Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Shane Marchant, a prisoner at HMP Leeds, on 21 January 2025

## A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

## OUR VISION

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

## WHAT WE DO


## WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Shane Marchant died after being found hanged in his cell at HMP Leeds on 21 January 2025. He was 52 years old. I offer my condolences to his family and friends.

Mr Marchant arrived at Leeds approximately ten hours before his death. Staff immediately assessed him as a risk to himself and started suicide and self-harm monitoring. He gave inconsistent accounts of his suicidal thoughts. After he confirmed he had tied a ligature in his cell, staff rightly increased his level of checks. Despite some shortcomings in information sharing and recording, the investigation found that staff carefully considered Mr Marchant's risk and acted appropriately to try and keep him safe. I make no recommendations.

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** **September 2025**

# Contents

# Summary

## Events

1. On 20 January 2025, Mr Shane Marchant was remanded to HMP Leeds charged with criminal damage. He had depression and anxiety and alcohol and drug misuse issues. Mr Marchant had last been in prison ten years earlier.

2. Mr Marchant arrived at Leeds around 3.00pm, with a suicide and self-harm warning form completed by the escort contractor which noted that police thought Mr Marchant had taken a drug overdose prior to his arrest. Prison staff immediately started suicide and self-harm prevention procedures, known as ACCT, with hourly checks. No concerns were raised during Mr Marchant's initial prison reception and health screenings. He denied that he had any current thoughts or history of attempted suicide or self-harm and denied having taken an overdose. He was located on the induction wing in a shared cell, with another prisoner who was also subject to ACCT monitoring.

3. At approximately 7.20pm, a GP assessed Mr Marchant. He expressed suicidal intent but gave no details. The GP recorded this in the wrong section of the ACCT document and did not pass this information onto prison staff verbally.

4. Staff did not record any ACCT checks for Mr Marchant until 7.30pm. Although for much of this time Mr Marchant was still undergoing his reception screening.

5. At 10.00pm, Mr Marchant's cell mate told staff that Mr Marchant had made a ligature. Mr Marchant confirmed this. Staff moved Mr Marchant to a single cell due to conflict with his cellmate. A prison manager completed an ad-hoc ACCT review. During this, Mr Marchant disclosed grief over his mother's recent death but denied that he had any current suicidal thoughts. Mr Marchant's demeanour appeared to improve during the review. Despite this, the manager increased his ACCT checks to three each hour and agreed to refer Mr Marchant for bereavement support.

6. On 21 January at 1.49am, an officer looked through Mr Marchant's observation panel and saw him hanging from a ligature attached to the window. The officer radioed a medical emergency code and staff responded quickly. Prison, healthcare and ambulance paramedic staff provided emergency care and Mr Marchant was transferred to hospital. At 3.00pm, hospital staff pronounced Mr Marchant's life extinct.

## Findings

7. Mr Marchant had several risk factors for suicide and self-harm. He had a history of attempted suicide and self-harm, substance misuse and depression and anxiety.

8. Mr Marchant's ACCT procedures were generally managed appropriately within the short time available. However, there were some missed checks, and important information about his well-being was not always recorded or shared with staff, and

so was not considered when assessing his risk. The prison has already taken steps to address these issues.

9. The clinical reviewer concluded that Mr Marchant's healthcare was of a good standard and at least equivalent to that he could have expected to receive in the community.

10. We make no recommendations.

# The Investigation Process

11. HMPPS informed us of Mr Marchant's death on 21 January 2025. 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.

12. The investigator obtained copies of relevant extracts from Mr Marchant's prison and medical records, CCTV footage, and body worn video camera (BWVC) footage. He also obtained ambulance records.

13. The investigator interviewed one prisoner and seven members of staff at Leeds in February and March 2025.

14. NHS England commissioned a clinical reviewer to review Mr Marchant's clinical care at the prison. The clinical reviewer and the investigator jointly interviewed staff.

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

16. The Ombudsman's office contacted Mr Marchant's family to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Marchant's family asked no questions.

17. Mr Marchant's family received a copy of the initial report. They did not make any comments.

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

# Background Information

## HMP Leeds

19. HMP Leeds is a local prison holding 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 and substance misuse services.

## HM Inspectorate of Prisons

20. The most recent inspection of HMP Leeds was in June 2022, which was followed by a review of progress inspection in July 2023. The initial inspection highlighted that the number of prisoners arriving each week was very high. Reception processes were respectful and delivered well and early days work to support new prisoners was now more robust. It noted that there was good support for prisoners who self-harmed regularly and assessment, care in custody and teamwork (ACCT) case management was of a reasonable quality overall.

21. The progress inspection reported that despite their previous concerns about the high number of prisoners who had taken their own lives, there had been a failure by leaders to make progress in reducing the rate of suicide, although the prison was making progress in some areas. Leeds had the second highest rate of self-inflicted deaths of any prison in England and Wales.

## Independent Monitoring Board

22. 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 2023, the IMB reported that it remained concerned about the high number of deaths in custody and the high level of illicit substances in the prison. The IMB noted that Leeds' reception area had clear procedures and facilities in place for checking property, reviewing prisoners' health and mental wellbeing, and screening for illicit items.

## Previous deaths at HMP Leeds

23. Mr Marchant was the 26th prisoner to die at Leeds since January 2022. Of the previous deaths, ten were due to natural causes, 15 were self-inflicted and one was drug related. Since the death of Mr Marchant, up to mid-June 2025, there had been four further deaths. Of these, two were from natural causes, one self-inflicted and one where the cause of death is yet to be confirmed. As a result of the number of deaths, Leeds was identified as requiring additional support and monitoring from regional and national safety teams.

24. In previous investigations, we found that Leeds needed to improve their assessment and management of prisoners at risk of suicide and self-harm. We have also found in this investigation that improvements still need to be made.

## Assessment, Care in Custody and Teamwork (ACCT)

25. 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.

26. As part of the process, support actions are put in place. The ACCT plan should not be closed until all the actions of the support actions 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. The *Prison Safety Policy Framework* sets out guidance on ACCT procedures.

# Key Events

### Police custody

27. On 18 January 2025 around 12.00am, police arrested Mr Shane Marchant for an outstanding warrant issued against him, after he had failed to appear at court, for offences of criminal damage (committed in September 2024). They took him into police custody.

28. Police records noted that Mr Marchant said he had asthma, chronic obstructive pulmonary disease (COPD – a group of lung conditions), depression and anxiety. He had recently consumed alcohol and drugs and said that he did not know if he had tried to harm himself recently. Mr Marchant said that he had "taken loads of drugs, everything". Police records noted that Mr Marchant appeared drowsy when he was brought into custody and struggled to answer questions. Due to his presentation, staff suspected that he had taken a drug overdose and took him to hospital.

29. At hospital, Mr Marchant was prescribed paracetamol, dihydrocodeine (used for pain management) and an inhaler. He was last given a dose of dihydrocodeine at 5.33am. At 5.52am, Mr Marchant returned to police custody. There is no record of whether he was treated for an overdose at hospital.

## 20 January 2025

### Leeds Magistrates Court

30. To aid communication of prisoners' risks between criminal justice agencies, a digital Person Escort Record (DPER) is completed for every prisoner who is securely transported between police stations, courts, and prisons.

31. On 20 January at 8.28am, the police handed over Mr Marchant to GeoAmey, the prisoner escort contractor, who transported Mr Marchant from Leeds Police Station to Leeds Magistrates Court.

32. The DPER completed by the police that travelled with Mr Marchant to court noted that he had taken an overdose prior to being arrested, had been assessed at hospital to manage his risk of suicide and self-harm and had been prescribed paracetamol, dihydrocodeine and an inhaler. Police had also noted that Mr Marchant was dependant on alcohol and was diabetic, which was controlled. Mr Marchant disclosed that he had a history of depression and stated he could not read or write.

33. GeoAmey opened a suicide and self-harm (SASH) document, based on the information contained in the DPER, which noted that Mr Marchant had taken an overdose prior to his arrest on 18 January. Mr Marchant told the escort contractor staff that he was okay and had no current thoughts of suicide or self-harm.

34. At court, Mr Marchant was remanded to prison and taken to HMP Leeds. He was due to return to court on 10 February for sentencing.

**HMP Leeds**

35. Mr Marchant arrived at HMP Leeds around 3.00pm. An officer noted that during the reception screening interview, Mr Marchant said he had recently taken an overdose (on 18 January) but did not know why. He described a history of alcohol misuse, and said he had no current thoughts of suicide or self-harm. Mr Marchant said that he had no next of kin or support but did not view this as a concern. The officer noted that Mr Marchant had last been in prison ten years ago. At 3.17pm, due to concerns about his well-being, an officer-initiated suicide and self-harm monitoring, known as ACCT, by filling in the concern and keep safe form, requiring hourly checks and four additional welfare checks during Mr Marchant's first night in custody.

36. At 3.48pm, a Supervising Officer (SO) from the Safer Custody team, interviewed Mr Marchant and completed the ACCT immediate action plan. The SO noted that Mr Marchant was relaxed and engaged in conversation. Mr Marchant denied that he had taken an overdose and said that he did not know why this information had been recorded on the SASH form. He said he had no thoughts to harm himself and was hungry. The SO explained the support that was available, including access to the Samaritan's phoneline and to Listeners (prisoners trained by the Samaritans to offer support to other prisoners). He informed Mr Marchant that he would see the GP later that day, to discuss his substance misuse issues and gave him food. He noted that Mr Marchant would be located on the induction unit, and staff were required to conduct hourly, irregular ACCT checks. Mr Marchant's cell sharing risk assessment (CSRA) noted that he could share a cell with another prisoner.

37. Around 5.00pm, a nurse completed Mr Marchant's initial healthcare reception screen. She noted that she had reviewed his DPER document, and that Mr Marchant had COPD and used an inhaler. Mr Marchant said that he was diabetic but had not taken medication relating to this for some time. He said he was not taking any other medication. Mr Marchant denied that he had taken an overdose before his arrest and denied any current thoughts or history of attempted suicide or self-harm. Mr Marchant said that when he was in police custody, "he had just said that" (referring to taking drugs), and that he did not need to be treated when he attended hospital. All Mr Marchant's physical observations were normal. Mr Marchant told the nurse that he drank alcohol daily and used heroin. He said he had last drunk alcohol three days ago. Using an alcohol withdrawal assessment tool, Mr Marchant's scores indicated that he may have an alcohol dependency, however any withdrawal symptoms he had were minimal to none, and therefore no immediate treatment was required. The nurse told us at interview that Mr Marchant displayed no physical symptoms of alcohol withdrawal.

38. Mr Marchant initially refused to provide a urine sample (to test for any illicit substances) and became aggressive towards the nurse. After a short time, he calmed down and agreed and provided a sample, which was negative for drugs. Nurse Brook reminded Mr Marchant of the support available to him under ACCT procedures and referred him to the mental health team.

39. Shortly afterwards, an officer saw Mr Marchant. He noted that Mr Marchant had completed his reception and healthcare screenings, had a shower and meal in reception, and had been issued his first night pack, which consisted of bedding, toiletries, cutlery, writing paper and pen. He explained more about the prison regime and told Mr Marchant that his prison induction would continue the next day. Mr Marchant was issued with canteen/vape packs and £1 credit to use the phone (once he had provided any phone numbers).

40. Around 6.48pm, Mr Marchant was located in cell D2-08 on D Wing, the induction unit. He shared a cell. At interview, the cellmate told the investigator that when Mr Marchant arrived they exchanged greetings. He told Mr Marchant that he wanted to be left alone as he would have preferred not to have shared a cell.

41. At 7.23pm, as part of his reception healthcare screening a GP, saw Mr Marchant. This assessment took place in the healthcare clinic, located on the ground floor of D Wing. The GP noted that Mr Marchant's physical observations were normal, and that he displayed no signs of withdrawal from alcohol or opiates. He noted that Mr Marchant's urine screen was negative for illicit substances. At interview, the GP told us that Mr Marchant had "firmly" requested that he be prescribed methadone. (Methadone is a synthetic opiate manufactured for use as a substitute for heroin in the treatment of heroin addiction.) The GP did not agree, as none of Mr Marchant's test results or his presentation supported this.

42. During the assessment, Mr Marchant told the GP that he was going to kill himself. Despite the GP's probing, Mr Marchant would not elaborate on how, when or whether he had current thoughts or specific plans. Aware that Mr Marchant was subject to ACCT monitoring, the GP retrieved the ACCT document from D Wing, as it had not accompanied Mr Marchant to the appointment as it should have done. The GP wrote in the ACCT document on the concern and keep safe page, "*Dr in reception – expressing suicidal ideation, mild withdrawal*".

43. After Mr Marchant returned to his cell, his cellmate told us that they did not speak much over the next couple of hours. Mr Marchant had, however, told Mr him that he had fallen out with his family. The cellmate said that Mr Marchant seemed unsettled and very agitated and was therefore unsure whether he was withdrawing from an illicit substance. He was aware that Mr Marchant had seen the GP and that he had not been prescribed any medication. The cellmate told us that he could not recall if Mr Marchant had shared any plans of self-harm or suicide with him.

44. At 7.30pm and 7.47pm, two officers completed ACCT checks on Mr Marchant. He raised no concerns. These were the first recorded ACCT checks since ACCT procedures had started at 3.17pm.

45. At 7.50pm, the GP noted in Mr Marchant's medical record that he had considered the recent overdose information that was recorded on Mr Marchant's DPER and that he had not showed any significant signs of withdrawal or scoring on relevant clinical assessment scoring tools, when assessed. Since the substance and quantity of the alleged overdose were unknown, the GP noted that the substance misuse team would assess him the following morning. The GP told the investigator that he told a nurse that he was slightly concerned about Mr Marchant due to his

suicide risk and the comments he had made. The GP said he asked that while he was being managed under ACCT procedures, staff also visually check Mr Marchant for any signs of alcohol withdrawal.

46. The investigator watched the CCTV footage for that evening. At 8.37pm, an officer completed an ACCT check. She raised no concerns about Mr Marchant. An officer arrived for duty on D Wing about 8.45pm. At 9.35pm, an officer completed an ACCT check on Mr Marchant and raised no concerns. Mr Marchant was sat on his bed watching television.

47. For the most part of the evening, the cellmate also watched television. He said that Mr Marchant repeatedly stood up and down from his bed and paced around the cell. At one point, Mr Marchant placed his mattress on the floor and then made a coffee. Just before 10.00pm, the cellmate said he heard the cell window open. When he looked, he saw Mr Marchant attempting to hang himself from a ligature (made from a bedsheet) attached to the window. He pressed the emergency cell bell to alert staff. At this point, Mr Marchant apparently removed the ligature and asked him, "why did you grass me up?". He said he explained that he was only trying to help him.

48. An officer responded to the cell bell and arrived at the cell at 10.00pm. The cellmate was sat on his bed and Mr Marchant was stood at the back of the cell, elevated on either the cell pipework or a chair. He had bedding in his hand but had not made this into a ligature. The cellmate told the officer that Mr Marchant had made a ligature. The officer could not see a tied ligature, nor did Mr Marchant have anything wrapped around his neck. She asked Mr Marchant to get down and to come and speak to her at the cell door. However, Mr Marchant lay on his mattress on the floor and told the officer to "fuck off".

49. The officer told us that she believed that Mr Marchant and the cellmate did not get along as the cellmate appeared annoyed with him. The officer told the cellmate that she intended to report the incident to a manager, and that he should ring the cell bell in the meantime, if he had any further concerns.

50. The officer left the cell and immediately reported the incident to the officer in charge of the prison, a Custodial Manager (CM). From checking paperwork and responding to the cell bell, the officer had realised that the cellmate was also subject to ACCT monitoring. She raised this with the CM when she spoke to him.

51. At 10.09pm, the CM arrived at Mr Marchant's cell, accompanied by an officer. He unlocked and entered the cell. Mr Marchant had returned the mattress to the top bunk. They could not see any ligatures. When questioned, Mr Marchant admitted that he had made a ligature. While trying to speak to Mr Marchant, the CM noted that the cellmate was becoming "incessant", kept butting into their conversation and expressed that he did not want to share a cell with Mr Marchant. Mr Marchant appeared agitated by this. The CM asked the officer to check the availability of any spare spaces or cells on the wing, concerned about the risk the two prisoners could pose to each other because they were both being monitored under ACCT procedures. One empty single cell was found. Mr Marchant also said that he would be happier if he moved cells.

52. At 10.13pm, the CM and the officer escorted Mr Marchant to a single cell, D4-32. At the cell, the CM spoke with Mr Marchant about the ligature incident. Mr Marchant initially said he had wanted to kill himself. During a lengthy conversation with the CM, Mr Marchant's mood improved, and he appeared calmer than earlier. He denied having current suicidal thoughts and engaged openly, recalling past time in custody, mentioning specific officers, and making jokes. Mr Marchant also spoke about his mother's recent death and its emotional impact. An officer offered bereavement support, which Mr Marchant agreed to receive from the chaplaincy team the next day. He admitted he had used the ligature incident to be moved to a different cell and said he was content being alone that night. He planned to watch TV and hoped to find a new cellmate the next day to help with reading and writing. Before the conversation ended, Mr Marchant apologised for his earlier behaviour.

53. The CM told us that Mr Marchant had said that he no current thoughts to harm himself, had displayed forward and future planning, had agreed to be referred for bereavement counselling and find a suitable cellmate the next day. However, he still considered that he was at risk to himself, as he had made a ligature. He therefore increased his ACCT checks to three each hour. He said that he had considered placing Mr Marchant under constant supervision, however, did not believe that, at that time, his risk level warranted this, due to the reasons stated.

54. The CM updated the ACCT record to note that he had completed an urgent ad-hoc case review. He also emailed the safer custody team to inform them that he had relocated Mr Marchant to a different cell and questioned why two prisoners who both were being supported by ACCT procedures had been placed in a cell together.

55. Staff completed ACCT checks on Mr Marchant at 11.05pm (an officer), 11.16pm (an officer), 11.45pm, and 11.55pm (an officer). Staff raised no concerns about Mr Marchant.

### Events on 21 January

56. The investigator watched CCTV and body worn video camera (BWVC) footage. He also reviewed information from NHS Yorkshire Ambulance Service. The following account has been taken from all sources.

57. An officer completed an ACCT check on Mr Marchant at 12.16am. At 12.30am, a nurse and a healthcare support worker (HSW) completed a welfare check on Mr Marchant. The nurse noted in his medical record that Mr Marchant appeared asleep and she saw evidence that he was breathing (his chest was rising and falling).

58. The officer completed further ACCT checks on Mr Marchant at 12.34am, 12.53am, 1.08am and 1.35am. She raised no concerns about Mr Marchant and noted he was in bed.

### Emergency response

59. At 1.49am, an officer went to Mr Marchant's cell to do an ACCT check. When she looked through the observation panel, she saw Mr Marchant with a ligature (made from bedding) around his neck, and he was suspended from the window. The officer immediately activated her BWVC and radioed a code blue (an emergency

code indicating that a prisoner is not breathing or is having difficulties doing so) at 1.50am. Staff in the control room called an ambulance immediately and instructed healthcare staff to go to Mr Marchant's cell. The officer entered the cell and cut the ligature with her anti-ligature knife and removed it from Mr Marchant's neck. She was assisted by a second officer who had arrived within four seconds and supported Mr Marchant's body. They laid Mr Marchant on the floor. Mr Marchant showed no signs of life. The CM arrived and started cardiopulmonary resuscitation (CPR) and rotated this with the officer.

60. A nurse arrived within two minutes of the code blue call, followed by further healthcare staff a minute later. She checked Mr Marchant for signs of life and took over his care, continuing chest compressions with the aid of emergency equipment that had been brought to the cell.

61. The first paramedics arrived at 2.01am and took over the care of Mr Marchant. Mr Marchant was transferred to Leeds General Hospital. At 3.00am, the hospital pronounced Mr Marchant's life extinct.

**Contact with Mr Marchant's family**

62. Mr Marchant did not provide any next of kin details upon arrival at Leeds. On 21 January, the prison offender manager and appointed family liaison officer (FLO), contacted the police for assistance in identifying Mr Marchant's next of kin. At 4.10pm the same day, Mr Marchant's brother and sister independently contacted the FLO, having learned of his death through a friend of another prisoner. The FLO informed them of the circumstances surrounding his death. The FLO maintained contact with the family, offering support and guidance. In accordance with national policy, the prison contributed to funeral costs.

**Support for prisoners and staff**

63. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoner support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

64. After Mr Marchant'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.

65. The prison posted notices informing other prisoners of Mr Marchant'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 Marchant's death. They also deployed Listeners to the wing to offer support to prisoners when Mr Marchant died.

## Post-mortem report

66. The post-mortem report was not available at the time of writing this report.

## Inquest

67. The Coroner's inquest held on 26 January 2026 determined the medical cause of death to be cerebral hypoxic injury and brain death, and strangulation by ligature. The jury concluded the death to be due to suicide.

# Findings

## Assessment of Mr Marchant's risk

### Risk assessment in reception

68. The *Prison Safety Policy Framework* sets out the risk factors and triggers that might increase a prisoner's risk of suicide and self-harm and the procedures (known as ACCT) that staff must follow when they identify a prisoner at risk. Prison Service Instruction (PSI) 7/2015, *Early Days in Custody,* requires reception staff to examine the PER and any other available documentation to identify immediate needs and risks already recorded. Staff are required to be aware that particular groups are at a higher risk of suicide/self-harm. Annex D of PSI 07/2015 lists the categories of prisoners who may be especially vulnerable to suicide or self-harm.

69. When Mr Marchant arrived at Leeds, he had a number of risk factors that indicated a risk of serious harm: he had a history of drug and alcohol misuse, depression and anxiety and his PER indicated that a suicide and self-harm warning form had been completed at court and that he had a history of self-harm and attempted suicide. He also had no contact with his family or friends. Staff appropriately started ACCT procedures when he arrived and referred him to the mental health and substance misuse teams.

### Assessment of risk of suicide and self-harm

70. Staff opened Mr Marchant's ACCT at 3.17pm on 20 January, with hourly checks required. However, staff recorded no ACCT checks until 7.30pm. Although Mr Marchant remained in reception for screening purposes during this time, the document did not travel with him to see the different members of staff as it should have done, nor were ACCT checks recorded as required.

71. At 7.23pm, Mr Marchant informed the GP that he was having suicidal thoughts. The ACCT document was not immediately available and had to be retrieved from the wing. The GP recorded details of the conversation in the incorrect section of the ACCT document and did not verbally communicate the increased risk to prison staff. Although he told the nurse, the failure to properly document and share this information meant that an urgent case review, required by policy, did not happen. Such a review could have prompted a reassessment of Mr Marchant's risk and potentially led to increased checks, especially as he had previously denied suicidal thoughts. We note that staff subsequently increased Mr Marchant's checks due to his later actions, but this represented a missed opportunity to reevaluate his risk at an earlier stage.

72. We are satisfied that when staff increased the frequency of Mr Marchant's ACCT checks after he tied a ligature, they had adequately considered his risk factors. They had spoken to him at some length and were reasonably assured that he had no thoughts of suicide or self-harm at the time. Staff judgement is fundamental to assessing a prisoner's risk and the CM took steps to try to ensure that Mr Marchant remained safe. In interview, the CM was able to clearly articulate how he reached

his decision on the appropriate frequency of checks and what information he had based his decision on.

73. Following Mr Marchant's death, Leeds' Early Learning Review and the Head of Operations at Leeds confirmed that all reception staff had been reminded, both verbally and in writing, of their responsibilities regarding ACCT procedures including recording ACCT checks while prisoners are in Reception. Similarly, the Head of Healthcare ensured all staff knew where to record information in ACCT documents and to ensure they raised any concerns directly with prison staff. We therefore make no recommendations on these issues.

### Co-locating prisoners on ACCT

74. Mr Marchant was initially placed in a cell with another prisoner who was also subject to ACCT procedures. The two prisoners were not previously acquainted and seemed to have a poor relationship. There is no evidence that staff conducted a risk assessment to evaluate the suitability of their co-location or to consider any potential risks or benefits of shared accommodation, as a form of peer support.

75. The Head of Operations at Leeds stated that, in such cases, staff are expected to make a defensible decision regarding cell sharing, particularly given the potential for increased risk. This issue has since been addressed with all reception and D Wing staff. We therefore make no recommendation.

76. It is unfortunate that the only other space available was in a single one, but staff understandably assessed that if Mr Marchant had remained in a cell with his cellmate, they might have increased each other's risk or indeed posed a risk of violence towards each other.

## Clinical care

77. The clinical reviewer noted that overall, the clinical care that Mr Marchant received was of a good standard and was equivalent to that which he could have expected to receive in the wider community.

78. Mr Marchant was only at Leeds for a short time. During this time, he received appropriate healthcare assessments and was referred to the mental and substance misuse teams for further support. Unfortunately, Mr Marchant died before this could take place.

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

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T I 020 7633 4100