Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Robinson, a prisoner at HMP Leeds, on 11 December 2022

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 HM Prison and Probation Service 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 Lee Robinson was found hanged in his cell at HMP Leeds on 11 December 2022. He was 39 years old. I offer my condolences to his family and friends.

Prison staff managed Mr Robinson under suicide and self-harm prevention procedures (known as ACCT) throughout his four months in custody. Evidence suggested that their support actions had helped to reduce his risk significantly in the time before his death. While subsequent events showed that Mr Robinson had not made as much progress as was thought, I am satisfied that his risk of suicide and self-harm was well-managed during his time in prison.

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 **August 2023**

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Summary

Events

1. On 10 August 2022, Mr Lee Robinson was remanded in custody to HMP Leeds, charged with murder. Prison staff started suicide and self-harm prevention procedures (known as ACCT) when he arrived. In his first weeks in prison, staff judged Mr Robinson to be at high risk of suicide and self-harm. He spoke about a clear intent to take his life and spent several weeks being constantly supervised as a resident of the healthcare inpatient unit.

2. By the end of September, Mr Robinson had moved to A Wing and was no longer constantly supervised. His ACCT case co-ordinator held frequent case reviews through October and November, and Mr Robinson began to make significant progress. He was asked to run Andy's Man Club (a suicide prevention charity) on A Wing, after engaging positively with it over several weeks. By 7 December, the ACCT case review panel was satisfied that Mr Robinson's risk had reduced sufficiently to allow three meaningful conversations and no observations during the day, with six observations at night.

3. At 2.06pm on 11 December, Mr Robinson's birthday, a prisoner looked into Mr Robinson's cell and saw him hanging from a ligature. He alerted prison staff who radioed for emergency medical assistance, cut the ligature and began cardiopulmonary resuscitation. Paramedics took Mr Robinson to hospital but confirmed his death later in the afternoon.

Findings

4. Prison staff took some positive, supportive actions to help Mr Robinson. His ACCT was well-managed in line with national instructions and through consistently attended, multidisciplinary case reviews. There were examples of good practice, including holding case reviews both before and after an important court appearance. While hindsight shows us that Mr Robinson's risk in the time leading up to his death had escalated, we are satisfied that staff judgements were based on clear evidence of Mr Robinson's apparent progress through custody.

5. While Mr Robinson's ACCT case management was mostly positive, there were some learning points. His desire to achieve the benefits of enhanced status on the prison's Incentives and Privileges Framework could have been supported through the ACCT care plan. On the morning of his death, the required meaningful conversation did not take place, which meant that prison staff missed an opportunity to identify any increased risk of suicide and self-harm.

The Investigation Process

6. The PPO was notified of Mr Robinson's death on 11 December 2022. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

7. The investigator visited Leeds on 20 December 2022. He obtained copies of relevant extracts from Mr Robinson's prison records and interviewed one prisoner.

8. The investigator interviewed 13 members of staff at Leeds between 6 and 8 February 2023.

9. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison. They jointly interviewed healthcare staff.

10. We informed HM Coroner for West Yorkshire (Eastern) of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

11. The Ombudsman's family liaison officer contacted Mr Robinson's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Robinson's mother asked whether he should have been awarded enhanced status on the prison's Incentives Policy Framework scheme and whether his risk of suicide and self-harm was properly assessed before his death.

12. We shared the initial report with HM Prison and Probation Service (HMPPS). They did not identify any factual inaccuracies.

13. We also shared the initial report with Mr Robinson's mother. She did not make any comments.

Background Information

HMP Leeds

14. HMP Leeds is a local prison holding up to 1,218 men who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. Midlands Partnership Trust provides psychosocial substance misuse services.

HM Inspectorate of Prisons

15. The most recent full inspection of HMP Leeds was in June 2022. Inspectors reported ACCT case reviews were comprehensive and included regular input from mental health staff. They found that the quality of entries in ACCT documents was reasonable and that surveyed prisoners who had been managed under ACCT procedures said that they felt cared for by staff. Inspectors also reported that the weekly safety intervention meeting (SIM) provided good-quality monitoring of those requiring additional support.

16. Inspectors reported that the number of deaths was high, including eight self-inflicted deaths since their last inspection (in November 2019). However, they found that the number of self-harm incidents was lower than at their last inspection and in similar prisons.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to December 2020, the IMB reported that they had raised concerns with the Governor about the death of a first-time prisoner who had received a long sentence within five days of imprisonment. They were informed that such prisoners, and those on remand and awaiting trials for serious offences, would be targeted by keyworkers to build a relationship and to identify risks of self-harm.

Previous deaths at HMP Leeds

18. Mr Robinson was the twenty-ninth prisoner to die at Leeds since December 2019. Of the previous deaths, nine took their own lives, including one prisoner who died earlier on the same day as Mr Robinson. Two of these prisoners had been managed under ACCT procedures in the period before they died. In one investigation, we found deficiencies in the management of the ACCT procedures, but in the other, we found evidence of good management and positive practice.

19. Since Mr Robinson’s death, five more prisoners have taken their lives at Leeds. As a result, Leeds is receiving additional support and monitoring from regional and national safety teams.

Assessment, Care in Custody and Teamwork

20. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be made at irregular intervals to prevent the prisoner anticipating when they will occur.

21. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011 on safer custody.

Key Events

22. In 2019, Mr Lee Robinson was detained for two weeks under the Mental Health Act after jumping from a bridge onto a motorway. His medical records recorded a history of depression and anxiety. In December 2020, Mr Robinson was sentenced to two and a half years in prison. During his time in prison, staff managed Mr Robinson under ACCT procedures on five occasions. In November 2021, he was released from custody.

23. On 10 August 2022, Mr Robinson was remanded to HMP Leeds, charged with murder. Court staff completed a suicide and self-harm warning form, in which they identified that he had tried to strangle himself on the way to court. The warning form also noted that he had attempted suicide during a previous prison sentence.

24. Prison staff started ACCT procedures when Mr Robinson arrived at Leeds. They recorded that he had deliberately banged his head on the wall, tied clothing around his neck and said that he would "kill himself at the first opportunity". A nurse referred Mr Robinson to the mental health team and a GP at Leeds prescribed medication for anxiety. The next day, an antidepressant was added to Mr Robinson's medication. (He only took the antidepressant for a few days before stopping due to its side effects.)

25. On 11 August, a Supervising Officer (SO) chaired the first ACCT case review, which included a mental health nurse and an operational manager. She recorded that Mr Robinson was upset and struggling with being in custody. Mr Robinson spoke about previous suicide attempts in custody and in the community and repeated that he intended to take his life at the earliest opportunity. The panel concluded that he should be monitored under constant supervision and be allocated a cell in the healthcare inpatient unit.

26. Over the following days, Mr Robinson said that he was struggling with guilt related to his offence. He told staff that he was crying all of the time, and that he had thought about how he could strangle himself. Two SOs chaired multidisciplinary ACCT case reviews which led to a reduction in Mr Robinson's ACCT observations, which they mitigated by giving Mr Robinson alternative clothing (designed with features that made it harder to rip). However, on 16 August, Mr Robinson tried to strangle himself with a towel. Prison staff reinstated constant supervision.

27. On 18 August, a psychiatrist at Leeds assessed Mr Robinson. He recorded that Mr Robinson reported a life-long fluctuation in mood and a history of suicide attempts and self-harm. The psychiatrist concluded that there was evidence of emotional dysregulation (emotional reactions that do not fall within traditionally accepted ranges) and that the mental health team should continue to monitor Mr Robinson. Mental health team staff continued to support Mr Robinson afterwards, including at ACCT case reviews.

28. For the remainder of the month, Mr Robinson continued to state that he intended to take his life as soon as he could. Staff recorded that visits from his partner and children put Mr Robinson in a "better place" but they considered that his risk remained very high and that he should continue to be monitored under constant supervision. Mr Robinson began to visit D Wing for association periods (when

prisoners mix with each other), as preparation for when he was ready to live on a standard residential wing.

29. In September, Mr Robinson stopped visiting D Wing as it caused him anxiety. Prison staff arranged for him to visit A Wing instead. He told staff that his anxiety was heightened due to guilt about the impact of his offence. Mental health team staff referred Mr Robinson to a psychologist and he started counselling.

30. On 7 September, an SO chaired an ACCT case review at which she concluded that Mr Robinson should remain under constant supervision but that staff should give him intermittent unsupervised periods of five to ten minutes.

31. On 21 September, the SO at an ACCT case review recorded that Mr Robinson was feeling much better in mood and said that he was coping much better with any suicidal thoughts. As he had also now started counselling, the panel agreed to reduce his observations to four per hour during the day and that he would remain under constant supervision at night. The following week, the observations were reduce to four per hour at all times.

32. On 29 September, Mr Robinson moved to a single cell on A Wing. His cell sharing risk assessment (designed to assess the risk of violence a prisoner poses either to or from a cellmate) was assessed as high as Mr Robinson had told prison staff that he was not willing to share due to the nature of his offence and his mental health.

33. In October, Mr Robinson saw doctors at Leeds for several medication reviews. He tried various medications and dosages for depression and anxiety before settling on promethazine (alongside propranolol, which had been prescribed when he arrived at Leeds).

34. The SO chaired weekly ACCT case reviews in October. In October, and in later months, the case reviews were multidisciplinary and, as well as the SO, included a safer custody manager, and representatives of the mental health team. As Mr Robinson was designated a complex case, his progress was discussed each week at the Safety Intervention Meeting (SIM, a meeting of senior managers to discuss those prisoners who require multidisciplinary risk management).

35. Mr Robinson spoke more positively as October progressed, although at times he also said that his mood fluctuated and that he had some periods of heightened anxiety. He began to attend the gym and engage in wing activity, although he refused a job that was offered as he was concerned that the monotony of a workshop would not be beneficial. Instead, Mr Robinson was placed on the waiting list for a job in the kitchens. By the end of the month, staff were satisfied that his risk was low enough to allow one observation every two hours.

36. In November, Mr Robinson began attending English classes every morning. The SO recorded that he continued to feel more positive and said that he was coping better.

37. On 25 November, the SO recorded at an ACCT case review that Mr Robinson was feeling low and reluctant to engage. He said that he had not contacted his family for a few days and had cancelled a visit that morning as he was not sure that he would be able to cope with it. Mr Robinson said that he had ended his relationship with his

partner. He also said that he was waiting to hear if his charge would be dropped to manslaughter, which was causing anxiety. Mr Robinson said that he had occasional suicidal thoughts that came and went, but that he did not want to act on them because of his children. The panel made no change to the ACCT observations.

38. On 1 December, a Custodial Manager (CM) reviewed Mr Robinson's level on the Incentives Policy Framework (IPF) Scheme (which aims to encourage and reward responsible behaviour in prisons). The CM recorded that Mr Robinson had not had any recent positive entries in his prison records and had refused to attend education several times. She recorded that Mr Robinson was "on the right track" but needed to do more to achieve enhanced status. (Mr Robinson's IPF status was standard, on a scale of basic, standard and enhanced.) The CM told us that IPF criteria were applied strictly, with little flexibility for individual cases, to ensure fairness for all.

39. On 2 December, Mr Robinson attended court via video link. As he might learn whether his charge had been changed to manslaughter, the SO arranged ACCT case reviews both before and after the hearing. At the first review, Mr Robinson said that his mood had improved and he felt more settled. He said that he had been assessed by a psychologist and given a diagnosis of ADHD which he said had "lifted a weight". At the later review, Mr Robinson said that the decision about his charge had been adjourned until 20 December to await further reports. He spoke about his trial, which was scheduled for February 2023, and said that he felt anxious about having to give evidence. The panel made no change to the ACCT observations.

40. The following week, Mr Robinson's keyworker asked him to manage Andy's Man Club at Leeds. (Andy's Man Club is a suicide prevention charity that provides men the opportunity to talk with a group of their peers about their mental health and other issues in a safe environment.) The keyworker had established Andy's Man Club at Leeds and told us that Mr Robinson had attended for much of his time at the prison. He recorded that Mr Robinson took well to the role and did a good job at managing the club.

41. On 7 December, the SO chaired Mr Robinson's ACCT case review. She recorded that Mr Robinson was observed beforehand to be in high spirits and was laughing with his peers. Mr Robinson said that he had some days when he felt low but managed well with support from his friends on the wing. He said that he thought that running Andy's Man Club, and helping other people through this, would be beneficial for him. The review panel reduced Mr Robinson's observations to one meaningful conversation every morning, afternoon and evening and six observations during the night. The SO told us that they reduced the observations because Mr Robinson was very positive throughout the review, he was engaged in prison life, he had a lot of support from his family and spoke about arranging visits for Christmas, and he said that his recent diagnosis had helped him to understand his anxiety much better.

42. On 10 December, Mr Robinson made four telephone calls to a friend and one call to his son. (All prisoners' telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. No one listened to Mr Robinson's calls until after his death.) In calls to his friend, Mr Robinson said that he had "really bad flu", which meant that he vomited anything he

ate or drank. (There is no evidence that Mr Robinson sought healthcare input for these symptoms.) He said that he had been crying a lot recently and that "it's all getting on top of me". In Mr Robinson's final call, to his son, he discussed an upcoming visit.

43. An officer recorded that she spoke to Mr Robinson about his purchases from the prison shop. Mr Robinson said that he had been charged for his purchases but they had not been delivered. The officer arranged for him to receive a refund.

11 December 2023

44. At around 9.30am on 11 December (Mr Robinson's birthday), an officer unlocked Mr Robinson's cell so that he could shower and exercise. Mr Robinson chose not to leave his cell due to feeling unwell.

45. At around 10.15am, an officer spoke to Mr Robinson about his morning medication. She recorded that Mr Robinson was lying on his bed watching television and said that he did not want his medication.

46. At around 11.55am, prisoners on Mr Robinson's landing were unlocked for lunch. Mr Robinson did not leave his cell. A prisoner, who was a friend of Mr Robinson, spoke to him at his cell for around one minute. He later told the police that Mr Robinson told him that he "felt a bit sick". He added that Mr Robinson had been unwell for a few days.

47. At 12.07pm, prisoners on the landing were locked in their cells for the lunchtime period.

48. At 1.48pm, an officer pushed a refund receipt through Mr Robinson's cell door for his purchases from the prison shop. She did not look in the cell or try to speak to Mr Robinson.

49. At 1.57pm, a male prisoner put weekly menus through every cell door on the landing. He also did not look into the cell or speak to Mr Robinson.

50. At 2.06pm, Mr Robinson's friend went to his cell to wish him a happy birthday. The prisoner told us that he looked through the observation panel and saw Mr Robinson by the window, hanging from a ligature. He shouted for help from officers on the landing below.

51. At 2.07pm, two officers arrived at and went into Mr Robinson's cell. An officer cut the ligature while the other officer radioed a medical emergency code blue, indicating a life-threatening situation. An officer then began cardiopulmonary resuscitation. At 2.09pm, three healthcare staff arrived at the cell and took over resuscitation efforts.

52. At 2.20pm, paramedics arrived at Mr Robinson's cell. At 3.00pm, Mr Robinson left the prison in an ambulance, while paramedics continued their resuscitation attempts. At 3.06pm, they confirmed that he had died.

53. Following Mr Robinson's death, police officers found a note in his cell addressed to his ex-partner. In the note, Mr Robinson indicated that he had intended to take his life.

Contact with Mr Robinson's family

54. At 3.04pm, the prison appointed an SO as family liaison officer and an officer as his deputy. At 4.00pm, they visited Mr Robinson's mother at her home address. Mr Robinson's mother said that she had already been told of the death by a neighbour who had a son on the same wing as Mr Robinson.

55. The prison contributed toward the cost of Mr Robinson's funeral in line with national policy.

Support for prisoners and staff

56. After Mr Robinson's death, a prison manager debriefed the 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. A prison manager contacted the ACCT case co-ordinator (who was not working on 11 December) to inform her and offer support before she returned to work.

57. The prisoner who was Mr Robinson's friend told us that he received support from various agencies in the prison, including from the Governor. Prison staff conducted additional case reviews for all prisoners who were being monitored under ACCT procedures. On 12 December, Samaritans attended Leeds to help Listeners provide support to those prisoners who had been affected following two self-inflicted deaths on the same day.

Post-mortem report

58. A post-mortem examination found that Mr Robinson died of hanging. Toxicology tests only identified prescribed medication and no illicit substances.

Findings

Managing the risk of suicide and self-harm

59. Prison staff appropriately started ACCT procedures when Mr Robinson was remanded to Leeds. It is apparent that many staff knew him well and some positive, supportive actions were taken. Constant supervision was used appropriately in Mr Robinson's first weeks in prison when he was judged to be at particularly high risk.

60. The ACCT case reviews were multidisciplinary and had good, consistent input from the mental health team (and the clinical reviewer found that the mental health team appropriately managed Mr Robinson). There was a consistent case co-ordinator and senior managers were involved in ACCT case management when appropriate, such as when constant supervision was in place. A safer custody manager attended most of the case reviews alongside the case co-ordinator and Mr Robinson was discussed at weekly Safety Intervention Meetings. There were some examples of good practice, such as when ACCT case reviews were held both before and after Mr Robinson's court hearing on 2 December.

61. Over time, staff judged that Mr Robinson's risk had substantially reduced and, at the ACCT case review on 7 December, his observations were stopped during the day (but remained in place at night). At the time, Mr Robinson appeared to have made significant progress. He had recently gained a leadership role with Andy's Man Club, as a reward for his positive contributions over the previous month. Mr Robinson began to spend more time out of his cell, had friends on the wing and spoke positively about his mental health. Setting ACCT observations is a matter of staff judgement and, while we would expect this to have been reassessed before his next court appearance, we do not think it unreasonable that Mr Robinson's observations had been reduced to this extent in the time before his death.

62. The Governor should commend the staff involved for the high standard of personalised, thoughtful care they provided to Mr Robinson.

Learning from risk management

63. While much of the ACCT case management was positive, there were some areas in which it might have been improved. PSI 64/2011 states that case reviews must set support actions that are meaningful and individualised, to reduce or mitigate the risk of harm. Mr Robinson's support plan contained a number of positive actions with varying aims, including settling on A Wing, attending the gym and finding paid employment. However, achieving enhanced status on the IPF Scheme was a goal of his that he was unable to attain and which was not addressed through the ACCT process. Enhanced IPF would have allowed Mr Robinson increased benefits, including more visits from his family, and strategies to help him achieve this could have been explored through the support plan.

64. PSI 64/2011 instructs that observations and conversations must be carried out in line with levels set by case review teams. It states that conversations must be meaningful, with written summaries included in the ACCT document. On the morning of his death, no one carried out the required ACCT conversation. While one officer spoke briefly with Mr Robinson about his medication, this did not

constitute a meaningful conversation as required by PSI 64/2011. More meaningful contact with Mr Robinson might have helped staff to identify any increased risk on the day that he died.

Inquest

65. The inquest into Mr Robinson's death concluded on 14 October 2024. The jury returned a narrative verdict that concluded that Mr Robinson died by suicide.

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