Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Reece Godward, a prisoner at HMP Leeds, on 23 February 2023

A report by the Prisons and Probation Ombudsman

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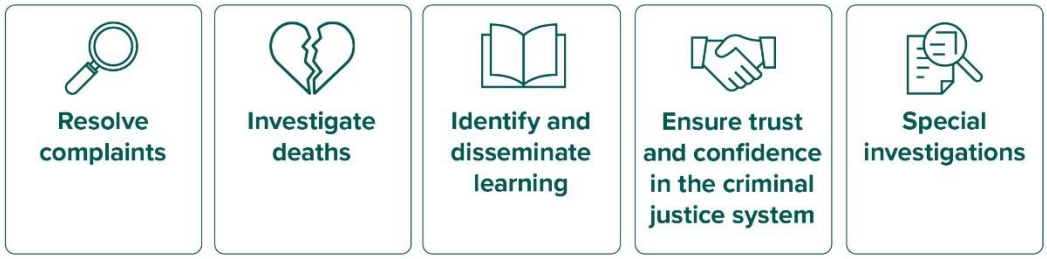
OUR VISION

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 Prisons and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate then our recommendations should be focussed, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Reece Godward died in hospital on 23 February 2023, having been found hanged in his cell at HMP Leeds the day before. He was 23 years old. I offer my condolences to Mr Godward's family and friends.

This was the sixth self-inflicted death in Leeds in a year and the twelfth in three years. There have been a further three self-inflicted deaths since.

Mr Godward was only in prison for twelve days before he took his own life. My investigation found that staff missed opportunities to assess, communicate and manage Mr Godward's risk to himself, most notably on the day he hanged himself. I found that some staff did not always treat prisoners in a respectful way.

The clinical reviewer concluded that Mr Godward's physical and substance misuse healthcare at Leeds were equivalent to that which he could have expected to receive in the community. However, they found that Mr Godward's mental healthcare was only partially equivalent as he never had a formal, individual assessment.

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 **December 2023**
Prisons and Probation Ombudsman

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Summary

Events

1. On 10 February 2023, Mr Reece Godward appeared in court and was sentenced to six months imprisonment for offences of assault and shoplifting. He was taken to HMP Leeds.

2. Staff began suicide and self-harm support procedures, known as ACCT, when Mr Godward arrived at Leeds as he was upset. Following a positive body scan indicating he had an item secreted in his body, he self-harmed and staff increased his ACCT observations. Mr Godward told a nurse that he had no drug or alcohol issues, suffered from anxiety, depression and post-traumatic stress disorder (PTSD). He also said he had a chest infection and a GP prescribed him antibiotics. After three more positive body scans, Mr Godward had a negative one and moved to the wing.

3. The next day, staff closed Mr Godward's ACCT. Three days later, staff re-opened his ACCT. On 17 February, Mr Godward cut his arm. A manager spoke to him, tried to alleviate his concerns and increased his ACCT observations. Prisoners told the investigator that they thought Mr Godward was using drugs in prison. They also said that he seemed worried.

4. On 22 February, Mr Godward's behaviour escalated. He allegedly threatened his cellmate who moved to another cell. He also repeatedly blocked his observation panel, barricaded his door and refused to engage with staff. An officer removed torn bedding from his cell at lunchtime. Staff did not reassess whether Mr Godward's risk to himself had increased, put in place any additional support or record details of his increasing risk.

5. Staff locked Mr Godward in his cell early that afternoon as he was spreading rumours about his former cellmate. At 4.21pm, an officer checking Mr Godward saw that he was lying on the floor in an unusual position. She got another officer to check who said that Mr Godward's face was blue. They immediately raised an emergency alarm. Other staff responded quickly, saw that Mr Godward had a ligature around his neck and made concerted efforts to get in the cell, which Mr Godward had barricaded. Staff managed to get in, cut the ligature and tried to resuscitate him. Paramedics arrived, took over treatment and regained a pulse. They took Mr Godward to hospital where he remained in a coma. On 23 February at 4.54am, Mr Godward died.

Findings

6. Mr Godward was subject to suicide and self-harm support for nine of the twelve days that he was at Leeds, including the last eight of his life. Staff appropriately assessed that Mr Godward was a risk to himself and often made concerted efforts to engage with him. However, they missed opportunities to adequately assess, communicate and manage Mr Godward's risk. In particular, his first ACCT was closed prematurely the day after he arrived in prison, the gap between case reviews was too long and most concerningly, incidents on the day he hanged himself were not considered in terms of Mr Godward's increasing risk to himself. However, given

the subsequent internal investigation which took place, the additional regional support and actions already taken, we do not make any further recommendation in this regard.

7. The investigation found that the way staff spoke to Mr Godward was not always respectful and we are concerned that there may be a problematic culture among some staff on B wing.

8. We also found that Leeds did not adhere to local and national guidance regarding the use of the body scanner when Mr Godward arrived. Scans were not correctly logged, and the secreted items policy was not followed.

9. The clinical reviewer found that Mr Godward's physical and substance misuse care were equivalent to that he could have expected to receive in the community. However, they found that his mental healthcare was only partially equivalent. Mr Godward should have had a formal mental health assessment.

Recommendations

- The Governor and Head of Healthcare should ensure that all staff follow local and national instructions regarding body scanners including that body scans are recorded appropriately, and decisions taken following scans are in adherence to the policy and clearly recorded.

- The Head of Healthcare should ensure that prisoners referred for a mental health assessment are offered an individual assessment, separate to the ACCT process.

The Investigation Process

10. We were notified of Mr Godward's death on 23 February 2023. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Godward's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Godward's clinical care at the prison. The investigator and clinical reviewer interviewed eight members of staff and two prisoners at Leeds in March 2023. The investigator interviewed three further members of staff and two more prisoners via telephone and MS Teams in May 2023.

13. We informed HM Coroner for West Yorkshire Eastern District of the investigation. The Coroner provided the post-mortem report. We have sent the Coroner a copy of this report.

14. West Yorkshire Police investigated Mr Godward's death and concluded that it was an isolated incident with no third-party involvement or responsibility.

15. The Ombudsman's family liaison officer contacted Mr Godward's mother to explain the investigation and to ask if she had any matters she wanted us to consider. She asked the investigation to consider:

    - Why Mr Godward had been located on a standard residential wing in the prison.
    - What ACCT observations Mr Godward was subject to and why was he not in a cell that was completely visible to staff on the day he died.
    - Whether staff knew that he had barricaded himself in his cell on 22 February and if so, at what time. She said she spoke to Mr Godward at 2.12pm when there were staff outside his cell, and he had barricaded himself in due to this. She telephoned the prison and told them this but did not believe any action was taken. She asked why there were staff outside his cell.
    - She said that Mr Godward was being bullied by Officer A and CM A. She said she heard them both being rude to Mr Godward when she was on the telephone to him.
    - She said that other prisoners had witnessed Mr Godward becoming distressed and threatening to kill himself and staff responding inappropriately to him on the day he died.
    - Why Mr Godward's cellmate moved out of their cell on 22 February.
    - What had happened to Mr Godward's missing trainers.
    - What time staff found Mr Godward unresponsive on 22 February.

16. Mr Godward was not subject to constant supervision (where the cell door is clear Perspex, and a member of staff is located outside the cell to observe the prisoner at all times) when he died. Constant supervision is used when a prisoner is considered to be at very high risk of suicide and self-harm. Mr Godward had not been assessed as such when he died.

17. The family liaison officer said that when he cleared Mr Godward's cell there were no trainers in there. He said that the police may have seized the trainers. Staff confirmed that property would never be transferred between prisoners with their knowledge.

18. The rest of Mr Godward's mother's questions are addressed in the report.

19. Mr Godward's mother and father received a copy of the draft report. They did not make any comments.

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

Background Information

HMP Leeds

21. HMP Leeds is a local prison holding a maximum of around 1,100 prisoners on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Practice Plus Group provides healthcare services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Leeds was in June 2022. Inspectors reported that Leeds was a well-led prison, with reasonable staffing levels and some caring and supportive staff-prisoner relationships. Prisoners' perceptions about relationships with staff had improved and fewer than at their last inspection reported verbal abuse or victimisation from staff. However, some prisoners expressed frustration at what they perceived to be staff's unhelpfulness and they noted more needed to be done to address the negative experiences of some prisoners.

23. Inspectors found reception processes were respectful and the use of the body scanner on all arrivals was effective in preventing the entry of illicit items into the prison. They noted that an effective searching strategy and other steps to reduce the supply of drugs getting into the prison had also been effective.

24. HMIP noted that there had been a high number of deaths at the prison. The number of self-harm incidents had reduced but some incidents had been very serious. They reported that there was good support for prisoners who regularly self-harmed and ACCT case management was reasonable overall. They found that the Listener scheme (prisoners trained by the Samaritans to provide confidential emotional support to prisoners) was not effective.

Independent Monitoring Board

25. 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 2022, they concluded that the prison was generally safe although the high number of self-inflicted deaths was concerning. They found that staff generally treated prisoners with care, dignity and respect. However, they also found that a significant number of applications to the IMB were related to the perceived behaviour of staff towards prisoners. IMB members had observed staff swearing both at prisoners and in general conversation and had raised this with the Governor who said this behaviour would not be tolerated.

Previous deaths at HMP Leeds

26. Mr Godward was the 31st prisoner to die at Leeds since February 2020. Of the previous deaths, 17 were due to natural causes, 11 were self-inflicted, one was drug related, and one is awaiting classification. There have been six deaths since, of which three were self-inflicted and three were due to natural causes. In one of

these subsequent deaths, the prisoner had also attached the ligature to the medication box in his cell.

27. Of particular note is that there were seven self-inflicted deaths between December 2022 and May 2023, of which Mr Godward's was the fifth death. As a result, Leeds was identified as requiring additional support and monitoring from regional and national safety teams.

28. In previous investigations we have recommended that improvements needed to be made to assessing and managing prisoners' risk of suicide and self-harm. We have also found that improvement was needed to mental health referral, assessment and treatment.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or 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.

30. As part of the process, a care plan (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care plan 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.

Challenge, Support and Intervention Planning (CSIP)

31. CSIP is a Prison Service scheme designed to address factors contributing to violence in prisons by managing the most violent prisoners and supporting the most vulnerable prisoners. Prisoners who are perpetrators of violence or who are vulnerable to violence or bullying are managed and supported on a plan with individualised targets and regular reviews.

Key Events

10 February

32. On 10 February 2023, Mr Reece Godward appeared in court and was sentenced to six months imprisonment for offences of assault and shoplifting. He was taken to HMP Leeds. His conditional release date was 11 May. It was not his first time in prison.

33. Mr Godward's Person Escort Record (PER – a document which contains offence and risk information and travels with a prisoner from court to prison) noted that Mr Godward was at risk of suicide and self-harm. In a separate PER information document, staff noted that Mr Godward said that he had overdosed the day before and had razor blades in his possession. Staff had searched him and found nothing. Mr Godward then told court staff that he had only said this as he was scared. At 2.04pm, court staff noted that Mr Godward had banged his head on the cell walls after being sentenced and was being constantly observed.

34. An officer spoke to Mr Godward in reception at Leeds. When the officer asked Mr Godward about his previous self-harm and whether he had any current thoughts, he got upset and cried. Mr Godward said that he didn't know where his head was at. The officer started HMPPS' suicide and self-harm support measures, known as ACCT. Custodial Manager (CM) A noted that Mr Godward would see the mental health team during his ACCT review the next day and should be observed hourly with three recorded conversations daily until then.

35. At around 3.15pm, as is standard for all prisoners arriving at Leeds, Mr Godward had his body scanned for illicit items. (This is an X-ray which identifies people who are trying to smuggle items into prison by secreting them internally.) This scan indicated that he had an item secreted inside him. He was put into a cell on his own while he was waiting to be re-scanned. CM A noticed that Mr Godward was crying and spoke to him. Mr Godward had cut his arm with some plastic cutlery. The CM asked Mr Godward why he had self-harmed, and he said he did not want to go to the segregation unit (as was policy as he had given a positive indication on the body scanner).

36. CM A increased Mr Godward's ACCT observations to three times per hour. He noted that Mr Godward was due to see the doctor and healthcare staff and he put him in a shared cell for his own safety. Staff scanned Mr Godward a further three times within 30 minutes and he gave positive indications each time. When Mr Godward was scanned for a fifth time, 35 minutes later, it was clear.

37. A nurse completed Mr Godward's initial healthscreen. Mr Godward said he had used drugs or alcohol in the last three months. He said he had been diagnosed with anxiety, depression and post-traumatic stress disorder (PTSD). (PTSD is an anxiety disorder caused by very stressful, frightening or distressing events. Someone with PTSD often relives the traumatic event through nightmares and flashbacks, and may experience feelings of isolation, irritability and guilt. They may also have problems sleeping, such as insomnia, and find concentrating difficult.)

38. Mr Godward said he self-harmed on impulse and would try “all sorts” to hurt himself. He said he had no thoughts of suicide but might self-harm. Mr Godward was upset and said his mental health was low. He said he had a chest infection and sore feet due to being homeless before coming to prison. Mr Godward asked to be referred to the mental health team for support. The nurse made an urgent referral to the team.

39. Mr Godward’s medical record evidenced a long history of suicide attempts and self-harm. He had overdosed and used ligatures in the past to cope with emotional stress. He had previously been prescribed medication to treat depression and anxiety, most recently in 2022. He also had a history of drug misuse including cannabis, amphetamines and psychoactive substances (PS).

40. At 7.20pm, a prison GP saw Mr Godward. Mr Godward said he had pneumonia and had recently had chest X-rays. The GP noted that Mr Godward had no cough or temperature and planned to review him the next day. He prescribed him antibiotics. Due to an administrative error, Mr Godward was not given his prescribed antibiotics until 16 February. The prescribing GP had accidentally future dated the prescription causing a delay in the medication being issued.

11 February

41. On 11 February, an officer conducted an introductory key worker session with Mr Godward. He explained that he would be allocated a key worker and the purpose of the role. Key workers are allocated to prisoners to meet with them weekly, to discuss and address their ongoing needs.

42. During an ACCT assessment, Mr Godward said he had PTSD, anxiety and depression but had not taken his prescribed medication for some time. Mr Godward said he smoked cannabis in the community to help him cope. He said that he had opened an old self-harm wound the previous day due to frustration but had no thoughts of suicide. He said he had a new partner who motivated and supported him.

43. At 10.30am, a Supervising Officer (SO) chaired an ACCT review with a nurse from the mental health team and Mr Godward. Mr Godward said that he could cope in prison and that the three months would “fly by” until his release. The nurse referred Mr Godward to a GP to consider prescribing antidepressants. (He was later scheduled an appointment with a GP on 6 March.) Mr Godward said he used cannabis in the community but did not want any support in prison as he did not think it was an issue. Mr Godward said he had no thoughts of suicide or self-harm. Staff present decided to close the ACCT. Mr Godward said that he was happy with this as being on an ACCT made him more anxious. The nurse noted that Mr Godward did not have any acute mental health needs and was aware of how to access help in a crisis. Mr Godward moved from the induction unit to B wing, a standard wing. He shared a cell with another prisoner until his last day at Leeds.

44. Mr Godward’s mother telephoned the prison as she was concerned about Mr Godward. Staff checked on him, he said he felt fine and that his mother often called when she could not contact him (his telephone numbers had not yet been approved by security so he could not call her himself).

14 February

45. On 14 February, a nurse assessed Mr Godward as he had chest pain. She took his clinical observations which were normal. Mr Godward told her that he had had a chest infection for which he had been prescribed antibiotics when he got to Leeds. She confirmed that these had been prescribed (she did not realise they had not been given to him) and advised him to take painkillers if needed. Mr Godward also asked to see the mental health team. She incorrectly thought that he was on an ACCT and that he would be seen by the mental health team as part of this, so she did not refer him to the team.

46. Mr Godward's mother rang the safer custody line and asked that someone check on her son and call her back as she had not heard from him. The officer who picked up the message passed on her concerns to wing staff and requested that they call her back.

47. From 3.30pm onwards, Mr Godward called his partner, mother and sister. At 5.00pm, CM A spoke to Mr Godward about how his first days at Leeds had gone. He said that he felt settled on B wing and he had not self-harmed since he had first come into Leeds. He said he still had chest pain. The CM noted that healthcare staff had seen him.

48. At 6.00pm, Mr Godward's mother emailed the complaints and correspondence email address at the prison to say that Mr Godward had cut his arms, was begging for help and Officer A had told him to "shut up". She said that Mr Godward had said that he did not know how he would get through and he felt like hurting himself. She wrote that she had telephoned the prison who had said they would check on him, but nothing had happened.

49. During the evening, Mr Godward rang his cell bell and asked an officer for a vape. She said that she could not get him an emergency vape at that time. Mr Godward was frustrated and told her to go away. Later, Mr Godward rang his cell bell again. Another officer responded. The cellmate told the officer that Mr Godward had made cuts to his arm using a razor blade and he gave it to the officer. He told staff it was because Mr Godward could not get a vape. Mr Godward refused to engage with staff or show them any evidence of self-harm. Staff re-opened his ACCT with hourly observations and three conversations daily.

15 February

50. On 15 February, a SO chaired an ACCT review with Mr Godward and a nurse from the mental health team. Mr Godward said that he had not really self-harmed the night before but had been frustrated by staff and his vape was not working properly. The SO told an internal investigation that she asked Mr Godward to show her his arms and there was no evidence of any self-harm, but she did not record this in Mr Godward's ACCT. Mr Godward was also frustrated that he had not received his medication (it is not clear if this related to antidepressants or antibiotics) and the nurse told him that he had been referred to the GP but would need to wait for the appointment. Mr Godward walked out of the review. Staff kept observations at once an hour with three conversations daily and set a review for the next day since Mr Godward had left this one early.

51. The complaints team forwarded Mr Godward's mother's email from the day before to the safer custody team and wing staff asking them to check on Mr Godward, record their interaction and ring his mother.

52. Mr Godward's mother telephoned the prison again and said that Mr Godward said he was being bullied by Officer A. She also told the prison that Mr Godward thought he had broken ribs and was not being allowed access to healthcare. The officer who picked up the message emailed the information to wing staff, asked them to check on Mr Godward and call his mother back.

53. At 6.00pm, an officer spoke to Mr Godward. Mr Godward said he was fine, settled on the wing and wanted to get a job. The officer asked about his issues with healthcare, and he said he was waiting for antibiotics and painkillers to be given to him. He said that he could complete a healthcare application if Mr Godward was still concerned about the pain in his ribs. The officer returned Mr Godward's mother's call to let her know that Mr Godward said he was okay.

54. Mr Godward's mother told the officer that Mr Godward had sold his clothing to buy drugs before coming into prison and that he was concerned his family would not be able to buy clothes and he would have to continue to wear his pyjamas. She asked the officer to tell Mr Godward that she had bought what he needed, and the officer passed this on. The officer told the investigator that Mr Godward's moods were very changeable. He could get very frustrated and annoyed but then later be calmer and apologise for his actions.

16 February

55. On 16 February, a Probation Service Officer spoke to Mr Godward about his plans for release, including accommodation, employment and finances. Mr Godward said that he had been using cannabis in the community but did not want any support with his drug misuse. He said he was waiting for medication for his mental health issues.

56. A SO chaired an ACCT review with Mr Godward and a chaplain. Mr Godward engaged well, said he had no thoughts of suicide or self-harm and wing staff had resolved his issues. Mr Godward asked to shower on his own, due to feeling self-conscious about his body and this was agreed. Mr Godward said that he was waiting for a medication review which he expected to happen soon, but his mental health was good. Staff reduced Mr Godward's observations to three times a day. The SO scheduled his next review for 1 March. She said that she set it so that she could chair the review herself and because she did not have any urgent concerns about Mr Godward.

17 February

57. On 17 February, Mr Godward made a superficial cut to his arm with a fork. He told staff he had done it because the money he had available to spend in his account was wrong and he would continue to cut himself. He said he had rung his mother to tell her that he was going to kill himself. Staff looked into it and informed Mr Godward that his account was correct. Mr Godward disagreed, covered his observation panel and barricaded his door.

58. A CM spoke to Mr Godward, who allowed him in his cell. The CM held an ACCT review, but no other staff were present. Mr Godward said that he had pulled a scab off an old cut due to being given the wrong account amount. The CM offered to get emergency funds transferred, but Mr Godward was not satisfied and said he would self-harm. He asked how he could help, but Mr Godward said that he wanted nothing and was going to make things difficult for the prison by going on constant watch (when staff constantly supervise the prisoner in a special cell) and trying to get to hospital. The CM repeatedly tried to reason with and reassure Mr Godward and removed the obstruction from Mr Godward's observation panel several times.

59. Mr Godward said he was in debt to other prisoners and owed a pack of vape capsules. The CM got him some vape capsules to repay his debt. They spoke about the difficulties of getting into debt in prison. Mr Godward said that he had no prison issue clothing, so the CM provided this, along with some food and credit for the phone. Mr Godward said that he had applied for work but had not heard anything. The CM agreed to chase this application on Monday. Mr Godward said that he had telephoned his mother to tell her he was going to kill himself.

60. The CM telephoned Mr Godward's mother, who said that he had been using crack cocaine and heroin in the community. He offered Mr Godward support for his drug misuse, but he refused. An officer was allocated as Mr Godward's key worker as they had a good rapport. Mr Godward said that he was no longer stressed, and he had no thoughts of self-harm. The CM increased Mr Godward's observations to hourly with three quality conversations a day.

61. Staff submitted a security information report detailing the CM interactions with Mr Godward. When security staff assessed this, they noted that a Challenge Support Intervention Plan (CSIP) should be opened, and an investigation completed. (CSIPs are a structured way of managing and supporting violent and vulnerable prisoners. Individualised plans with targets and reviews are used to assist prisoners feel safe or reduce their violent behaviour.) Staff submitted a CSIP referral. A SO and CM A (both from B wing) investigated this. They noted that Mr Godward had made threats to hurt himself seemingly to "get his way". They noted that he had not been on the unit very long but had been demanding of staff and their time. On the basis of this evidence, a CM decided that a CSIP was unnecessary.

19 February

62. On 19 February, prisoner spoke to Mr Godward who seemed stressed and said he had lost a parcel. He believed Mr Godward meant he had been trying to bring illicit items into the prison. Mr Godward said that he wanted to jump headfirst off the landing as he was also stressed about his account information. The prisoner gave him some of his own canteen items and told Mr Godward he could always ask him for more. He encouraged Mr Godward to speak to the officers if he felt under threat, but Mr Godward said that he could handle himself. The prisoner said he asked an officer to "keep an eye" on Mr Godward.

63. The cellmate said that Mr Godward could be difficult to staff if he did not get what he wanted, such as food or vapes. He said that sometimes Mr Godward laughed after officers had left their cell and he said he would get staff sacked. He also said that Mr Godward was always fiddling with his trainers, and he believed he had

drugs hidden in them. He said that Mr Godward used drugs daily, his mood varied, and he thought that Mr Godward traded drugs for other items such as food or vapes. He said that Mr Godward used his vape to smoke drugs as he saw him tampering with it and it smelt of burning. He thought Mr Godward had run out of drugs around this time.

64. The cellmate said that Mr Godward repeatedly asked him to fight him. Mr Godward told him he was going to hang himself from the landing netting, but he did not know if Mr Godward was being serious. He said that he told officers this. This is not recorded anywhere nor did staff recall being told this. He said that Mr Godward's mood was very changeable.

65. Another prisoner had met Mr Godward a few times in prison over the years. He said that he seemed preoccupied when he was in Leeds this time, as if he was worried about something. He told the prisoner that he was finding it difficult to cope but did not say why. The prisoner never had any concerns that Mr Godward was a risk to himself.

21 February

66. On 21 February, CM A noted that he had spoken to Mr Godward's mother about several messages she had left on the safer custody telephone line and an email she had sent to the complaint and correspondence inbox. He recorded that Mr Godward's mother understood that Mr Godward was getting along fine now. She said she had a visit booked and would drop off clothing soon.

67. In the afternoon, an officer spoke to Mr Godward who said he was doing well. Staff recorded in Mr Godward's ACCT that he had stayed in his cell in the afternoon and was upset about an incident with CM A. No further details were recorded about this. An HMPPS internal investigation after Mr Godward died noted that this was due to Mr Godward feeling upset at the way the CM had asked him to wait to collect his medication. In the evening, Mr Godward had a shower, engaged with other prisoners and seemed in a good mood. Mr Godward ordered several items from the canteen to be delivered the following week.

68. Mr Godward regularly phoned his mother, normally several times a day. On 21 February, they spoke eight times. The investigator listened to these calls. They had general conversations including about Mr Godward's release and where he would live. He asked his mother to contact his probation officer.

Events of 22 February onwards

69. On 22 February at 10.04am, the cellmate rang the cell bell. At 10.13am Officer B responded. He asked to leave the cell because Mr Godward had threatened to stab him. Mr Godward covered his observation panel while the officer and his cellmate were talking outside the cell. The officer moved the cellmate to another cell.

70. At 10.21am, Officer B returned to Mr Godward's cell to get the cellmate's belongings. Officer C activated her body worn camera (BWC). Mr Godward obstructed his door, blocked his observation panel and would not talk to Officer B. She requested assistance. Staff responded and another officer tried to get into his

cell but was unable. She encouraged him to remove the observation panel covering and talk to her, but he did not. A SO then came to the cell and tried to get a response from Mr Godward but could not. Staff removed the inundation point (a circular hole in the cell door used to insert a hose in the event of a cell fire) and saw Mr Godward walking round the cell. CM A (who was working as an officer on the wing on overtime) then got to the cell. There was no CM supervising the wing at the time. During this time, Mr Godward rang his mother and left her a voicemail, stating that his cellmate had lied to staff, and he had lots of officers at his cell door.

71. CM A told Mr Godward that he had spoken to his mother the day before. Mr Godward replied that the CM had lied to her. The CM said that he had not and asked him to come to the door so that they could speak properly. He asked Mr Godward if he was okay, what had happened and asked him to take the cover off his observation panel. Mr Godward did so, and the CM thanked him. The CM told Mr Godward that there should be "no fucking about", Mr Godward was on an ACCT, so staff needed to observe him. It is not possible to hear what Mr Godward said on the footage. Staff then went into his cell, along with the cellmate.

72. The cellmate took his belongings. The BWC footage is from outside the cell and so the conversations inside the cell cannot be clearly heard. The SO said that there was a disagreement between the cellmate and Mr Godward, as the cellmate thought that Mr Godward had some of his paperwork. They searched the cell and could not find it. The cellmate collected his belongings and left the cell at 10.35am.

73. The BWC then moved inside the cell. Some of the conversation between CM A and Mr Godward can be heard. The CM said to Mr Godward, "just look at the work you caused us, I know you're not arsed", to which Mr Godward replied that he was stuck in his cell all day. The CM replied that he had only been at Leeds a week and if he had some patience, staff would work with him and observe him on an ACCT, but he was not helping his cause. Mr Godward's reply cannot be clearly heard but it sounded like it was to do with the disagreement with his cellmate. The CM then told him not to make threats: Mr Godward denied that he was. Then the CM raised his voice slightly and said… "it's not fucking school, you're acting like it's the fucking playground, its fucking jail, you've been here before, you're in for a short sentence, get your head down. Are you capable of doing that?" Mr Godward has his arms folded and is looking at the floor. The CM then said, "get your head down like every other fucker in here, have a think about it mate". The CM then turned to the cell door and the recording stopped at 10.37am.

74. Officer B also activated her BWC. When the footage starts, Mr Godward was at the back of his cell facing away from the CM and SO, with his head and shoulders under the curtain across the window. Only some of the conversation can be heard on BWC. The CM said that Mr Godward said, "you're going to have another constant watch on your hands tonight". He told Mr Godward that they were trying to support him on an ACCT and asked him why he wanted to be on a constant watch. He then raised his voice when Mr Godward did not respond and asked if he could not talk to them. Mr Godward raised his voice too and said he wanted them to leave him alone. Mr Godward turned around and came out from under the curtain. He said that officers were making sly comments to him, and something had moved from the bed. He then turned back around and put his head under the curtain. The CM said that he was going to leave Mr Godward, they had a duty of care towards

him and to “have a fucking word with yourself”. At 10.40am, staff locked Mr Godward in his cell.

75. At 11.02am, Officer B went to do an ACCT check on Mr Godward, but his observation panel was covered. She told CM A, who went to the cell with two officers and spoke to Mr Godward though the door for two minutes. Staff checked on Mr Godward twice more in the next 30 minutes. The only note in Mr Godward’s ACCT from the morning was from Officer B, who recorded that he had slept for most of the morning but woke up very agitated and covered his observation panel.

76. At 12.15am, Mr Godward collected his lunch and took it back to his cell. At 12.35pm, Mr Godward called his mother and left a voicemail stating that he had rung her six times that day and it kept going to voicemail.

77. At 12.50pm, Officer D tried to do an ACCT check. Mr Godward’s observation panel was covered. Having tried to speak to him, she opened the inundation point. At 12.59pm, she went into the cell with Officer C. Officer D said when they went into the cell, Mr Godward was sitting on his bed, smoking his vape, smirking at them. On BWC footage, Officer D can be heard saying, “fucking hell Reece, why are you not answering us, I bet you always win at hide and seek, not talking. I’ll take this cover off, are you alright, talk to me, you know where we are if you need a chat”. Mr Godward did not reply. She left the cell. She told the investigator that she had no concerns about Mr Godward, and he seemed much calmer than when she had seen him in the morning. She told CM A and other staff what had happened during the lunchtime period.

78. At 1.03pm, Mr Godward rang his sister and spoke to his mother. He told her that his cellmate had moved out as he had lied to staff about Mr Godward threatening him. He said that he would get him “done in if he carries on talking shit about me”. He said that he would ring her later on.

79. At 2.07pm, Officer B did an ACCT check on Mr Godward via his inundation point as his observation panel was covered.

80. At 2.39pm, Mr Godward rang his cell bell, Officer B responded and unlocked his cell as it was time for association. He left the cell and spoke to other prisoners. At 2.53pm, Officer B went into Mr Godward’s cell to remove the paper he had been using to cover his observation panel. While she was in there, another prisoner was standing outside the cell and told her that Mr Godward was telling prisoners that his cellmate was a sex offender. Five minutes later, she left the cell with broken wood she had found under a mattress, ripped bedding and paper.

81. Officer B said that she took the items to the office and showed Officer C. She said that Officer C told her to put the items on the side. Although Officer B had been aware that prisoners sometimes used torn bedding as ligatures, she said she had shown a more experienced officer the items who was unconcerned, so she returned to the landing. Officer C did not remember Officer B showing her the items. She said if she had been aware, she would have arranged an immediate ACCT review.

82. The cellmate spoke to Officer B and said that Mr Godward was telling other prisoners that he was a “nonce.” He said that he felt scared, so she took him back to his cell. She informed CM A.

83. A prisoner said that he saw Mr Godward during association, they shook hands, and he asked him if he was “alright”, to which Mr Godward replied that he was. He said that he was moving quickly as if he was trying to obtain something, such as a vape.

84. At 3.16pm, CM A spoke to Mr Godward on the landing about what he had said about his cellmate. This conversation is on CCTV although there is no sound. The CM said that he told Mr Godward that he had caused damage by spreading lies. He said that Mr Godward was smirking, would not listen to him and continued to call his cellmate derogatory names. He said that he gave Mr Godward a chance to stop and carry on with his association period. As he was walking away, he said that Mr Godward said, “watch yourself”. He then told Mr Godward to go to his cell. At 3.18pm, he escorted him back to his cell and locked him inside without either of them saying anything.

85. During this conversation, CCTV shows that several prisoners were nearby and had stopped what they were doing, apparently listening to the conversation the CM and Mr Godward were having. Officers B and C were nearby and said that neither of them were shouting, but that it was a “heated discussion” with frustration apparent.

86. Two prisoners told the investigator that before CM A took Mr Godward up to his cell, Mr Godward had said, “If you put me in my cell, next time you see me I’ll be in a body bag.” One of the prisoners said that the CM responded to this saying, “get back to your door now you scruffy little cunt”. The other prisoner said that he could not remember if the CM had replied. The CM denied that Mr Godward had made this comment or that he had made the alleged following remark.

87. At 3.29pm and 3.34pm, Officer B opened Mr Godward’s observation flap and looked in quickly, but the panel was obscured. The officer left the flap open on the second occasion. At 3.35pm, the paper covering Mr Godward’s observation panel dropped halfway down and remained like that.

88. Officer B noticed from the other side of the landing that the paper had fallen down on Mr Godward’s observation panel, so she shouted across to Officer E to ask him to check him. At 3.56pm, Officer E looked into Mr Godward’s cell for a few seconds. He could not recall doing this check but accepts that he did and said there must not have been anything that concerned him. A short time later, Officer B said she asked him what he had seen in Mr Godward’s cell. He said that Mr Godward had seen him and ran to lie on his bed. At 4.20pm, an officer closed the observation panel and did not look into the cell.

89. At 4.21pm, Officer B went to Mr Godward’s cell to do an ACCT check. She said this was an extra check as what Officer E had told her, “Just didn’t sit right”. Mr Godward’s observation panel was still blocked halfway, and it was quite dark in the cell. She turned on the night light and thought she could see Mr Godward lying on the floor to the left side of the door in an unusual position. He did not respond to her. She left the cell and asked Officer F, who was on the other side of the landing, to come to the cell as she was taller to confirm if she could see Mr Godward.

90. Officer F looked in the cell and could see that Mr Godward was lying on the floor in front of the door and his face was blue. She told Officer B, who radioed a code blue (an emergency code used when a prisoner is not responding or having difficulty breathing). Control room staff requested an ambulance immediately. Officer C got

to the cell seconds later. When she got there, she said that the two officers already there looked “pale and frozen”. Officer B said she was in shock. Officer C looked in through the observation panel and could see that Mr Godward had hanged himself from his medication locker. She tried to open the door, but Mr Godward had put furniture in front of his door which prevented it opening.

91. Thirty seconds after the code blue, several other staff arrived, including CM A, and they managed to get into the cell at 4.23pm. Mr Godward was hanging by a ligature made from bedsheets with much of his body lying on the floor behind the cell door. The CM cut the ligature using his anti-ligature knife, lay Mr Godward on the floor and checked for signs of life. At this point, two nurses got to the cell. They told staff to start chest compressions, which the CM did immediately. They assessed Mr Godward, inserted an airway and administered oxygen, while staff continued chest compressions. Staff attached a defibrillator. At 4.33pm, paramedics arrived and took over Mr Godward’s treatment. They regained a pulse and took Mr Godward to hospital at 5.25pm. He remained in a coma. On 23 February at 4.54am, Mr Godward died.

92. Police found a note in Mr Godward’s cell addressed to his mother. He wrote that he was depressed and did not want to live anymore. He apologised but said that when he was gone, he would be at peace and not hurting anymore.

93. On 26 February, staff submitted an intelligence report that a prisoner had told staff that Mr Godward had taken his own life because he had come into prison “full of Spice and had run out”. The prisoner refused to speak to the investigator. Staff we spoke to said Mr Godward did not seem under the influence of drugs while he was at Leeds.

Contact with Mr Godward’s family

94. At 5.00pm on 22 February, a family liaison officer (FLO) was appointed. At 5.20pm, he called Mr Godward’s mother, but she did not answer. He then called Mr Godward’s sister and told her that Mr Godward had attempted to take his own life. She agreed to collect her mother from work and take her to the hospital. At 9.00pm, the Duty Governor went to the hospital and met with several members of Mr Godward’s family.

95. After Mr Godward died, the FLO rang Mr Godward’s mother and expressed his condolences. He remained in contact with Mr Godward’s mother, offered a contribution to funeral expenses in line with HMPPS’ policy and returned her son’s belongings to her.

Support for prisoners and staff

96. After Mr Godward’s death, the Duty Governor 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. Healthcare staff did not have a separate debrief as would usually be the case.

97. The prison posted notices informing other prisoners of Mr Godward'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 Godward's death.

98. A SO said that she had not felt well supported immediately after Mr Godward had died but knew where to access support if she needed it. CM A said that the support offered to staff had been on his day off and he had not been offered anything since aside from by a colleague in safer custody in relation to the subsequent investigations that occurred. Another manager said he had not been offered any support.

Post-mortem report

99. The post-mortem report concluded that Mr Godward died of multiple organ failure, caused by a cardiac arrest which was caused by hanging. The toxicology report noted that Mr Godward had cannabinoids in his system and there was evidence that he had used cannabis before he died. This can be detected post-mortem for several days after a person has last used it.

Findings

Assessment and management of risk

100. 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.

101. Mr Godward had been at Leeds for 12 days when he took his own life. He was subject to ACCT support for a day when he first arrived and for the last eight days he was there. There were some good examples of staff engaging with Mr Godward, trying to understand his concerns and manage his risk. However, we found significant issues with risk assessment and management at Leeds, which have also been identified following investigations into previous deaths at the prison.

102. Mr Godward was constantly observed at court after banging his head on cell walls. Staff opened an ACCT appropriately when Mr Godward got to Leeds. He self-harmed later that day after a positive body scan. CM A recorded this in his ACCT, noting he was very upset. He was subsequently scanned a further four times, the last of which was negative. This further information was not recorded in Mr Godward's ACCT, nor was the information about the positive body scan included in Mr Godward's ACCT assessment the next day.

103. During the first ACCT review, Mr Godward's ACCT was closed. We consider that this was premature given Mr Godward's self-harm the day before. Staff present did not discuss the positive body scan with him.

104. Mr Godward's ACCT was reopened on 14 February following concerns that he had self-harmed. On 16 February, a SO set Mr Godward's next review for 1 March. This was so that she could chair the review herself. While this would have allowed for a consistent case manager, it meant that objectives on Mr Godward's care plan would not be reviewed for a fortnight. We consider this was too long a gap between case reviews.

105. Mr Godward's mother called and emailed the prison a number of times during his short time at Leeds. Once he was able, Mr Godward telephoned his mother numerous times a day and she was clearly an important source of support to him. However, a SO did not know Mr Godward's mother had contacted the prison. She said she knew that families could be involved in a prisoner's ACCT but had never done so herself. We consider that, in Mr Godward's case, involving his mother in the ACCT process might have allowed staff to better understand his needs and concerns. The Governor will wish to consider how they can improve the involvement of families in ACCT processes.

106. On 17 February, it is clear that a particular CM made considerable efforts to address Mr Godward's concerns and returned to his cell several times when Mr

Godward became agitated. He dealt with Mr Godward's issues sensitively, providing him with phone credit, clothing and food from the canteen. The CM appropriately increased Mr Godward's observations to hourly. However, he did not review Mr Godward's ACCT document or consider the other factors in his care plan. Mr Godward's next review remained 1 March. Again, given Mr Godward's behaviour that day, the increase in observations and Mr Godward's statement that he would be subject to constant watch before the end of the day, we consider an ACCT review should have been held.

107. Mr Godward's actions on 22 February indicated a worrying escalation in his behaviour. He allegedly threatened his cellmate (who was moved cells, removing this protective factor), repeatedly blocked his observation panel, barricaded himself in his cell, refused to engage with staff and told CM A that he would be subject to a constant watch later.

108. Staff also removed ripped bedding from his cell which is often used as a ligature in self-inflicted prison deaths and is indeed what Mr Godward later used to hang himself. Later, Mr Godward's afternoon association was ended early due to him spreading rumours about his cellmate. We were also told that Mr Godward told CM A he would leave the prison in a body bag. We have not been able to corroborate this.

109. Despite Mr Godward's escalating behaviour on 22 February and several factors which indicated his risk to himself might have increased, no one considered holding an ACCT review or increasing his ACCT observations. In addition, none of the incidents on 22 February were documented in Mr Godward's ACCT, general prison record, security information or the wing observation book.

110. Mr Godward tied the ligature to the medication box in his cell. Two months after this, another prisoner took his life using the same method. We understand that the prison considered whether the medication boxes should be moved but decided that this was not proportionate given that there are other ligature points in standard cells.

Staff conduct

111. Mr Godward's mother raised concerns about how Officer A and CM A had treated Mr Godward. We did not find any evidence that Mr Godward was bullied by Officer A.

112. CM A had been temporarily promoted from officer to supervising officer in September 2021 and had worked on a project outside of the prison for a year. He returned to Leeds in September 2022, temporarily promoted to the role of custodial manager. As a result of the events surrounding Mr Godward's death, he was demoted and resumed his substantive position as an officer. He was doing overtime on the wing as an officer on 22 February. However, with no other CM supervising the wing that day, and it being the usual wing he managed, staff naturally looked to him for authority, and we consider that he accepted a managerial role in the events surrounding Mr Godward's death.

113. CM A had ACCT case coordinator training around January 2023. However, he said he had not case managed an ACCT and could not recall if the course covered how

to recognise signs a prisoner's risk to themselves could be escalating. When questioned by the investigator, he did not seem confident in aspects of ACCT documentation or assessing risk. When discussing the events of 22 February, he said he did not know he could arrange an ad hoc ACCT case review unless a prisoner had actually self-harmed.

114. We consider that CM A took a caring, supportive approach when Mr Godward arrived in Leeds and increased his ACCT observations when he self-harmed. He also made efforts throughout his time on the wing to engage with Mr Godward. However, some of the interactions between him and Mr Godward on 22 February did not meet the required standard. His tone and language when talking Mr Godward were not indicative of a consistently respectful, professional relationship. There was at least one other occasion when a different officer swore at Mr Godward on his last day in Leeds. Both HMIP and the IMB had raised such issues in their latest reports and the Governor at the time had indicated that swearing would not be tolerated. In an investigation into a self-inflicted death two months after Mr Godward on B wing, we had concerns about another officer's conduct and the way they interacted with prisoners.

Action taken by Leeds since Mr Godward's death

115. After Mr Godward's death, the then Acting Governor commissioned an internal investigation, which raised concerns regarding CM A's management of Mr Godward's risk on 22 February. Despite his inexperience at case managing ACCTs, the investigation noted that he had been recently ACCT trained and the actions available to him, such as increasing observation levels, speaking to the safer custody department, ACCT case manager or holding a review were not complex. The investigation found the CM had not recognised Mr Godward's escalating risk on 22 February and recommended a disciplinary investigation. The CM accepted the findings of the report and had reflected on them. He received a disciplinary warning.

116. The internal investigation recommended that the Governor reviewed ACCT quality assurance processes to ensure that there was a robust system in place. The then Acting Governor introduced a new quality assurance process in response.

117. Leeds has also received additional support from the regional directorate and developed an action plan to address the issues identified. This included further training, more Listeners (prisoners trained by the Samaritans to provide support to peers), providing further information for managers on how to use ACCTs and CSIPs, regular reviews of their death in custody action plan and rolling out Andy's Man Club (peer led groups with the aim of preventing suicide) across the prison. Since 1 March 2023, 253 prison staff have received suicide and self-harm training and eight staff have received risks and triggers training. The prison now has ten staff to deliver this training themselves.

118. The investigator spoke to the Governor, who said that she was taking steps to challenge and improve the staff culture at Leeds. In November 2023, she ran a two-day visions and values workshop with prisoners and staff. She had planned a seven week focus on culture starting in January 2024, run by the psychology department. She said that there was a new CM on B wing who was managing staff in a robust, supportive way. She also intended to reconsider the distribution of SOs on the wing. In a recent full staff meeting, she had reiterated her expectations about how staff

spoke to and treated prisoners. She said that B wing had not been identified as a particularly problematic wing to her when speaking to staff and prisoners. We consider that the Governor has taken steps to respond to our concerns about ACCT weaknesses, individual staff short comings and the culture on B wing, and that work will continue in 2024. As a result, we make no recommendation.

Body scanning

119. All prisoners arriving at Leeds are subject to a body scan. HMPPS' national policy framework *Use of X-Ray Scanners (Adult Male Prisons)* October 2022 states that following a scan, local operating procedures must provide clear instruction as to where and how the prisoner will be safely located during this period.

120. Leeds' secreted items policy states that when a prisoner has a positive body scan, they must be isolated and supervised by staff at all times. Staff must inform the Duty Governor, Orderly Officer and Segregation Unit Manager. The prisoner must be located in the segregation unit. A prisoner must give a negative body scan before being moved from the segregation unit.

121. HMPPS' policy states that following a positive scan, healthcare staff must be informed in case the internally concealed item may cause a risk to the prisoner. The prisoner should be asked to hand over the item if it is accessible and this must be retained as evidence and processed according to policy. If a prisoner refuses to hand over the item, staff should consider whether to place the prisoner on report. If they refuse or are unable to give the item to staff, staff must consider the risks presented by the prisoner to themselves and others. If a prisoner states they are no longer concealing an item, staff can consider whether a further scan is appropriate.

122. Mr Godward's first scan was positive. Staff put him into a cell on his own while he waited to be rescanned. He then self-harmed as he was worried about being segregated. CM A increased his ACCT observations and moved him to a shared cell for his own safety. While this was a compassionate approach, it was in contravention of national guidelines.

123. Mr Godward was then scanned a further three times within 30 minutes, all of which were positive. At some point after the first positive scan, a nurse assessed Mr Godward but there was no reference to the positive body scan in her assessment or a review of the potential risks to Mr Godward. When Mr Godward was scanned a fifth time it was clear. Again, this approach was in breach of both the local and national policy.

124. *Use of X-Ray Body Scanners (Adult Male Prisons)* states that the date, justification and radiation dosage of the body scan must be recorded in the personal care needs section of the prisoner's prison record. This is to manage the prisoner's radiation exposure and to ensure that it does not exceed the maximum annual allowance. Staff involved in scanning Mr Godward did not follow this guidance. We make the following recommendation.

The Governor and Head of Healthcare should ensure that all staff follow local and national instructions regarding body scanners including that body scans are recorded appropriately, and decisions taken following scans are in adherence to the policy and clearly recorded.

Substance misuse

125. Mr Godward had a well-documented history of substance misuse. He was offered support for his substance misuse on several occasions but declined every time. The clinical reviewer concluded his substance misuse care was appropriate and equivalent to that he could have expected to receive in the community.

126. However, Mr Godward told a CM that he had got into debt with other prisoners. It is not known how, but this may have been as a result of substance misuse. His cellmate believed that he had drugs hidden in his shoe which he used himself or traded with other prisoners. Two prisoners said that they thought he had run out of drugs in the days before he died. The toxicology report indicated that Mr Godward had used cannabis at some point in the days before he died. However, staff did not record any suspicions that Mr Godward was under the influence of illicit substances at Leeds.

127. The Governor told us that Leeds' drug strategy was constantly evolving. Their first approach was to be non-punitive and offer support and assistance, which is what staff did with Mr Godward. Staff have held focus groups with prisoners to try to understand what is driving demand and used this to identify new actions for the drug strategy. The prison also introduced a new core day at the end of September 2023, which allows prisoners more time out of their cell to reduce boredom (often linked to drug use). Given the positive steps Leeds is taking to understand and address drug supply and demand at the prison, we make no recommendation.

Clinical Care

Physical healthcare

128. There was a delay of six days in Mr Godward receiving his antibiotics due to a prescribing error by the GP. The GP concerned has since completed a reflective review on how the date error occurred to ensure lessons are learnt.

129. The clinical reviewer concluded that overall Mr Godward's physical healthcare was equivalent to that he could have expected to receive in the community.

Mental healthcare

130. Mr Godward's mental health was reviewed by mental health nurses twice during ACCT reviews. On 11 February, the nurse present referred him to the GP for consideration of prescription of antidepressants. (Unfortunately, this appointment did not take place before Mr Godward died.) However, the ACCT care plan did not reflect how mental health staff would support Mr Godward other than by the facilitation of a medication review. The clinical reviewer concluded that this meant mental health staff did not think they had a therapeutic and functional role in Mr Godward's ongoing care.

131. A nurse told the investigator that if a prisoner is on an ACCT and has been referred to the mental health team, mental health staff present at the ACCT review do their mental health triage at the same time. Mr Godward did not have a separate mental health assessment. The clinical reviewer concluded that Mr Godward should have

been offered an individual, formal mental health assessment that considered his longer-term mental health presentation, his historical and current risks. She therefore viewed Mr Godward's mental healthcare as only partially equivalent to that he could have expected to receive in the community.

132. In an investigation into a death six weeks before that of Mr Godward, which was published in August 2023, we found that mental health staff had not adequately assessed the prisoner's mental health or ensured that he was collecting his antidepressant medication. We recommended that the prison review the procedures in place for assessing the mental health needs of prisoners who have requested mental health support. At the time of writing, the prison had not yet responded to this recommendation and so we repeat the recommendation:

The Head of Healthcare should ensure that prisoners referred for a mental health assessment are offered an individual assessment, separate to the ACCT process.

Governor and Head of Healthcare to note

133. Staff and prisoners had mixed experiences of the support they received after Mr Godward died. Healthcare staff said they had not had a separate debrief to prison staff following the emergency response, as would usually be the case. A SO and CM A said that they had not felt well supported. Another manager said that he had not received any support. The Governor and Head of Healthcare may wish to ensure that they are employing a postvention approach to self-inflicted deaths. This is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody.

Inquest

134. The inquest into Mr Godward's death concluded on 7 October 2024. The jury concluded a narrative verdict and that Mr Godward died of suicide.

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