

HMP Liverpool Justice Committee: INQUEST briefing note

23 January 2018

About INQUEST

INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. INQUEST's specialist casework focuses on deaths in prison and other forms of detention, mental health settings, and deaths where wider issues of state and corporate accountability are in question, such as Grenfell Tower. Our policy, parliamentary, campaigning and media work is grounded in the day to day experience of working with bereaved people.

INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody, and was until recently a member of the Independent Advisory Panel on Deaths in Custody. She was an advisor to the Harris Review into self-inflicted deaths in custody of 18-24 year olds published in 2013, and advisor to the Corston Review on women in prison published in 2007. Over almost 40 years of work on deaths in custody, INQUEST has published numerous reports, books and given evidence to many parliamentary committees.

We hope this briefing note may be of use in your important discussion of HMP Liverpool and the current crisis in prisons.

HMP Liverpool

The recent report on Liverpool prison is one of the most shocking indictments of a prison by inspectors in years. However the inspection is only a small part of the range of damning evidence on the prison's conditions. Institutional neglect, violence, bullying, and inhumane conditions at HMP Liverpool have been highlighted time and time again at recent inquests. The prison has had the second highest number of self-inflicted deaths of any prison in England and Wales. INQUEST has worked with many families bereaved by a death in HMP Liverpool.

As with Nottingham prison, where the Inspectorate found serious safety failures repeated from earlier inspections, previous recommendations for improving the Liverpool regime have been effectively ignored. As have the findings of inquest's, detailed below.

We also note that despite the deaths and failures at HMP Liverpool, NHS England are cutting the healthcare budget at the prison ([as reported by the BBC](#)). Since 2011 there have been at least 17 self-inflicted deaths in the prison, many raising concerns about the level of healthcare provided. That NHS England are cutting the budget just shows the lack of priority afforded to prison healthcare. It is clear they are ignoring the warnings and increasing the risk of further deaths. Prison and health ministers must act on these risks to prisoner health and safety.

Recent deaths and inquest conclusions: neglect, bullying and failures

Recent inquest conclusions have shown evidence of systemic neglect and repeated serious failings by prison staff and managers, including failing to implement suicide and self-harm monitoring policies (known as ACCT). Inquests have also found that violence and bullying have contributed to self-inflicted deaths.

HMP Liverpool has had the second highest number of self-inflicted deaths of any prison in England and Wales in the last ten years. HMP Woodhill has had the highest number. In 2017 there were four deaths in HMP Liverpool, three self-inflicted and one awaiting classification. In the five years from January 2012 to December 2017, 31 people died in HMP Liverpool. Of these, 14 deaths were self-inflicted and two await classification.

We invite the committee to consider the outcomes of recent inquests as part of their evidence, detailed further in the following media releases.

- Carl Newman, 23, died of a self-inflicted death on 11 November 2017, just a month after the inspectors left. We await the inquest into his death.
- John Duffey died in July 2016. The inquest concluded that bullying, debt and drug abuse in HMP Liverpool exacerbated the conditions that led to the death of John Neil Duffey, ([Media release](#), November 2017)
- Sam Molyneaux died in April 2016. The inquest concluded bullying contributed to his death, ([Media release](#), September 2017)
- Edwin 'Ned' O'Donnell died in October 2016. The inquest jury found neglect contributed to his death, ([Media release](#), July 2017)
- Ashley Gill died in April 2015. An inquest jury found that neglect contributed to his death, ([Media release](#), September 2016)
- Lee Rushton died in January 2015. An inquest jury found neglect contributed to his death in damning narrative conclusion, ([Media release](#), May 2016)

HMP Nottingham

We also note our strong concern about the situation in HMP Nottingham, as highlighted by the inspectorate. Ten prisoners have died in two years, compared with four deaths in the previous 10 years.

The majority of recent deaths were of men in the first night centre or on induction. Both HM Inspectorate of Prisons and the Independent Monitoring Board had previously raised concerns about the influx of vulnerable prisoners arriving at HMP Nottingham each day, and reception staffing and procedures. Yet the situation was allowed to continue and five newly arrived prisoners died over a four-week period in Autumn 2017.

Why was this not stopped in its tracks when problems were so clear and well documented? That the inspectorate are still finding lamentable dangers and failings in care is reprehensible. This points to INQUEST's ongoing concern about failures in the mechanisms of accountability. This is a broken prison within a broken system.

More information on this can be found in our recent [press release](#), and this [article](#), which INQUEST assisted with following the deaths in October.

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