Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Alan Whelan, a prisoner at HMP Leeds, on 30 December 2024

A report by the Prisons and Probation Ombudsman

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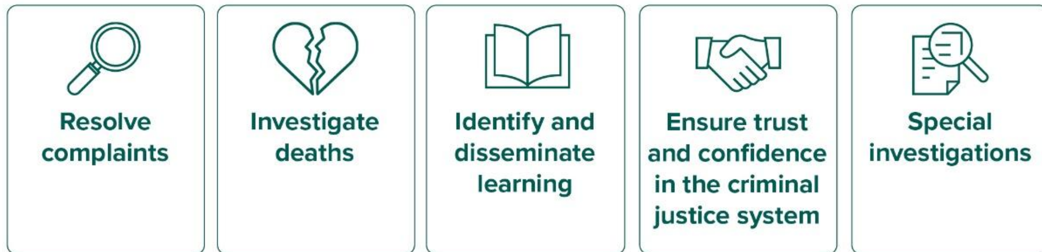
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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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 Alan Whelan was found hanged in his cell at HMP Leeds on 25 December 2024. He was 41 years old. I offer my condolences to Mr Whelan's family and friends.

Mr Whelan was the fifteenth prisoner to take his own life at Leeds in three years.

Mr Whelan had a history of self-harm, anxiety and paranoia. He believed that he was under threat from other prisoners due to a historical offence and gave this as his reason for self-harming. My investigation found some issues in the management of suicide and self-harm prevention procedures (known as ACCT), particularly on 25 December. The prison also failed to thoroughly investigate Mr Whelan's claim that he was under threat or support him appropriately.

Due to the high number of self-inflicted deaths at the prison, Leeds continues to be supported by the regional and national safety teams to improve the quality of ACCT management and support for those who feel at risk from others. I have previously commented that this is much needed, but clearly there are still some issues that need to be addressed.

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**

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Summary

Events

1. On 4 July 2024, Mr Alan Whelan was remanded to HMP Doncaster charged with coercive behaviour. This was not his first time in prison. On 6 August 2024, Mr Whelan transferred to Dovegate.

2. Mr Whelan had a history of substance misuse, anxiety and paranoia and was prescribed medication for his conditions. He also had a history of self-harm and during his time at Dovegate he was subject to suicide and self-harm monitoring (known as ACCT).

3. Mr Whelan had regular contact with his family by telephone; in particular, he spoke to his mother regularly and he viewed this as significant in reducing his risk.

4. On 3 September 2024, Mr Whelan transferred to HMP Leeds on an open ACCT.

5. On his arrival, reception staff reviewed the ACCT document and it remained open until 8 October, when they considered his risk had reduced and he no longer needed the additional support. Staff applied for vulnerable prisoner status on Mr Whelan's behalf because he felt under threat from other prisoners due to a historical offence.

6. During December, Mr Whelan's self-harm and suicidal behaviour increased. Staff started ACCT monitoring after he made cuts to his head, set fire to his cell and was twice found with a ligature around his neck. As a result of setting fire to his cell, Mr Whelan was moved to the segregation unit for his own safety. Mr Whelan continued to say that he self-harmed because he felt under threat. Staff considered his fears and found no evidence to support his belief. Mr Whelan accepted that he could be paranoid due to historical heavy cannabis use. No further action was taken in relation to his fears.

7. On 25 December, an officer was running late conducting Mr Whelan's ACCT check. At 11.24pm, he went to Mr Whelan's cell and found his observation panel covered and he was unable to get a response. The officer asked the night manager to attend the wing. When the night manager and three other members of staff entered Mr Whelan's cell, they found him suspended by a ligature around his neck. At 11.28pm, they radioed a medical emergency code, released Mr Whelan from the ligature and started CPR. Nursing staff attended and continued to treat Mr Whelan until paramedics arrived at 11.36pm.

8. The paramedics established a pulse, but Mr Whelan remained unconscious. At 12.27am, he was taken to hospital and placed on life support.

9. At 6.51am on 30 December, a hospital doctor confirmed that Mr Whelan had died.

Findings

10. Mr Whelan had several risk factors for suicide and self-harm. He had a history of self-harm and suicidal behaviour, substance misuse, anxiety, and paranoia. He was

twice monitored under ACCT procedures including at the time he was found hanging. The management of the first ACCT procedures provided good support to Mr Whelan, but we identified some deficiencies in the decision making and management of the second process.

11. Although staff found no evidence to support Mr Whelan's claims that he was under threat from other prisoners, we found that the prison did not investigate his concerns adequately.

12. The officer who conducted the last ACCT check on 25 December was 13 minutes late and failed to provide a justifiable reason for this delay. Two other officers who were required to conduct ACCT checks that morning falsified the ACCT document. The investigator referred the officers' actions to the police, who advised us that they would not be investigating the matter. The prison is conducting an internal investigation into the officers' actions.

13. The clinical reviewer concluded that the physical and mental health care Mr Whelan received at Leeds was equivalent to what he could have expected to receive in the community.

Recommendation

- The Governor should provide training and guidance for duty governors on segregation Defensible Decision Logs and how and when these should be completed.

The Investigation Process

14. HMPPS notified us of Mr Whelan's death on 30 December 2024.

15. 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.

16. The investigator visited Leeds on 7 January 2025. He obtained copies of relevant extracts from Mr Whelan's prison and medical records, along with CCTV and Body Worn Video Camera (BWVC) footage.

17. The investigator interviewed 11 members of staff at Leeds on 24 and 25 February 2025.

18. NHS England commissioned a clinical reviewer to review Mr Whelan's clinical care at the prison. The clinical reviewer attended all interviews with the investigator.

19. We informed HM Coroner for Wakefield of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's office contacted Mr Whelan's family to explain the investigation and to ask if they had any matters they wanted us to consider. The family did not respond.

21. An inquest into Mr Whelan's death was concluded on 16 March 2026. A narrative verdict was given, which stated:

    Alan Joseph Whelan was found ligatured in his cell on 25 December 2024 and subsequently died on 30 December at Leeds General Infirmary. It is possible that loss of work was a trigger to Alan's mental state and thought process. Following previous incidents, we feel that observations should have been made more regularly, and any ACCT reviews should have considered previous incidents. It cannot be established that Alan not being more frequently observed probably contributed to his death, but it is possible that it did so.

    Admissions by MoJ

    The prison officer conducting ACCT observations on Alan on the night of 25 December did not comply with the requirement to conduct one check at irregular intervals every 60 minutes. By the time he conducted the check which led to Alan's discovery, it had been 1 hour and 11 minutes since the last check. It cannot be established that this finding probably contributed to the death but may have done so.

Background Information

HMP Leeds

22. HMP Leeds is a local prison holding male prisoners 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

23. The most recent inspection of HMP Leeds was in June 2022, which was followed up by a review of progress inspection in July 2023. Inspectors said that since their last inspection in June 2022, seven prisoners had taken their own lives and Leeds now had the second highest rate of self-inflicted deaths of any prison in England and Wales. The inspectors highlighted Prison and Probation Ombudsman reports and outlined repeated failings in identifying risks when prisoners arrived. They found unemployment and the long periods spent locked in their cells during the weekend were common factors in many of the previous deaths. Inspectors noted that leaders seemed unable to focus on these key issues while they were managing an unwieldy plan with more than 100 recommendations from the various recent reviews, audits and investigations that had followed the incidents.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2023, the IMB reported that it remained concerned about the number of deaths at Leeds.

Previous deaths at HMP Leeds

25. Mr Whelan was the 23rd prisoner to die at Leeds since January 2022. Of the previous deaths, seven were from natural causes, 14 were self-inflicted and one was drug related. Up to the end of June 2025, there have been two further self-inflicted deaths at Leeds since Mr Whelan's death.

26. As a result of the self-inflicted deaths at Leeds, Yorkshire Prisons Group Regional Safety Team and the National Safety Team are supporting Leeds to improve the quality of ACCT management and support for those who feel at risk from others.

27. In previous investigations, we have found that Leeds needed to improve their assessment and management of prisoners at risk of suicide and self-harm. Previous clinical reviews have also found that improvement was needed to mental health referral, assessment and treatment. The same issues were found in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

28. Assessment, Care in Custody and Teamwork (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.

29. 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 multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap identifying support actions is put in place. The ACCT plan should not be closed until all the support actions on the caremap have been completed.

Key Events

30. On 4 July 2024, Mr Alan Whelan was remanded to HMP Doncaster charged with coercive behaviour. This was not his first time in prison as in December 2023, he had been released from HMP Leeds. He transferred to HMP Dovegate on 6 August 2024.

31. Mr Whelan had a history of self-harm. Staff started suicide and self-harm monitoring (known as ACCT) at Doncaster and Dovegate after Mr Whelan self-harmed by cutting. He said that he felt under threat due to a previous offence and that other prisoners had called him names.

32. On 3 September, Mr Whelan transferred to HMP Leeds on an open ACCT to facilitate his court appearance.

33. On his arrival at Leeds, Mr Whelan went through the reception procedures. He had a shower, a meal, and tried to call his mother but there was no answer. Mr Whelan told staff that he was happy to be back at Leeds. The digital person escort record (DPER – an electronic document that travels with a prisoner and records key information about them) highlighted Mr Whelan's risk factors, which included previous self-harm, mental health issues, depression, anxiety and attention deficit hyperactivity disorder (ADHD). Mr Whelan told staff that he wanted to apply for vulnerable prisoner (VP) status because he was concerned he might be under threat. Due to limited spaces on the VP wing, Mr Whelan was located on D wing (induction wing).

34. Staff held an ad-hoc ACCT review. Mr Whelan said that his anxiety had reduced now he was back at Leeds. He said that he had not seen his family for around nine weeks, although he had spoken to them on the telephone. Staff agreed that ACCT welfare checks would remain at two an hour until a full ACCT review could take place.

35. On 4 September, Supervising Officer (SO) A chaired an ACCT review. Mr Whelan and Nurse A from the mental health team attended. SO A recorded that Mr Whelan engaged well and answered all questions openly. Mr Whelan said that he believed he had been transferred to Leeds to facilitate a pre-trial hearing. He said he had applied for VP status due to an offence he had committed when he was 17 years old. He said that he was worried about being located on D wing. SO A reassured him and explained that he would be located on D wing until space became available on E wing, the VP overflow wing, due to the main VP wing (F wing) being full.

36. Mr Whelan said that he experienced paranoia which he blamed on 20 years of cannabis use and that he intended to engage with the substance misuse team. Mr Whelan said he was prescribed propranolol for anxiety and had previously been prescribed sertraline (an antidepressant), but this had been stopped at Dovegate as it was felt it was making his paranoia worse. Mr Whelan said that although he felt anxious waiting for a decision on his VP status, he felt better now that he was at Leeds. The review concluded that the ACCT would remain open with staff required to check him once an hour and a further review would take place on 12 September.

37. On 12 September, SO A chaired the ACCT review. Mr Whelan engaged well, and it was recorded that his application for VP status had been accepted and he would be moved to the overflow on E wing when space became available. Mr Whelan said that he had been in contact with his mother, who he said was a source of support. Mr Whelan said that he had a court appearance the following day but that he had no concerns around this. SO A recorded that because Mr Whelan was still located on D wing and the court appearance was taking place the following day, the ACCT would remain open with staff required to check him six times throughout the night and record their interactions with him during the day. A further review was scheduled for 20 September.

38. On 20 September, SO B chaired the ACCT review in SO A's absence. A member of the mental health team attended. Since the last review, Mr Whelan had moved to E wing. He said that he had not liked being on D wing and claimed that while on the wing, prisoners shouted abuse at him, but he did not specify what this had been. There were no entries in the ongoing ACCT record to support these claims. Mr Whelan spoke about his positive relationship with his mother and brother, that he wanted a fresh start and wanted to avoid returning to excessive alcohol and cannabis use on his release. He said that while on D wing, he had made cuts to his leg due to feeling stressed and described his current mood as low but said he had no thoughts or plans of suicide or self-harm. Staff agreed that ACCT checks would be increased to hourly, with a review scheduled for 1 October.

39. SO A, chaired the ACCT review on 1 October, and a member of the mental health team attended. Mr Whelan said that he had been 'up and down', but he had not self-harmed since the previous review. He was collecting his medication and all his meals but said he was not leaving his cell much because he could hear people talking about him. Mr Whelan accepted that he was experiencing paranoia. He said that he had been speaking with his family daily and was hopeful that they would book a visit. He spoke positively about completing the induction and said that he was keen to work and keep busy. SO A told him that she would chase a work placement with the activities team, but due to the large VP population, places were limited. It was decided that the ACCT would remain open and ACCT checks would remain at hourly, with a further review on 8 October.

40. On 8 October, Mr Whelan said he had been allocated a job in the workshops. He spoke positively about the future and his family and denied any thoughts of suicide or self-harm. Staff agreed that the ACCT could be closed. He also moved to the main VP unit on F wing.

41. On 2 December, Mr Whelan was de-selected from his position in the textiles workshop because he no longer met the criteria. Staff noted that following a review of work placements, a decision was taken that only prisoners who were risk assessed as low or medium could be allocated to the workshop. Mr Whelan had been assessed as high risk prior to his arrival at Leeds and therefore no longer met the criteria. Mr A, workshop instructor, noted that Mr Whelan had worked well without any disruption for several weeks and when he was informed that he would no longer be able to work there, he was compliant and showed a positive attitude.

42. At 8.40am on 19 December, Officer A, who knew Mr Whelan well, answered his cell bell. On looking through the observation panel in the cell door, Officer A saw Mr Whelan with blood dripping from his head. Officer A entered the cell and Mr Whelan

told him that he had self-harmed because he 'had had enough of everything'. Officer A alerted a nurse who was on the wing and shouted to his colleagues for assistance. Mr Whelan said that he had used a razor to cut his head. The wound was cleaned but did not require stitches. Anything sharp was removed from his cell. Mr Whelan said that he had not been taking his anxiety medication. Officer A opened an ACCT and checks were set at hourly, pending an assessment and initial ACCT review. Mr Whelan was allocated a Listener (A prisoner who has volunteered to be trained by the Samaritans to offer confidential support to prisoners in crisis).

43. At 11.00am on 20 December, SO A chaired the ACCT review along with Nurse B from the mental health team. Mr Whelan said that he had self-harmed because he was stressed about losing his job and had only been given a vague reason for it. SO A sent an email to the activities team to explore why he had been removed. They responded and explained the change in position. SO A noted that Mr Whelan's removal from employment had been a trigger for his recent self-harm. While acknowledging his recent self-harm, Mr Whelan said that he was glad that he was not dead. He said that he had chosen not to engage much with the wing regime and preferred to spend time in his cell. He said that he was eating, drinking and taking care of his personal hygiene. Mr Whelan also said that he felt people were talking about him but acknowledged that he may be experiencing paranoia. Staff agreed that observations would be reduced to one check every two hours and the next ACCT review would be held on 2 January 2025.

44. Following the ACCT review, Nurse B recorded in Mr Whelan's medical record that that Mr Whelan had not shown any symptoms of an acute psychotic illness and there was no indication of a mental health crisis at that time.

45. At 5.27am on 21 December, Operational Support Grade (OSG) A completed a routine check on Mr Whelan and discovered that he had tied a ligature to the upper part of his bed frame and around his neck and was lying on his back on his bed. OSG A radioed a code blue (indicating a prisoner is unconscious or having difficulty breathing) and immediately entered the cell. Officer B was the first to respond. The ligature was not tied in such a way that it was putting pressure on Mr Whelan's neck, but he was clearly shaken. Nurse C attended and quickly established that an ambulance was not required and Mr Whelan did not need medical intervention. Mr Whelan told staff that two prisoners had recently moved onto the wing and they 'had it in for him'.

46. Custodial Manager (CM) A spoke with Mr Whelan. Mr Whelan said that he was being bullied by a prisoner and gave a name. CM A asked an officer to check for the named prisoner on E or F wing. There were two prisoners of that name at Leeds but they were housed on different wings and staff were confident that Mr Whelan would not have come into contact with them. There were no prisoners matching the name on E and F wing.

47. When asked about his current thoughts of further self-harm, Mr Whelan said that he was a '6 out of 10' but he could keep himself safe. CM A noted from the previous ACCT reviews that Mr Whelan experienced paranoia. Mr Whelan had mentioned that he preferred to stay in his cell. CM A arranged for Mr Whelan to be referred for a Challenge, Support and Intervention Plan (CSIP, a tool designed to manage prisoners who are violent but, in some prisons, used to manage potential victims of violence too) and the Safety Intervention Meeting (SIM, where complex or at risk

prisoners are discussed). Nurse C also noted on his medical records that Mr Whelan had said that he was unsure whether he would self-harm again. Checks were raised to twice an hour and the next ACCT review remained scheduled for 2 January.

48. On 23 December, SO C completed a CSIP investigation. He recorded that Mr Whelan had been interviewed, but we were not provided with any evidence that he was spoken to as part of the investigation process. SO C noted that he had spoken to SO A, who was Mr Whelan's appointed ACCT case manager, and had been told that Mr Whelan was very paranoid and felt that staying in his cell was safer. SO C concluded that no further action was necessary.

49. At 2.50pm on 24 December, Mr Whelan deliberately set a fire in his cell. Staff used a fire hose to tackle the fire before they removed Mr Whelan from the cell. He was initially unresponsive and staff called the emergency services. Once he had recovered, Mr Whelan was assessed to have no injuries from the fire. He was escorted without force to the segregation unit.

50. Mental Health Nurse D assessed Mr Whelan for the purposes of completing the segregation safety algorithm (which assesses whether a prisoner can safely be segregated). Nurse D noted that Mr Whelan said that he was being bullied on the wing, had been raising this for a few days with no benefit, was struggling and said that he wanted to die. Nurse D noted that Mr Whelan was on an open ACCT and was now subject to five observations an hour in line with the segregation policy (set out in Prison Service Order (PSO) 1700), but she did not deem him fit for a prolonged stay in the segregation unit due to the increased risk to himself.

51. Mr B, the duty governor, attended the segregation unit, completed a defensible decision log (which sets out the rationale for segregating someone on an open ACCT) and recorded that Mr Whelan could not be located anywhere else in the prison and that the segregation unit was the safest location to manage his risk at that time. He recorded that he had considered alternative locations including other wings and the healthcare unit, but due to Mr Whelan's current risk level, they were not appropriate, and that the decision for Mr Whelan to remain in the segregation unit was considered by 'all parties' to be the safest (although Mr B did not detail who the other parties were).

Events of 25 December

52. The following account has been taken from documentary evidence provided by Leeds, CCTV and Body Worn Video Camera (BWVC) footage, medical records and transcripts of interviews with staff.

53. At 10.30am on 25 December, SO C chaired an ACCT review. Mr C, the duty governor, and mental health nurse Nurse A attended. The reasons for Mr Whelan being located in segregation were recorded, and Mr Whelan said that he was happy to engage with the review. Neither Mr C nor SO C had had any previous interaction with Mr Whelan. SO C told the investigator that SO A (with whom he worked in the safety team and who was on duty that morning) had told him about Mr Whelan's issues.

54. Mr Whelan spoke about his family and said that he hoped that he would be able to telephone his mother that afternoon. He said that recently, his sleep had been broken and spoke about his paranoia and anxiety. Mr Whelan said that he had felt that people were after him because they believed him to be racist. He had asked staff to move him back to the VP overflow wing to avoid conflict. Mr Whelan said that he was happy to remain in the segregation unit until a transfer to another prison could be arranged. SO C said that this was not an option and that Mr Whelan would need to return to the residential wing before a transfer could be arranged.

55. Mr Whelan talked about working and how he had enjoyed this until a change in the risk assessment meant he could no longer be employed. It was recorded that Mr Whelan was 'future focused' although the review did not record any conversations around Mr Whelan's current thoughts of further self-harm or further actions about his mental health concerns. Staff decided Mr Whelan would be checked once an hour. The next review date was left as 2 January. No updates were made to the defensible decision log. When interviewed, all those present at the ACCT review told the investigator that they were not aware that prior to Mr Whelan's move to the segregation unit, he had been subject to two ACCT checks per hour.

56. During the afternoon, Mr Whelan telephoned his mother from the unit phone (segregation cells do not have in cell telephones). He told her that he loved her and wished her a Merry Christmas. Mr Whelan's mother told us that there was nothing unusual in Mr Whelan's tone or manner during the call. CCTV showed Mr Whelan returning to his cell at around 2.20pm. This was the last time Mr Whelan was captured on CCTV.

57. Segregation unit staff checked Mr Whelan every hour during the afternoon and evening as part of the ACCT checks. Officer C, the night officer on the segregation unit, checked Mr Whelan at 10.11pm and recorded no concerns.

58. At approximately 11.24pm, Officer C went to check on Mr Whelan and found his observation panel to be covered. He called out to Mr Whelan but he did not respond. Officer C radioed Custodial Manager (CM) B to attend. While waiting for him to arrive, Officer C continued to check on other prisoners.

59. At 11.27pm, CM B arrived in the segregation unit along with Officer D, Officer E and Officer F. CM B immediately entered Mr Whelan's cell and found him hanging at the back of the cell with a ligature around his neck made from bedding. At 11.28pm, staff radioed a code blue and control room staff called an ambulance. CM B and the officers supported Mr Whelan, removed the ligature, placed him on the floor and started CPR.

60. At 11.28pm, Nurse E responded to the code blue. Nurse E noted that Mr Whelan's face was blue and he was cold to the touch. A defibrillator was applied which advised there was no shockable rhythm.

61. At 11.36pm, paramedics arrived and took over treatment. They managed to regain a pulse, but Mr Whelan remained unconscious. At 12.27am, Mr Whelan was taken to hospital by emergency ambulance.

62. In hospital, Mr Whelan was placed on life support until a decision was taken to remove treatment on 29 December.

63. At 6.51am on 30 December, Mr Whelan died.

Contact with Mr Whelan's family

64. Following Mr Whelan's admission to hospital, the prison appointed Ms A as family liaison officer. Ms A along with Officer G visited Mr Whelan's mother's address and informed her that her son was in a serious condition in hospital. They drove her to the hospital and arrived at around 11.00am. They remained with the family at the hospital but later left so the family could be with Mr Whelan. Ms A remained in contact with the family and after Mr Whelan's death, arranged for the family to visit the prison and collect his belongings.

65. The prison contributed towards funeral expenses in line with national policy.

Support for prisoners and staff

66. 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.

67. After Mr Whelan was taken to hospital on 26 December, Mr C 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 were also available to offer support.

68. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm. The Samaritans were notified on 26 December that Mr Whelan had attempted to take his own life and visited Leeds to offer support. Further support was provided on 30 December. There is evidence that Leeds followed postvention procedures.

Post-mortem report

69. The Coroner gave Mr Whelan's cause of death as hypoxic ischaemic encephalopathy caused by hanging.

Findings

Assessment of risk

70. At the time of Mr Whelan's death, Prison Service Order (PSI) 64/2011 set out the procedures (known as ACCT) that should be followed when a prisoner is identified as being at risk of suicide and self-harm and listed risk factors and potential triggers for suicide and self-harm. (In January 2025, the PSI was replaced by the Prison Safety Policy Framework in which the assessment of risk and management of ACCT procedures remain largely the same). The PSI said that all staff should be alert to the increased risk of self-harm or suicide 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 ACCT procedures.

ACCT management

71. When Mr Whelan arrived at Leeds, he had a number of significant risk factors for suicide and self-harm including previous self-harm, mental health issues (paranoia and anxiety) and a history of substance misuse. He transferred to Leeds on an open ACCT.

72. Mr Whelan continued to be supported through ACCT monitoring until 8 October and it provided effective support for him and Mr Whelan remained stable and ACCT support was ended.

73. On 19 December, staff began ACCT procedures again after Mr Whelan self-harmed. We identified some concerns about the decision making and management of ACCT processes during the period that followed.

74. The case manager at the review on 20 December set the next review date for 2 January. We consider that this was too long a gap between reviews. The following day, Mr Whelan was found to have tied a ligature around his neck. Night staff held an ad-hoc case review and increased the frequency of welfare checks to two an hour. They did not bring forward the date of the next scheduled review. Given that there was a change in the method and potential lethality of Mr Whelan's self-harm, we consider that the amount of time between reviews was too long and the frequency of checks was too low. We also consider that the actions recorded on the care plan did not always sufficiently reflect discussions in the ACCT reviews.

75. On 24 December, Mr Whelan set fire to his cell and was moved to the segregation unit and placed on five observations an hour, pending an ACCT review. The following day, SO C chaired an ACCT review. SO C had not met Mr Whelan before but said he was briefed by SO A. When staff present at the ACCT review were interviewed, they said that they were not aware that prior to his move to the segregation unit, Mr Whelan had been subject to two checks an hour. The record of the ACCT review did not detail the reasons for Mr Whelan's recent behaviour and the assessment of his risk appeared to be largely based on his presentation at the time. The review reduced the frequency of checks to one an hour, despite Mr Whelan stating that he had set fire to his cell with the intent of taking his own life.

76. We do not consider that SO C and the staff at the ACCT review on 25 December adequately considered Mr Whelan's increased risk or provided meaningful support. While we consider that the frequency of checks was too low given Mr Whelan's recent behaviour, we do not think that there was sufficient evidence to suggest that he should have been subject to constant supervision.

ACCT observations

77. Officer C was responsible for checking Mr Whelan on the night of 25 December. He completed a check at 10.11pm but did not check Mr Whelan again until 11.24pm (an hour and 13 minutes later). We cannot say for certain whether earlier intervention would have made a difference in this case, but given paramedics were able to regain a pulse and transfer Mr Whelan to hospital, it may have done. Officer C's actions on 25 December are subject to an ongoing internal investigation.

78. Following a recent PPO investigation, Leeds introduced an audit process to check the accuracy of recorded ACCT checks against CCTV to ensure that there was not a systemic issue with false entries or missing checks. Following Mr Whelan's death, CCTV from the segregation unit was viewed and identified that ACCT observations recorded for Mr Whelan on the morning of 25 December had been falsified. The investigator raised the issue of falsified ACCT checks with the police, who said that they would not be investigating the matter. However, the actions of those staff involved are the subject of an ongoing internal investigation.

79. Leeds have introduced various measures to improve the quality of ACCT management since 2024. These include increased risks and triggers training and additional suicide and self-harm training for prison staff. A new ACCT quality assurance process was developed in May 2024 to better identify and manage individuals' risks and identify staff who need support. The regional and national safety teams have also provided more extensive guidance and resources to support the prison, and this is ongoing.

80. Leeds has also introduced a detailed project plan which highlights all recommendations from early learning reports, PPO reports and actions identified internally by the prison as risks. These are used to record progress against actions and evidence quality checks of all safety related processes. While we make no recommendation to reflect the ongoing work at Leeds, we are concerned that Leeds received additional support after a high number of deaths in 2023, continue to receive support and have put in place more robust quality assurance processes yet many of the same issues have been identified again in this investigation.

Segregation

81. Prison Service Order (PSO) 1700 Segregation states that a safety algorithm must be completed in all cases where a prisoner is located in segregation within two hours of the move. When a healthcare professional considers there are healthcare reasons to advise against segregation and the duty governor considers that segregation is appropriate for operational reasons, they must immediately chair a case review to determine the prisoner's location. The nurse who assessed Mr Whelan did not consider him suitable for prolonged segregation.

82. On 24 December, Mr B completed the decision log as required however, we found he did not sufficiently explain his decision and what the exceptional circumstances were for segregating Mr Whelan, against the nurse's advice. The document requires managers to outline what other locations were considered and why they were deemed not suitable. Mr B detailed those areas he had considered but the reasons for them being unsuitable were vague and unspecific ('his current risk level' and 'the risk he posed to others') without further exploration. The decision to segregate Mr Whelan was not subject to a case review as it should have been. The defensible decision log should have also been updated and signed daily by the duty governor, but Mr C did not update or sign the log on 25 December. We make the following recommendation:

The Governor should provide training and guidance for duty governors on segregation Defensible Decision Logs and how and when these should be completed.

Challenge, Support and Intervention Plans (CSIP)

83. At Leeds, individuals at risk of violence can be supported through a CSIP. When Mr Whelan arrived at Leeds, he told staff that he felt under threat and continued to do so during ACCT reviews and in general conversation. He was isolating or not engaging in the daily regime, but a CSIP referral was not made until 21 December. SO C recorded that he had completed the CSIP investigation to decide next steps, but there is no evidence that he sought any further information, spoke to wing staff or Mr Whelan. He concluded Mr Whelan's concerns were the result of paranoia and indicated there was no need for further action.

84. The Head of Safety and the regional safety team identified the quality of CSIP investigations as an issue in a previous investigation and as a result, the prison introduced a more robust quality assurance process and educated staff about the need for thorough CSIP investigations and plans. Staff had received training on CSIP prior to Mr Whelan's death. Clearly there are still issues in this area that the Governor will want to address to ensure that those systems are working as intended.

Clinical care

85. The clinical reviewer concluded that the physical and mental health care Mr Whelan received at Leeds was equivalent to what he could have expected to receive in the community. She noted that Mr Whelan was a complex individual with a long-standing history of impulsive and self-harming behaviour. The healthcare staff tried to support Mr Whelan as best as they could, based on his presentation at that time.

86. The clinical reviewer has made no recommendations relating directly to Mr Whelan's care or linked to his death but has made recommendations to the Head of Healthcare specifically about mental health assessments during ACCT reviews, contemporaneous record keeping and multi-disciplinary communication between the mental health and primary care teams. Some of the recommendations are repeated, having been made in a previous review. We bring this to the Head of Healthcare's attention.

Governor to note

87. Mr Whelan was removed from the textile workshop on 2 December, following an internal risk review for workshops at Leeds. Mr Whelan clearly enjoyed his job and received positive feedback about it. About two weeks after being removed he began to self-harm, which he had not done since starting work. During ACCT reviews, work was said to have been a supportive factor for him. Mr Whelan appeared confused about why he had been removed and had not been found alternative employment before his death. We consider that the handling of this issue was sub-optimal. The Governor will wish to consider the learning.

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