant extracts from Mr Fielding's prison and medical records. She also interviewed two prisoners.

15. The investigator interviewed 11 members of staff and one prisoner at Liverpool in March. She interviewed one member of staff via MS Teams on in April.

16. NHS England commissioned to review Mr Fielding's clinical care at the prison. She conducted eight joint staff interviews with the investigator, and one joint interview with a prisoner.

17. We informed HM Coroner for Liverpool and the Wirral of the investigation. We have sent the Coroner a copy of this report.

18. The Ombudsman's office contacted Mr Fielding's mother to offer condolences and to ask if she had any matters she wanted us to consider. Mr Fielding's mother asked:

    - Why Mr Fielding was not on an ACCT at Liverpool as he had been at HMP Forest Bank.
    - Whether Mr Fielding's records were transferred from Forest Bank.
    - Why, when she phoned Liverpool to pass on concerns that Mr Fielding had cut himself, was she directed to an answerphone in the safer custody department, and nothing was done?

    We have answered these questions in this report.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

20. Mr Fielding's family received a copy of the initial report. They pointed out some factual inaccuracies and omissions. This report has been amended accordingly.

Background Information

HMP Liverpool

21. HMP Liverpool is a Category B local reception and resettlement prison for adult males. There is a healthcare inpatient facility. Primary healthcare services are provided by Spectrum Healthcare UK Limited. Mersey Care National Health Service Foundation Trust provides mental health services. Spectrum Community Health delivers clinical substance misuse services in partnership with Change, Grow, Live who are sub-contracted to deliver psychosocial support services.

HM Inspectorate of Prisons

22. The most recent inspection of Liverpool was in July 2022. Inspectors reported it was an encouraging inspection and there was a positive and caring culture at the prison. However, they found that the supply of illicit items including drugs and mobile phones remained a significant threat to the prison, with prisoners stating that the limited regime often led to drug use. However, inspectors also found that recorded levels of self-harm had fallen by 60% from the last inspection and were now lower than most comparable prisons. Most prisoners who had been on an ACCT were positive about the care they had received. Inspectors found that staff had a good understanding of prisoners' risks and triggers of suicide and self-harm.

23. A well-led and resourced mental health service provided timely screening and assessment of need and risk. This was complemented by appropriate interventions which optimised patient outcomes. An effective integrated substance misuse service provided a wing-based patient-led service, and a tailored approach focused on recovery through joint care planning and interventions. Inspectors found that the supply and oversight of medicines was mostly good, although the administration of medicines was sometimes inconsistent.

Independent Monitoring Board

24. 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 January 2022 to December 2022, the IMB reported that the Board had witnessed the prison raise awareness of actions to take during a medical emergency.

25. They found that a more pro-active approach to reducing the supply and demand of drugs within the prison was needed to improve safety.

Previous deaths at HMP Liverpool

26. In the three years before the death of Mr Fielding, there were 17 deaths at Liverpool. Ten of these were due to natural causes, two were due to drugs, one was unascertained and four were self-inflicted. Up until the end of May 2024, there had been one death since that of Mr Fielding due to natural causes.

27. Following previous self-inflicted deaths in 2021 and 2023, we found failings in Liverpool's key worker scheme and ACCT management.

Assessment, Care in Custody and Teamwork

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

29. As part of the process, a care-map (plan of care, support, and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care-map have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key worker scheme

30. The key worker scheme was introduced in the men's prison estate in 2018. It provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

31. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

32. Mr Daniel Fielding had a history of suicide attempts, self-harm and substance misuse in custody and the community. He had been in prison several times. He was under the care of the community mental health team until August 2023.

33. On 13 October 2023, Mr Fielding was remanded to custody charged with theft. He was taken to HMP Liverpool. Mr Fielding engaged with the first night induction and healthcare screenings. He was subject to substance misuse monitoring as he told staff that he used heroin and crack cocaine in the community and he was prescribed methadone and other medication to lessen his withdrawal symptoms. Mr Fielding said he was prescribed quetiapine in the community (an antipsychotic medication) as he had emotionally unstable personality disorder (including paranoia, impulsivity and emotional dysregulation which culminated in self-harming behaviours and suicidal thoughts and attempts), depression, and anxiety. He said he had self-harmed three to four weeks earlier when he was not taking his medication. Mr Fielding said he had no current thoughts of suicide or self-harm. A nurse referred him to the mental health team.

34. On 16 October, a mental health nurse assessed Mr Fielding. He did a Generalised Anxiety Disorder (GAD) assessment, which showed that Mr Fielding did not have significant anxiety or depression. The nurse noted that Mr Fielding said he had been prescribed quetiapine in the community but had not received it in prison.

35. On 17 October, a substance misuse recovery worker for Change Grow Live (CGL) saw Mr Fielding. He noted that Mr Fielding was positive about his recovery. He continued to see Mr Fielding regularly over the following months, completing eight contacts between October and January. They covered relapse prevention, risks of using drugs and methadone reduction. He told the investigator that Mr Fielding did not disclose any substance use in custody, nor did he ever have reason to suspect he was using any substances.

36. On 26 October, a mental health administrator telephoned Mr Fielding's community GP requesting information about Mr Fielding's diagnosis and treatment. On 9 November, a prison GP prescribed Mr Fielding quetiapine, which he started taking the next day. On 15 November, Mr Fielding was allocated a prison job.

37. An officer completed a key worker session with Mr Fielding on the 28 November. She recorded that Mr Fielding had no issues or concerns.

December 2023

38. On 11 December at 9.23am, Mr Fielding's mother contacted the prison's safer custody careline and left a message telling them that Mr Fielding had self-harmed. Safer Custody staff listened to this message on 12 December at 8.57am. As a result, a Supervising Officer (SO) and another member of staff spoke to Mr Fielding. He said that he was struggling with his mental health, and not being able to have contact with his girlfriend (due to domestic abuse allegations) affected him. He said he had self-harmed by cutting his legs to "release pressure" and did not want to end his life. Staff started prison suicide and self-harm monitoring and support procedures, known as ACCT, and placed Mr Fielding on hourly observations.

39. On 13 December, an officer completed Mr Fielding's ACCT Assessment. Within this, Mr Fielding disclosed that he was in debt due to vapes and was struggling because he missed his family.

40. A SO later chaired Mr Fielding's ACCT review. The clinical team leader of the Integrated Mental Health Team (IMHT), an officer and Mr Fielding were also present. Mr Fielding told staff that he felt increasing pressure in prison but had no currents thoughts of suicide or self-harm. Staff reduced his observations to four through the day and four through the night. They did not discuss Mr Fielding's disclosure that he was in debt.

41. The officer recorded in the ACCT document that Mr Fielding had disclosed he was in debt to her during an ACCT check conversation and requested a 'drop down' (an early release of money from a prisoner's private funds to their prison account). This was agreed on this occasion to try and stop Mr Fielding from worrying (we do not know who agreed the drop down). The SO told us that he was not aware that Mr Fielding had disclosed that he was in debt. The officer told us that she did not discuss Mr Fielding's debt with him any further.

42. On 18 December, a SO chaired an ACCT review with a Custodial Manager (CM) and Mr Fielding. Before the review, the SO contacted the mental health team who said they could not attend due to the large amount of ACCT reviews scheduled that day. They also did not provide input via telephone or in writing. The SO and CM agreed to close Mr Fielding's ACCT as he reported no thoughts of suicide or self-harm and said he had good contact with his family. Phone records confirm that he had regular calls with his mother.

43. On 30 December, Mr Fielding's mother contacted the safer custody careline and left a message that Mr Fielding had self-harmed. An orderly officer listened to this message. He checked Mr Fielding and found that he had self-harmed by superficially cutting his neck. Staff started ACCT procedures and set half hourly observations. A Healthcare Assistant (HCA) examined Mr Fielding and noted that his injuries were superficial and did not require any follow up.

44. On 31 December, following his ACCT assessment, a CM chaired Mr Fielding's ACCT review, with a nurse (IMHT) and Mr Fielding. He said that he had self-harmed because he was having a "blip" and "a low moment in the festive period". Staff decided to close his ACCT as they felt that Mr Fielding was no longer in crisis. Neither the CM nor the nurse had had any prior contact with Mr Fielding. The CM was unaware of the extent of Mr Fielding's self-harming history.

January 2024

45. On 2 January 2024, an officer completed a key work session with Mr Fielding. Mr Fielding said that he had struggled over the holiday period but currently felt "fine". He said he was in regular contact with his mother and family.

46. On 9 January, a substance misuse recovery worker completed a detox assessment after Mr Fielding had asked to start reducing the methadone he was prescribed. Mr Fielding spoke about continuing the reduction in the community if he was released.

47. On 12 January, Mr Fielding attended court via videolink. Mr Fielding's pre-trial hearing was set for 26 February. There are no notes to indicate Mr Fielding was spoken to following this, as he should have been.

48. On 17 and 18 January, Mr Fielding refused to attend work and gave no reason. On 17 January, Mr Fielding phoned a friend and told her that he had refused to attend work because of his 'head' (the context suggests Mr Fielding was struggling with his mental health). Mr Fielding also said that he had been smoking Spice. We interviewed a prisoner, who also said that Mr Fielding smoked Spice during his time at Liverpool. He said that he was not aware of Mr Fielding having any issues with other prisoners on the wing.

49. An officer had contact with Mr Fielding on 16, 17, and 18 January. She recalled that he appeared fine. On 18 January, a nurse met Mr Fielding on the landing for his 13-week recovery assessment. He had no concerns about Mr Fielding's state of mind, although he acknowledged that he did not complete a comprehensive assessment.

50. At 4.15pm on 18 January, Mr Fielding went into his single cell, which an officer then locked. The officer told Mr Fielding that she would see him on Saturday (20 January), and he replied, "Okay, Miss." She had no concerns about Mr Fielding's mood during their final contact.

51. At 6.38pm, Mr Fielding phoned his mother. During their conversation, the investigator noted that Mr Fielding seemed upbeat and told his mother that he loved her and would speak to her the following day. A prisoner told us that on this day, Mr Fielding "had perked up" and it was as if "all his problems were gone". Before this, he said Mr Fielding's moods varied and he had made a comment about a "noose fitting through the light fitting" (it was not clear when this comment was made). During interview, the prisoner stated that he had reported this comment to prison staff who, he said, would keep an eye on Mr Fielding.

Events of 19 January 2024

52. The investigator watched CCTV footage, body worn video camera (BWVC) footage and listened to prison radio transmissions from 19 January. She also obtained information from the Northwest Ambulance Service. The following account has been taken from all sources.

53. Officer A did a routine morning check of all prisoners at approximately 4.55am. She recalled that Mr Fielding was asleep in bed at the time.

54. Prisoner A told police that, before he was unlocked, at around 7.00am, he looked through his observation panel across to Mr Fielding's cell (they lived on opposite sides of the landing). He said that Mr Fielding looked like he was stood behind his cell door as he could see a shadow at the bottom of his cell door. He said that this slightly concerned him as he did not know what Mr Fielding was doing. He began to worry that Mr Fielding had "done something" as he thought he had been struggling recently.

55. At 7.55am, staff unlocked the prisoner from his cell. CCTV shows that, from the other side of the landing, he appeared to look at Mr Fielding's cell for five seconds before he continued to walk down the landing. At the same time, Officer B was

carrying out a welfare check of all prisoners. She looked through Mr Fielding's cell observation panel briefly before moving on to the next cell. She did not unlock Mr Fielding's door as he was not on the morning list to attend work. We have been unable to interview her as she was on extended leave following Mr Fielding's death. She has not responded to the prison's attempts to contact her on our behalf.

56. Prisoner A saw Officer B check Mr Fielding and therefore doubted himself that there was anything wrong. At 7.59am, he went to Mr Fielding's cell and looked through the observation panel. He told police that he could see that Mr Fielding had hanged himself. He walked to the shower area and appeared to gesture towards Mr Fielding's cell and put his hand on his neck. He went back into his own cell briefly and then walked down the landing out of view of the camera. He told police that he had told Prisoner B that Mr Fielding had hanged himself. (We tried to speak to Prisoner A ourselves, but he was too distressed to be asked about the incident.)

57. At 8.00am, Prisoner B walked quickly down the landing shouting to staff. Officer C told us that she could hear him shouting but could not clearly hear what he was saying. She and Officer B went straight to Mr Fielding's cell, looked through the observation panel and saw he was hanging from the light fitting by a ligature made of bedsheets. At 8.01am, the officers went into the cell. Officer B radioed a code blue (used to indicate a medical emergency where the prisoner is having breathing difficulties or is unconscious). However, this was not clear to control room staff. (This emergency code can be clearly heard on BWVC footage, but not on the radio transmissions.) Both officers supported Mr Fielding's body weight and tried cut the ligature using their anti-ligature knife but could not do so as it was very thick. A SO responded to the officers' screams and arrived at the cell 20 seconds later. Another officer, following the SO, radioed a code blue and control room staff immediately called an ambulance.

58. The SO supported Mr Fielding, while Officer B untied the ligature from the light fitting and they laid Mr Fielding on the floor. The SO managed to remove the ligature from Mr Fielding's neck and started CPR.

59. A nurse got to Mr Fielding's cell at 8.02am, along with other healthcare staff. They noted that Mr Fielding had no signs of life and looked grey. Healthcare staff took over his treatment and administered oxygen while CPR continued. Paramedics arrived at 8.21am and took over Mr Fielding's care. At 9.01am, the paramedics pronounced that Mr Fielding had died.

60. After Mr Fielding had died, police found a final note in his cell stating that he loved his mum and daughter and apologising for 'what I've done'. Prison staff also found a pipe in his cell which tested positive for synthetic cannabinoids.

Contact with Mr Fielding's family

61. The prison appointed a family liaison officer and a deputy family liaison officer. At 11.40am, they visited Mr Fielding's mother at her home address and broke the news of her son's death and offered their condolences. Liverpool contributed to Mr Fielding's funeral costs in line with national instructions.

Support for prisoners and staff

62. After Mr Fielding's death, the Governor debriefed the prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

63. The emergency response nurses told us that they were not invited to the prison debrief. A nurse said she thought that the debrief was called over the radio, which healthcare staff did not hear. Healthcare staff discussed the incident during their lunchtime handover later that day. The nurse did not receive any communication from the safer custody team or the Trauma Risk Management team (TRiM). Another nurse said that more could have been done to support healthcare staff.

64. The prison posted notices informing other prisoners of Mr Fielding's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Fielding's death.

Post-mortem report

65. The pathologist concluded that Mr Fielding died because of neck compression due to hanging. They also noted that Mr Fielding had synthetic cannabinoids in his system, which he may have been experiencing the effects of at the time of his death.

Findings

Assessment and management of risk of suicide and self-harm

66. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, lists risk factors and potential triggers for suicide and self-harm. It says all staff should be alert to the increased risk of suicide or self-harm posed by prisoners with these risk factors and should act appropriately to address any concerns. Any prisoner identified as at risk of suicide and self-harm must be managed under Assessment, Care in Custody and Teamwork (ACCT) procedures. PSI 64/2011 also states that any information that becomes available which may affect a prisoner's risk of harm to self must be recorded and shared, to inform proper decision making.

67. Mr Fielding had several risk factors including an extensive history of deliberate self-harm and suicidal thoughts, mental illness diagnosis, personality disorder diagnosis, recent contact with psychiatric services (discharged in August 2023), impulsiveness, relationship difficulties, and drug use.

68. Mr Fielding was subject to ACCT support twice in December (once for seven days and then for two days). Both times, staff opened the ACCT after Mr Fielding's mother had called the prison and left a voicemail for staff to say that he had self-harmed. We have some concerns about the management of these ACCTs:

- Given Mr Fielding was regularly seen by a substance misuse worker, it would have been good practice to invite him to ACCT reviews.
- Despite Mr Fielding disclosing he was in debt during his first ACCT assessment, staff never subsequently discussed this with him or offered him support.
- The first ACCT opened had no care plan to identify ways to support Mr Fielding and lessen his risk to himself.
- When staff closed the first ACCT, no healthcare staff were present, nor did they provide any input. Given Mr Fielding's mental health diagnosis and prescription of quetiapine this was a missed opportunity to holistically assess his risk. The Head of Healthcare told us she would expect staff to provide a written contribution if they could not attend a review. However, both prison and healthcare staff told us that this did not occur in practice.
- Staff closed his second ACCT after one day. Neither of the members of staff present had any previous knowledge of Mr Fielding or his significant risk history. Given this lack of knowledge, we consider this was premature, particularly as Mr Fielding said that the festive period was a trigger for him, and it was New Year's Eve. When assessing his risk, staff placed too much emphasis on what Mr Fielding said rather than objectively considering his known risk factors.
- Despite both ACCTs being opened following Mr Fielding having told his mother he had self-harmed, there is no evidence that staff considered asking Mr Fielding if she could be involved in the ACCT. She would have been able to provide a different insight into Mr Fielding's behaviour and support that had helped in the past.

69. Despite our concerns about the management of Mr Fielding's ACCTs, we have not found anything to suggest that staff should have considered he was at increased or imminent risk of suicide when he died or foreseen his actions. Neither wing staff nor the prisoner we spoke to had any concerns about him.

70. The HMPPS Early Learning Report identified the need for staff to undertake the relevant ACCT case manager training in relation to risks, triggers and protective factors and how this translates into a meaningful plan to reduce the risk of harm. They also highlighted a need for a robust system of quality assurance of ACCT plans, to ensure a system is in place to monitor the completion of reviews with appropriate multi-disciplinary attendance.

71. The Head of Safer Custody told us that in response all SOs within the establishment were either refresher trained or sent on initial case manager training. ACCT training is now scheduled on all lock down training days with external support provided by the regional safety team on specific risks, triggers, and protective factors training. She also told us that they have additional staff in safer custody and have created a database to ensure regular quality assurance of new ACCTs, open ACCTs, and closed ACCTs. Any issues identified within the quality assurance process are logged and the individual responsible is required to attend safer custody for feedback and support.

72. We are satisfied that the actions taken by Liverpool are positive and afford greater knowledge and oversight of the ACCT process and the identification of risk factors. We therefore make no recommendation.

Debt

73. Mr Fielding disclosed that he was in debt due to vapes to two different officers. However, given that Mr Fielding used drugs while he was at Liverpool, the debt may have been connected to substance misuse. Despite staff recording information about Mr Fielding being in debt in his ACCT document, staff did not discuss it with him further in terms of how it affected his risk to himself. They also did not submit an intelligence report or refer Mr Fielding for a Challenge, Support, Intervention Plan (CSIP – to support those who are perpetrators of or at risk of bullying or violence). Since these actions were not taken, staff also did not review Mr Fielding's debt in the multi-disciplinary Safety Intervention Meeting (SIM) meeting.

74. Liverpool does not have a debt policy. The Liverpool *Safer Strategy* (April 2022) records debt as a contributing factor 'that can cause men in custody to present with complex and challenging needs which can make them a risk to themselves or to others'.

75. The Head of Safer Custody told us that when informed of debt, staff must complete an intelligence report and CSIP referral. This is reviewed in the safety intervention meeting (SIM) weekly. Staff we interviewed were all unaware of this process.

The Governor should introduce a standalone comprehensive debt strategy which is communicated to and understood by all staff, including providing appropriate support and intervention to prisoners where there are any concerns about debt.

Substance Misuse

76. Liverpool's Drug Strategy, published in April 2022, identifies the cycle of disruption and violence associated with misuse of drugs. It goes on to highlight consequences of drug misuse such as an unstable regime, debt, and self-harm.

77. The PPO investigation identified that Mr Fielding had been using Spice at Liverpool. During interview, staff stated that they were unaware that Mr Fielding had been using Spice. Staff reported no suspicions of him being under the influence of illicit substances at Liverpool.

78. The recently appointed Head of Drug Strategy told us that Liverpool are in the process of reviewing their drug strategy. The focus will be on restricting supply, reducing demand, and building recovery across the estate. The prevalence of drugs within the establishment is one of the Governor's current six priorities. They have rolled out training to front-line staff to administer Naloxone (which can reverse the effects of an opioid overdose) as a priority.

79. It is concerning that Mr Fielding was able to obtain and use Spice while he was at Liverpool. It may have impacted on his state of mind when he took his own life. However, we are satisfied that the prison is taking proactive steps to reduce the supply of and demand for Spice at the prison and while this work takes place, we make no further recommendation.

Welfare Check

80. Liverpool's *Safer Strategy* instructs that staff do a welfare check on every prisoner before they are unlocked in the morning. It notes that this is separate to the routine checks. The strategy does not define what a welfare check is. We consider that, at the very minimum, it is a check for signs of life and that there is nothing obviously wrong with the prisoner. Staff confirmed that this was the case and that, during the day, staff should also get a verbal response from the prisoner.

81. The Head of Safer Custody provided the investigator with copies of notices issued to staff in July 2022 and February 2023 regarding welfare checks. The 2023 notice highlights that staff should physically check the presence of the occupants in every cell, ensure they receive a positive response from prisoners and receive a gesture of acknowledgement from them, and if they fail to get a response must use the medical emergency code.

82. On 19 January at 7.55am, Officer B did the welfare check on Mr Fielding. She looked through his observation panel and moved onto the next cell. As already stated, we were unable to interview her.

83. We conclude that Officer B did not complete an adequate welfare check as, according to the evidence of others, Mr Fielding had already hanged himself at this time which she failed to notice. We note that the observation panels on H Wing are small circles, rather than hatches that can be opened. During our investigation, the investigator looked at the observation panels and noted that the visibility into cells is poor. However, a prisoner was able to look through the panel and quickly identify that Mr Fielding was hanging, and it therefore should have been possible for staff to do so.

84. Following Mr Fielding's death, the Head of Safer Custody told the investigator that she was concerned that welfare checks were not always being done adequately. We have not seen any evidence that Liverpool has taken a robust approach to improving the quality of these checks. We make the following recommendation:

The Governor should ensure that welfare checks are clearly defined in Liverpool's Safer Strategy, that staff complete welfare checks in line with this strategy and that there is a robust quality assurance process in place to ensure these checks are done correctly.

Key working

85. An officer was allocated as Mr Fielding's key worker. Between October 2023 and January 2024, she recorded three key working sessions. In interview, she described the frequent contact she had with Mr Fielding through which he seemed well supported (most of this contact was not recorded in his record). She also highlighted that key working often does not happen due to staffing levels Concerningly, all staff we interviewed said that key working was not happening consistently.

86. Since Mr Fielding's death, Liverpool confirmed that they are operating on an amber/red regime, meaning they are unable to achieve the expectation of delivering one key work session per month to all prisoners. They have recently identified four members of staff who work as dedicated key workers, with a target that each new prisoner receives a key work session within their first 14 days at the prison. Staff in the segregation unit and healthcare department will also be expected to complete one key work session per month with prisoners in those units. Once the prison moves to an amber/green regime, the dedicated keyworkers will target prisoners on Imprisonment for Public Protection sentences, young adults, and those whose ACCT is in post-closure. Liverpool has based the model on those considered at highest risk by the safety department.

87. Given the staffing pressures that Liverpool was under, we are satisfied that they have a plan in place, based on identified risk, to increase key working within the establishment. In addition, Mr Fielding appears to have been well supported by his key worker, albeit that this was not always documented. We make no recommendation.

Clinical care

88. The clinical reviewer concluded that the physical and mental healthcare Mr Fielding received was of a reasonable standard equivalent to that which he could have expected to receive in the community. However, she raised some procedural concerns relating to healthcare systems and processes, which she did not assess contributed to Mr Fielding's death. The Head of Healthcare will wish to address these concerns, some of which are detailed further below.

Head of Healthcare to note

Delay in prescription of quetiapine

89. Mr Fielding disclosed during his reception screening process, on 13 October, that he was prescribed quetiapine in the community. Mr Fielding was not prescribed quetiapine at Liverpool until 9 November and received the first dose of this medication the next day. The Head of Healthcare will want to ensure all healthcare staff ensure continuity of prescribing of all significant and/or critical medicines, after arrival in prison without delay and additionally that doses are not missed due to delays in repeat prescriptions.

Recording information

90. The clinical reviewer concluded that healthcare staff did not always adequately record their contact with prisoners. The Head of Healthcare will want to ensure this is improved.

Governor to note

91. Mr Fielding's mother said that she telephoned the prison concerned for her son's welfare five times and was directed to leave a message on the safer custody answerphone. Staff responded to two of these calls, on one occasion almost 24 hours after receiving the call. The prison could not identify calls that Mr Fielding's mother said she made on 17 October, 7 December, or 9 January.

92. Safer custody staff, or an orderly officer, check the answerphone daily. When asked how members of the public would raise urgent concerns about a prisoner (as it could be considered these were), staff said that they should leave a message on the answerphone. We do not consider that this is appropriate where there are concerns about an imminent risk to a prisoner. The public should be able to raise these directly with a member of staff to act on immediately. The Governor will wish to assure himself that such calls are directed appropriately once received at the prison.

Governor and Head of Healthcare to note

93. Healthcare staff were not invited to the debrief after Mr Fielding died. Those we interviewed said they had not felt adequately supported. We bring this to the attention of the Governor and Head of Healthcare.

Inquest

94. At the inquest, held from 16 June to 20 June 2025, the jury concluded that Mr Fielding died by suicide.

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