Investigation into the circumstances surrounding the death of a man at HMP Leeds in October 2010

Report by the Prisons and Probation Ombudsman for England and Wales

July 2011

This is the report of the investigation into the death of a man in October 2010. At the time of his death, he was a remand prisoner at HMP Leeds. He was 29 years old. I would like to offer my condolences to his family and friends for their loss.

The man had been on remand at Leeds since 30 September, during which time he had been monitored for alcohol withdrawal. He had spoken to nursing staff about concerns he had about contact with his family and also appeared to be worried about other prisoners finding out about the nature of the offences for which he had been charged.

In October staff discovered the man hanging by a ligature from the window in his cell. They immediately requested emergency assistance and went into the cell, removing the ligature and attempting cardio pulmonary resuscitation (CPR). Paramedics arrived soon afterwards and continued to administer treatment, but at 5.51am he was pronounced dead.

The investigation was conducted on my behalf by a Senior Investigator with my office. I would like to thank the Governor of Leeds and his staff for their assistance with the investigation. The clinical reviewer conducted a review of the medical care given to the man in custody on behalf of the local Primary Care Trust (PCT), and I am grateful for his report.

The investigation found that the detoxification assessment and subsequent monitoring of the man was thorough and maintained until clinical staff considered that his alcohol detoxification was no longer a risk factor. During his relatively short time in custody, he discussed with staff his concern about not being able to contact his partner. However, it seems that having been in custody on a number of previous occasions, he would have been well aware of the restrictions placed on him due to the nature of his alleged offence.

The man also spoke to a fellow prisoner about taking his own life if he was not able to escape from court when he next appeared, but these conversations were not shared with prison staff.

I am satisfied that, generally, the man was managed appropriately and that when he was discovered swift and correct action was taken to try and resuscitate him. However, I am concerned that the information passed to the prison from the police was overlooked and accordingly there was missed opportunity to determine whether he required additional monitoring under the suicide prevention and self-harm management procedures. I make four recommendations relating to initial reception and information sharing, mental health assessments and ACCT training. Three of these recommendations have been fully accepted by the Prison Service, with one being partially accepted. Full feedback can be found on page 26.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton
Acting Deputy Ombudsman **July 2011**

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SUMMARY

The man was remanded to HMP Leeds on 30 September 2010. This was not his first time in prison custody, he was 29 years old.

Prior to his arrival at Leeds, the man had been in police custody, where he had been subject to regular observations after saying that he intended to take his life. The police completed a risk assessment on him and when he was taken to Leeds this documentation was handed to reception staff. During the reception procedures, this risk assessment was not recorded and does appear to have been referred to. However, he made no further comments about taking his own life and when asked about any suicidal thoughts, he replied that he had none.

As part of the reception healthscreen, staff identified that the man required monitoring for alcohol detoxification. His symptoms were not considered to be severe enough to require medication, but monitoring by substance misuse trained nursing staff took place for the first three days.

Due to the nature of his alleged offences, the man was not allowed to communicate with his ex partner. On 3 October he told a nurse that he was finding it difficult to cope with being away from his family and asked if she would contact them on his behalf. However, she told him that she was unable to do this as it would be a breach of security policy. The nurse recorded that he was tearful, but said that she did not have concerns about his well-being in terms of self-harm.

Despite the restrictions placed on him, the man made calls on the prisoners' telephone system by using another prisoner's access code and contacted his ex partner on two occasions. On the last occasion, she reminded him that he should not be contacting her and he told her that once other prisoners found out about his charges he would be a "dead man".

The man did not tell prison staff that he had any thoughts of harming himself, but on 5 October he spoke to a fellow prisoner and said that if he was not able to "jump the dock" while at court he would "kill himself". This prisoner did not mention his conversation with him to staff.

On the evening of 5 October at around 8.00pm, one of the prison officers was conducting a count of all prisoners on the wing. When she looked in on the man he was sitting watching television and did not raise any concerns. The officer had no other reason to look in on him during the remainder of the night duty until she carried out a further count of prisoners the next morning.

Just after 5.30am, the same officer looked into the man's cell via his observation panel and noticed that he was not in his bed. When she looked towards the back of the cell, she noticed that the privacy screen was drawn around the toilet area and she could make out a shadow behind. She attempted to gain a response and when there was none, she immediately radioed for staff assistance.

Both prison and medical staff responded and found the man suspended by a ligature from the window of his cell. Staff removed the ligature laid him on the floor and

attempted cardio pulmonary resuscitation. Paramedics arrived at 5.45am, and after assessing him, pronounced him dead at 5.52am.

THE INVESTIGATION PROCESS

1. The investigator visited HMP Leeds to open the investigation on 7 October 2010. Notices were issued informing all staff and prisoners at Leeds of my investigation and inviting anyone with relevant information about the man to contact my investigator. No responses to the notices were received.

2. During his visit, the investigator met a representative of staff from the Prison Officers' Association (POA) and a member of the Independent Monitoring Board (IMB) and explained the purpose of the investigation. In addition, he also had a meeting with the Deputy Governor to discuss the potential issues.

3. One of my family liaison officers (FLO) wrote to the man's family on 4 November, telling them of my investigation and explaining the investigation process. She explained in the letter that both she and the investigator would be happy to visit them to discuss any concerns that they may have about his death. However, no further contact was received. The family were sent a copy of the draft report, and given the opportunity to respond. However, she wrote to the family again on 15 July as no response had been received, and said that if nothing was heard by 22 July the final report would be issued. No response has been received.

4. The local PCT were asked to conduct a clinical review into the medical care the man received while at Leeds. The PCT appointed a clinical reviewer, an independent General Practitioner (GP), to conduct this review. His report was received on 28 March 2011.

5. The investigator wrote to HM Coroner to inform him of the nature and scope of my investigation, and to request a copy of the post mortem. The post mortem report was not available at the time of issuing my report.

6. The investigator also liaised with the police in relation to sharing of information relating to the man's death. I am very grateful to the Detective Sergeant for providing information to the investigator that has aided the investigation.

7. Interviews were conducted with officers and nursing staff at Leeds in December 2010.

HMP LEEDS

8. HMP Leeds was built in 1847. It accepts adult male prisoners from the courts in West Yorkshire. The prison has an operational capacity of 1,004 prisoners and always functions at or near full capacity. It was expanded from four to six wings in 1994. The man was accommodated on D wing, which is the induction unit and incorporates the First Night Centre. Prisoners usually move on to other residential wings once they have completed their induction, but he remained longer while he was being monitored by the substance misuse team.

9. Leeds has 24 hour healthcare cover. During the day, a doctor is in the prison and there is nursing cover at all times. Nursing staff are not based in the healthcare centre. They are allocated to specific wings but work on other wings on occasions when staffing levels require it.

10. There have been a total of 42 deaths at HMP Leeds, including that of the man, since this office took over responsibility for investigating all deaths in prison custody in 2004. These deaths have been a mixture of self-inflicted, natural causes and a murder. The recommendations made by my office following these investigations are not relevant to this report.

HM Chief Inspector of Prisons' report

11. HM Chief Inspector of Prisons carried out an unannounced inspection of Leeds between 3 and 12 March 2010. In the report of the inspection, HM Chief Inspector said that there had been some signs of improvement since the previous inspection in 2007. However:

    "… Safety at Leeds remained a concern. As at previous inspections, first night arrangements were good, but they were let down by poor induction processes and ongoing support after the first night. More prisoners than at comparator prisons said they had felt unsafe. They did not report high levels of victimisation, but systems to investigate and monitor alleged incidents were weak. A great deal of attention had been given to suicide prevention strategies and procedures, following a large number of self-inflicted deaths, and in general support arrangements had improved, with especially good support on B1 landing for prisoners with a range of vulnerabilities. Progress had been maintained in the segregation unit, and levels of use of force remained relatively low, but oversight of its use remained inadequate. The level of illicit drug use was high, and there was insufficient attention to supply reduction.

    "There had been a noticeable improvement in staff-prisoner relationships and considerable management attention to aspects of diversity, in particular race. Prisoners reported that the majority of staff treated them reasonably, though on all wings there were reports of a minority of staff who were dismissive or racist, and there was little proactive personal officer work …"

Independent Monitoring Board report

12. All prisons in England and Wales have an Independent Monitoring Board (IMB), responsible for monitoring life in the prison and ensuring proper standards of care and decency. The last report produced by the IMB for HMP Leeds was published in 2010.

13. The judgement of the IMB at Leeds was that they had noticed a significant improvement in many areas of the prison during the last reporting year. The Board said that they had no major concerns about the way in which Leeds was being run, although they had expressed a number of serious concerns about matters beyond the Governor's control. They also said that they were pleased to report that prisoners and their families could be assured the Governor and staff were committed to ensuring that all prisoners are held safely, as well as being treated fairly and with respect.

Cell Sharing Risk Assessment (CSRA)

14. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

15. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, and can offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application.

Critical Debrief

16. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Cut down tools

17. Cut down tools are used to cut ligatures. All staff in closed and semi-open prisons that have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool.

Emergency response codes

18. Emergency codes are used to summon staff to deal with particular situations. If there is a medical emergency a ‘Hotel’ call sign (healthcare) is called over the radio and a code referring to a specific life threatening situation such as hanging, severe blood loss or cardiac arrest is given. Such emergency situations require immediate attention from healthcare staff as the prisoner cannot normally be escorted to the healthcare centre for treatment.

19. The general alarms are linked to the Control Room. When the button is pressed (found on the wing landings), wherever it’s pressed on the house block, that will register in the Control Room and then will be broadcast over the radios throughout the establishment that there is a general alarm in that location so that staff from other areas can respond.

20. Healthcare staff have emergency bags available. These contain life support equipment which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. Defibrillators are also available to nursing staff. A defibrillator is a device that can be attached to a patient in the event of cardiac arrest and will deliver a controlled electric shock to put the heart back into a normal rhythm, a defibrillator cannot restart a heart that has stopped.

Person Escort Record (PER)

21. This is a form that accompanies prisoners on all journeys between prisons, police stations and the courts. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, eg meals served, times journey started etc. .

Reception and induction

22. On entry to the prison, the warrant that accompanies a person in custody is checked to make certain that the establishment has the authority to keep that person. All clothing and property is searched, prisoners are strip-searched, seen by a member of the healthcare team, given the opportunity to have a shower and convicted male prisoners are given prison clothing. The initial healthcare screen concentrates on the prisoner’s immediate well-being, their mental health, risk of self-harm or suicide and any drug or alcohol withdrawal or detoxification issues.

23. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The form is handed to the First Night Centre staff who conduct a confidential interview. The document is then passed to healthcare staff. Although the CSRA is primarily used to determine suitability for cell sharing, it also covers other instances when space may be shared, for example to accommodate a Listener. (Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress.)

24. Prisons National Offender Management Information System (PNOMIS) is an electronic case management system which was recently introduced in all public sector prisons in England and Wales. (Reception staff do not routinely have access to a prisoner's past records, unless the prisoner has previously been allocated a new PNOMIS number.) The system allows a prisoner to be allocated a unique number which can be used to access their information on all future periods of custody. If this is not available, then the prisoner is the main source of information.

25. All new prisoners are located on the induction wing. At Leeds this is D wing. Prisoners are asked about any immediate concerns, such as disability, their offence and general well-being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, personal identification (PIN) numbers to access the telephone system and visiting arrangements are explained.

Roll check

26. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff must ensure the prisoner is in his cell by seeing his face or getting a response from him and prove the cell door is locked. If this cannot be achieved, staff must open the door to investigate further until satisfied.

Suicide and self harm monitoring

27. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to provide such support as is necessary to ensure the safety of a prisoner identified as being at-risk of suicide/self-harm. All members of staff should have clear responsibilities under the ACCT system, but preventing suicide/self-harm is wider than caring for those identified as at-risk.

28. ACCT has been introduced at all prisons to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner will be subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.

KEY EVENTS

Police custody on 29 September 2010

29. The man was arrested and taken into police custody in the early hours of 29 September. He was 29 years old. It is recorded in police documents that when he arrived into custody he was agitated and aggressive. He had been subdued with CS gas on his arrest. The police completed a risk assessment during which he told them that he was asthmatic and was taking pain killers for headaches. When he was asked whether he had ever tried to harm himself, either while in custody or in the community, he said that he had tried to hang himself a week earlier and that he would "string himself up in custody".

30. As part of the risk assessment, the man was asked about any previous mental health problems to which he replied, "I'm a f….ing loony". Throughout the police administration procedures he is reported to have been obstructive and abusive. The police believed that his behaviour was due to consuming excessive alcohol. As a precaution, he had to wear a paper suit to prevent him from using his clothing to harm himself, and staff checked on him in his cell every 30 minutes.

31. The man remained in custody throughout 29 September, in a cell with a camera due to concerns about his welfare. He told the police that he had past personal problems and used alcohol and illicit drugs as a way of dealing with them. He asked to be moved to a cell with a toilet and one of the police officers told him that she would speak to someone about this. He reassured her that he would not harm himself. The police officer then spoke to a nurse who said that she had questioned him earlier that evening about his comments about harming himself. He had again said that he would hang himself, but then immediately said that he was only joking. Because of his remarks to the nurse, he remained in the camera cell for the remainder of his time in police custody.

32. Police escorted the man to Magistrates Court on 30 September where G4S court services staff then became responsible for him. All the necessary documentation went with him. Court staff asked him about the comments he had made to the police in relation to harming himself and he said "I just said that to get some attention". After appearing in court, he was remanded into prison custody, and told that he would appear again at Crown Court on 7 October.

HMP Leeds, 30 September to 6 October 2010

33. This was not the first time the man had been in prison. On arrival at Leeds, staff went through the reception procedures which included him confirming that he understood why he was in custody. The cell sharing risk assessment (CSRA) was started by reception staff. The person escort record (PER) handed to reception staff detailed his previous self-harm as told to the police. It also indicated that he could be violent and aggressive and had been threatening to harm himself while in police custody. In addition to the PER form, the risk assessment completed by the police was also given to prison staff and this also detailed issues of self-harm and actions taken by the police.

34. Senior Officer (SO) A was on duty when the man arrived into custody. He was not interviewed by my investigator as he had provided a statement to police. He confirmed that he had completed the initial documentation which included recording the man's personal and next of kin details. The SO said that part of his role is to check the paperwork that accompanies a prisoner from court or police custody. This would indicate that he had sight of both the PER form and police custody assessment, but the self-harm issues were not written on the prison documents. He said that he could not specifically recall him and that he saw many prisoners on a daily basis. He said that the fact that no risks were recorded would indicate that he had not disclosed to him anything associated with risk.

35. After completing the reception process, the man was taken to the first night centre on D wing. During the CSRA, he indicated to staff that he had concerns about sharing a cell. It is recorded that he told them that if he shared a cell with someone he did not like he would "chin them". The answers provided by him led the officer completing it to assess him to be a medium risk if placed in a cell with someone else.

36. As part of the first night assessment prisoners are also seen by nursing staff who conduct an initial healthscreen. Nurse A, a healthcare support worker, completed the initial assessment with the man. She explained that the assessment is a template on the medical computer system which asks a series of questions. They cover previous medical history, details of community doctor, any existing conditions or ongoing treatment. In addition, he would have been asked about previous mental health concerns as well as previous and current thoughts or attempts at self-harm.

37. The man told the nurse that he had attempted suicide 18 months before. The nurse said that although he mentioned this, she did not gain the impression that he was having such thoughts at that time and he did not mention feeling suicidal or wanting to harm himself. She also said that he had not indicated feeling low or depressed.

38. The second part of the healthscreen was carried out by Nurse B, a bank nurse who works part-time at Leeds. (A bank nurse is registered with a bank administered by the employer and is available to be called into work in a casual capacity to fill a temporary vacancy.) The investigator was unable to interview her, but Nurse A was familiar with and explained the process completed by the nurse. She said that the second healthscreen sought to provide further information on the man's alcohol and illicit drug use. It was explained that Nurse B had carried out an alcohol withdrawal assessment and recorded that he had no nausea, there were moderate tremors when his arms were extended and he was mildly anxious, but there was no agitation or visual disturbances. He said that he drank around four times a week and would consume about seven to nine drinks at a time. He also told her that in the last year he had been having six or more drinks every day and had felt the need to drink first thing in a morning. A family history of diabetes was also recorded.

39. Following the nurse's assessment a prison doctor reviewed the man as part of the reception clinic. At Leeds chlordiazepoxide is a drug commonly used for the treatment of alcohol detoxification where it is considered necessary. The doctor recorded that as he was not exhibiting any active signs of withdrawal, he should be monitored and not started on treatment immediately. He was monitored by nursing staff following the Clinical Institute Withdrawal Alcohol (CIWA) score. This enables staff to score a patient depending on what symptoms they are displaying. A score of ten or over indicates that medication is required and for under ten monitoring would be the preferred intervention.

40. Nurse B completed the medical section of the CSRA and, like the reception staff, indicated that the man should be considered as a medium risk of sharing a cell. A cell sharing minimisation plan was then completed by the duty governor that day. He recorded that he should be a medium risk, and that he had stated he would prefer to share a cell with someone he knew owing to the nature of his alleged offences. It was decided that he would have seven days to agree to a suitable cell mate.

41. The man was remanded for sexual offences. He had been offered the option of vulnerable prisoner (VP) status, but had declined this on reception. Certain charges, including those of a sexual nature, can make prisoners targets for bullying within prison. Such prisoners are offered the opportunity to be classified as VPs and are then given a cell on separate residential units where they are at less risk. However, it is not compulsory and they may decline this option.

42. Once all first night procedures and the medical screening were completed, the man was shown to a cell on D wing, D4-7. He shared the cell with a prisoner whom he told staff he was happy to share with.

43. During the afternoon on 1 October, the man was allowed out of his cell for association. (Association is the term given to the time that prisoners are allowed out of their cells, and can take part in recreational activities such as pool or use the telephone and they can socialise with one another.) He introduced himself to another prisoner, Prisoner A, and told him his name. He talked to him about his offence and told him that he had been remanded for domestic violence. In a statement given to the police, the prisoner said that he told him that he had not been provided with a PIN for the telephone, and asked if he could use his. He allowed him to use the PIN and he then went off to use the telephone saying he wanted to contact his mum. He returned a few moments later and gave back the PIN. He did not see him again that day.

44. Due to the nature of his charges, the man had certain restrictions placed upon his contact with others outside prison. During the reception process, he signed to say he understood. To ensure that a prisoner subject to restrictions abides by them, they are not immediately provided with a PIN number. A day or two after they arrive into custody the prisoner is asked to provide a list of telephone numbers for people who they wish to contact and these are checked by the public protection department to ensure they are appropriate. The telephone records provided by Leeds show that despite these restrictions, on 1 October he telephoned his ex-partner, using the Prisoner A's PIN . There was no association

during the day on 2 October and prisoners remained in their cells, apart from being unlocked to collect meals.

45. Between 30 September and 3 October, the man was monitored both during the day and at night by the substance misuse nurses. On the first night, Nurse C carried out routine checks on him and recorded that each time she checked he was sleeping. On the night of 1 October, she recorded that he “has shakes, but no visible withdrawal elsewhere” and she gave a CIWA score of two. During the following day, Nurse D assessed him. She recorded that he had very mild sweating, was mildly anxious, fidgety and restless. He also complained of a headache and mild dizziness. She gave him a CIWA score of eight and these assessments continued.

46. Nurse C conducted her final checks on the man during the night of 2 October and early hours of 3 October and he asked her for some paracetomol. She gave him this to him and told him to speak to the nurse during the day if he required any more. The CIWA score she gave at that point was zero. She also told the investigator that during the checks he was “bubbly and joking about his withdrawal” and that “he never showed any sign of being upset or that he was not coping”. Nurse D assessed him during the day on 3 October. She said that:

    “when I assessed him for the last time he was doing very well. I was going to discharge him from being monitored because he was doing really, really well.”

47. Nurse A was also present during Nurse D’s final assessment with the man. She told the investigator that she picked up that he seemed withdrawn. He told her that he felt he needed some emotional support with dealing with being away from his children. He also said that he had not been given a PIN for the telephone when he arrived at Leeds, and asked her if she would contact his partner on his behalf. She replied that she was unable to do this as it would be a breach of security, but that she would speak to wing staff. She recorded that he had become “tearful and distressed” during their conversation. The investigator asked whether this had concerned her. She explained that during the conversation her impression was that his frustration was with not being able to contact his ex partner or children, and not about how he was feeling about himself. She said that she did not get the impression that he was likely to harm himself and he did not mention self-harm or feeling depressed.

48. Following her conversation with the man, the nurse spoke with wing staff who advised her to speak with the chaplain. She discussed his situation with a chaplain. During interview, the chaplain said that the nurse had told him that the man was upset that he could not contact his family. He said that there was no mention by the nurse of him saying he would harm himself, but she was seeking advice on what she could do to help him. He told her that he would contact the public protection office on the Monday and see if the man was subject to any restrictions. When he contacted the public protection office he was told that he was subject to restrictions which prevented him from contact with his ex partner or her children. The chaplain was asked whether he went to see the man to tell him what had been said, but he had not as he felt he was probably already aware that he should not be contacting them.

49. Just after lunch on 3 October, Nurse A had to return to D wing to collect something, so went up to see if the man was alright and whether he had settled down from the morning. She said that at that time there was only one officer on the wing so he unlocked him and she spoke to him on the landing rather than taking him down to the treatment room. She asked him whether he was alright, and he appeared quite agitated, as if he did not wish to speak to her. She asked him again and he replied "I just need to get out of here" and seemed angry. The investigator asked the nurse whether during these interactions with him she had considered the need for him to be monitored under the ACCT suicide prevention and self-harm management procedures. She said that although he appeared to be angry and frustrated, he had given her no indication of an intention to harm himself or take his life. Her perception was that he might consider escape and she therefore completed a security form to alert staff to this. She said that if she had suspected he would harm himself she would have definitely opened an ACCT, but he was angry when she spoke with him and told her he was going to get another prisoner to contact his partner.

50. That afternoon, prisoners on D wing were unlocked for association. The man spoke to Prisoner A in the shower area and asked to borrow his PIN again to call his mother. He gave it to him, but said that he appeared different from when he had first spoken to him. He seemed to be "stressed" and "on edge", as well as "short and snappy" in his conversation and did not seem to want to talk.

51. The record of the calls made on the prisoner's PIN account show that the man contacted his ex partner again on the afternoon of 3 October, not his mum. The recording of the telephone call indicates that he was quite distressed and asking his ex partner to visit him and stand by him. During the call, his ex partner was very upset and reminded him that he should not be contacting her. He said that he was a "dead man" when other prisoners find out his offences, then the call ended.

52. There is very little documented about the man's movements on Monday 4 October, and he was no longer being monitored by the substance misuse team. Officer A started a week of night duties on 4 October and recalled that during the Monday night she answered a cell call bell to the man and his cell mate. (Each cell has a bell which prisoners can use to get the attention of staff.) She said that he was "in good spirits" and asked her for some paracetomol. The officer asked Nurse D who was also working a night shift to give him some paracetamol and she had no further contact with him during that shift. The following day, the cellmate was transferred to HMP Wealstun, which due to the earlier risk assessment left him in a single cell. While sharing a cell with him, the cellmate said that he had never heard him mention self-harm or feeling suicidal.

53. Again little information was written on 5 October in the man's records about any interaction with staff. However, Prisoner A said that he was standing on the landing during that day waiting for an officer to unlock his cell and saw him standing across the landing. He told the prisoner that he wanted to escape and asked how he could do this. The prisoner said he just laughed; the man then said "if I cannot jump the dock when I am next in court I am going to kill myself".

(A dock is the term for the area in a court where the accused person will stand to address the court.) He was due to appear at Crown Court again on 7 October. He then asked the prisoner how long he expected his sentence to be, and he said he was expecting between four and eight years. He tried to reassure the man and told him that he would only serve half that sentence, and he would soon be out of prison and able to see his children. He described him as looking emotionless. Officers then arrived and let the prisoner into his cell and he did not see him again. The man did not repeat his remarks to staff and the prisoner did not mention his conversation with him to officers.

54. When the investigator spoke to Nurse C she said that she had been told that the man's case was broadcast on the local news during the evening of 5 October. The investigator was unable to confirm this, but if it was broadcast it is possible that prisoners watching the programme would have been made aware of the reasons he was in custody.

55. When Officer A started her night duty on 5 October, she said that she began by conducting a check of all prisoners on D wing between 8.00pm and 9.30pm. She said that during the initial check when she looked in on the man she noted that he was on his own in the cell due to his cellmate's transfer and was sitting watching television. He raised no concerns and the officer continued with her checks on the remainder of the wing.

56. In her statement provided for the police, the officer said that on the same landing as the man there was another prisoner who was subject to ACCT monitoring. She was required to check him every hour and had to pass his cell to do this. When carrying out these observations, the officer said that she was not aware of any problems with him during the night and had no reason to go to his cell.

57. At 5.30am on 6 October, the officer started her morning check of all prisoners on D wing. Just after 5.30am she arrived at the man's cell and looked in via the observation panel, it was very dark so she turned the night light on in the cell, to get a better view. (All cells have a night light that provides a low level of lighting to aid the vision of someone looking into the cell, without disturbing the occupant.)

58. The officer explained that there was a toilet at the far end of the cell which had a privacy curtain around it, about 12 inches from the floor. She noted that the curtain was pulled around the toilet. The curtains are designed with two vents across them, above and below waist height, so that if a prisoner is behind the curtain during a check they can be accounted for. She saw a shadow behind the curtain and, at first, thought he was standing using the toilet so she kicked the bottom of the door to try and gain a response. As there was no response, she kicked it again and still got no response. She then used her radio and requested immediate assistance from other staff. Even though she could not see his face, after requesting assistance she looked again and through the vents on the curtain could see that he appeared to be standing against the back wall. When she looked for his feet below the curtain, she realised that they could not be seen. At this point, she said that she realised he must be "hanging".

59. Senior Officer (SO) B was the orderly officer on the night and as such was responsible for the running of the prison. He said that he had been doing some work and was just returning to the residential wing when the call came over his radio for “urgent assistance required D4-7”. He said that D wing was around 20 to 30 metres from where he was standing and he immediately made his way there. When interviewed, the investigator asked him whether nursing staff had been requested at this time. He said that in addition to the call for staff there was also a radio call that said “nurse assistance required D4-7, code blue.” (Code Blue refers to a prisoner who is not breathing and indicates that nursing staff will need to bring the necessary equipment to treat this type of emergency.) As he approached D wing, Officer B called to him and said that he would get other staff. The SO explained that during the night staff do not carry keys and are locked within their respective areas of work. Therefore if staff needed to attend another area of the prison they would have to be collected by either himself or his assistant, Officer B, as they were the only two staff that held keys.

60. The SO said that when he went onto D wing he left the gates open behind him and was called from the fours landing by Officer A. When he got to the cell she was trying to open her sealed pouch to get the emergency cell key. (Although staff do not carry keys on night duties, for security reasons each member of staff on a wing is provided with a sealed pouch containing a single cell key that can be opened in an emergency.) The SO told her not to bother and he opened the door with his keys.

61. As he went into the cell, the SO called out to the man and walked about four paces into the cell. As he pulled back the privacy curtain, he saw that he was suspended by a ligature made from torn bedding around his neck, which was attached to the window. He described him as “ashen” in colour and said that his eyes were open. He asked Officer A to pass him her cut down tool. Officer C had also arrived in the cell and supported him as the SO used the cut down tool to release the ligature from the window and they then laid him on the floor. The SO said that he then attempted to use the cut down tool to remove the remainder of the ligature from around the neck, but as he did so it “just unravelled”.

62. Once the ligature had been removed, the SO checked to see if the man had a pulse. He could not find one and he then began to carry out cardio pulmonary resuscitation (CPR). (CPR consists of a series of chest compressions followed by a number of mouth to mouth breaths on a repeating cycle.) The SO said that he did not give any breaths as his tongue was swollen which made this impossible.

63. Nurse D and her colleague were in the medical reception located just off D wing when the emergency call came over the radio. Nurse D said when they heard the call they immediately broke the seal on their pouches and let themselves onto D wing, arriving at the cell around three minutes after the SO. She said that she did not recall a medical code being called over the radio as described by the SO, so took with her an emergency bag. When she arrived at the cell she said the man was lying on his back on the floor and she instructed her colleague to collect the resuscitation bag. Her first impression was that he was dead and there were signs of “rigor mortis”. (Rigor Mortis is the name given to a chemical

change in the muscles after death that causes them to become stiff and difficult to move.)

64. Despite these observations, the nurse said that she continued with CPR. She said that she is not qualified to pronounce death as it has to be done by either a doctor or paramedic, so she continued with CPR. Due to the man's swollen tongue, she used an ambu-bag to get oxygen into him. (An ambu-bag is also known as a bag valve mask, and is used to provide oxygen to a patient who is not breathing.) After every 30 chest compressions she used the ambu-bag. She said that she began CPR at 5.40am as she recalled asking staff present to note the time.

65. The paramedics arrived at the prison at 5.40am, and after spending three to four minutes getting through the gates, they arrived at the cell around 5.45am. When they arrived, the nurse was still doing CPR and she continued while they prepared their equipment. In a statement provided to police one of the paramedics said that as he got beside the man to continue with the CPR he noticed that he was very pale and stiff with signs of rigor mortis. At this point he believed him to be dead. The paramedics then attached an electrocardiogram (ECG) to him. (An ECG is a device that can trace a heart beat by attaching electrodes to a patient's chest.) The paramedics left the ECG in place for one minute but it showed no trace of a heart beat. The paramedics pronounced him dead at 5.52am.

Actions following the man's death

66. The senior management team spoke to all staff involved in attempting to treat the man and made them aware of the support that was available to them. Members of the staff care and welfare team also spoke to them. All staff interviewed during the investigation said that they felt that they had been supported well after his death. A critical incident de-brief to provide staff with a further opportunity to discuss how the events of 6 October have affected them has yet to take place.

67. A Senior Officer was appointed by the prison to act as the family liaison officer and, along with a governor, visited the man's mother at 9.55am on 6 October to break the news of her son's death. She reassured the family of the support that was available to them and also explained the processes that would follow. She remained in contact with the family and attended the funeral with the governor on 2 November. The prison also contributed to the funeral expenses.

ISSUES

Information provided on reception

68. When the man went into custody, the risk assessment completed by the police was handed to reception staff. During the investigation, it was apparent that this form had not been seen or used by relevant staff, including nurses, when firstly taking him through the reception procedures and then by staff on the first night unit.

69. Although the man did not raise the same issues that he had while in police custody when he arrived at Leeds, given his answers during his healthscreen, those matters should still have been explored. All information received by a prison that raises current or previous concerns about an individual's welfare should be followed up. The concerns may not be an issue at the time of their reception, but by making enquiries they will be recorded and provide information in the event of future concerns. As the content of the police risk assessment was not considered, the information was never recorded on the prison's or healthcare team's computer system, as part of his history.

70. As part of his clinical review, the clinical reviewer commented on the use of healthcare assistants to complete the initial health screenings. He said that due to the importance of the information to be obtained, an experienced nurse should complete the process. However, during my investigation there was no indication that Nurse A was any less able to conduct an in-depth healthscreen due to her being a healthcare assistant. He has made a recommendation on this within his report that I draw to the attention of both the Governor and the Head of Healthcare. I make the following recommendations in relation to initial reception into prison:

    The Governor should issue reception staff and internal probation staff with clear instructions on the actions they are expected to take when information on a prisoner's welfare is received from the police, court or other outside agency.

    The Head of Healthcare should ensure that nursing staff who are conducting the initial health screen have access to the Person Escort Record in all cases and any other risk assessments relating to medical concerns, completed prior to a prisoner's arrival into custody.

Drug and alcohol detoxification

71. On his reception, nursing staff identified the man as withdrawing from alcohol. They assessed him using the correct screening tools and all relevant questions were asked. A further assessment by the prison doctor concluded that he did not require detoxification medication, but nursing staff should monitor him.

72. The checks carried out by Nurses C and D were regular and followed the correct procedures to ascertain the man's level of withdrawal and potential health risks.

The monitoring continued for the first three days, and was only stopped following a full assessment by Nurse D.

73. The investigation has found that the systems at Leeds for treating and caring for prisoners identified with drug or alcohol issues on reception are working well and follow the correct procedures.

74. The clinical reviewer has commented on the detoxification arrangements at Leeds, "in this case careful attention was paid specifically to monitoring alcohol withdrawal". However, the clinical reviewer considers that while this was completed well, other important factors such as the man's mental well-being were managed poorly.

Mental health assessment

75. Nurse A recorded that a referral would be made to the mental health team at Leeds, but there is no evidence that this was completed. The clinical reviewer also commented on this and concludes that the key opportunity for the man's mental health to be assessed would have been when he presented as "tearful and distressed" to the nurse on 3 October. The clinical reviewer judged that these concerns should have been taken more seriously given his previous self-harm history. To ensure that healthcare staff are provided with the correct training that enables them to understand the implications of a person's mental health, he makes the following recommendation which I have slightly recast.

    The Head of Healthcare should carefully evaluate the training, experience and expertise of the healthcare team to ensure that they fully understand the serious implications custodial care can have on a prisoner's mental well-being and, where concerns are raised, are able to make timely referrals to the mental health team.

76. In response to the draft report the Prison Service provided an explanation of the process which Nurse A completed. They said:

    > '…Task is a function on SystmOne which allows for health issues to be highlighted to teams or individuals which they may need to know or action. Nurse A did not refer to a nurse as patient was displaying predominantly security 'risk' statements not self-harm statements. Therefore ACCT deemed inappropriate. Task to mental health was to allow patient the time an opportunity to discuss/ventilate his thoughts and feelings. This task was sent to the Mental Health In-Reach Team (MHIRT), although intended for the Primary Care Mental Health Team. Entry recorded that a Security Information Report (SIR) was submitted by Nurse A because patient stated he had asked another prisoner to contact his wife on his behalf and also stated 'he had to get of here.' The task sent to the MHIRT on Sunday 3rd October 2010 was sent back to Nurse A from a member of the MHIRT suggesting she task primary care.'

Monitoring under the suicide prevention and self-harm management procedures

77. The Assessment, Custody, Care and Teamwork (ACCT) procedures rely on staff being able to identify potential risks to a prisoner. However, it is also about sharing and acting on relevant information. The Prison Service provides training to all staff that have direct contact with prisoners to enable them to carry out this task efficiently.

78. The police had raised concerns and recorded the comments made by the man. This included, trying to hang himself a week earlier, and telling police officers that he would hang himself while in their custody. As previously mentioned, this information was passed to the prison on his arrival but was not shared.

79. The medical screen asked about thoughts of self-harm or suicide. The man answered ‘no’, but also disclosed his previous attempt at suicide 18 months earlier. He was identified as withdrawing from alcohol, and from the information he provided to the nursing staff he drank heavily in the community. People who withdrawing from alcohol are at risk of seizures and as such, prisoners should be monitored regularly. As mentioned earlier in my report, this did happen. However, withdrawal also increases the risk of self-harm.

80. Nurse A spoke with the ma on 3 October, and recorded that he had asked for “emotional support” and spoke about missing his family. He was aware that he was not allowed to contact his family due to his offences. He asked her if she would make contact with them on his behalf, which she declined, as this would breach security. She also recorded that he became “tearful and distressed” during the conversation. Such emotions would normally raise concern and she was asked about the comments that she had made in the medical record. She said that his distress was due to him being told that she was unable to contact his family for him. At no time did she feel he was at risk of self-harm and when she spoke to him later, he was not upset but appeared angry.

81. The nurse assured the investigator that if she had concerns about the man or self-harm she would have definitely opened started the ACCT monitoring procedures. Again, I raise the issue of the police information not being shared. Had this been recorded on the medical system when she spoke to him, it may have given her a different view of the potential risk. She also told the investigator that despite her role bringing her into direct contact with prisoners, often on their first night in custody, she had not been trained on ACCT procedures.

82. Information provided by a prisoner after the man’s death indicates that he had mentioned taking his life if he was unable to “jump the dock” while at court. Unfortunately, he did not share these thoughts with prison staff, neither did the prisoner tell staff about his conversation with him. If he had done so then such information would probably have resulted in an ACCT plan being opened.

83. The man had a self-reported history of attempted suicide. He was a heavy drinker and had been remanded on a serious charge. While in police custody, he had threatened to take his own life and as a result had been placed in a

camera cell in which he was observed regularly. I judge that this information, if properly shared as well as the other factors mentioned, provided enough concern for an ACCT document to be opened when he arrived at Leeds. I have already made a recommendation about the way in which information received about a prisoner is handled so make no further recommendation on this point.

84. In general, the ACCT procedures at Leeds seem to work well with staff being aware of what they are required to do. Despite her lack of training, Nurse A was able to explain the ACCT procedures and how she would open a document if she felt it was required. I consider that she had made the decision not to open an ACCT based on the available information, but again I cannot speculate as to whether this would have been different if she had been aware of the police paperwork. However, as a member of staff whose position brings her into direct contact with prisoners often on their first night in custody she should be supported with ACCT training. This is a view shared by the clinical reviewer, and I make the following recommendation:

    The Governor and Head of Safer Custody must ensure that any member of staff who has not been trained to carry out ACCT procedures are prioritised for this training and that it is provided at the earliest opportunity.

Emergency response

85. When they discovered the man, staff responded quickly and professionally. Officer A's efficient checking of each prisoner meant that he was discovered rather than assuming that he was going to the toilet. The clinical reviewer commented that rigor mortis was present when he was discovered which would suggest that he had been hanging for several hours. Despite this, staff attempted resuscitation prior to the arrival of paramedics, whose response was rapid. The clinical reviewer also considered that staff attempted resuscitation promptly and appropriately, but concluded "in light of rigor mortis there was no possibility that resuscitation would be successful".

CONCLUSION

86. The man had only been in Leeds for a few days before he took his life. He seemed desperate to contact his family. However, he had been in prison custody on previous occasions and was aware of the restrictions, imposed by the court, on him contacting his family and the reasons. He would also have known that using another prisoner's PIN to access the telephone was an offence within prison.

87. The charges for which he had been remanded were evidently of concern to him as well as the worry of other prisoners finding out about the offences. He told his ex partner on the telephone that he would be "a dead man" when the offences were reported. Despite his concerns, he had declined the opportunity offered to him to be located on a wing where he would be at less risk from other prisoners, and it is not clear why he decided against this.

88. While regularly consuming alcohol in the community, his withdrawal was monitored effectively when he went into prison and he reported no concerns about this during his time there.

89. The man never directly mentioned harming himself to prison staff, although he did so to another prisoner. Nevertheless, information provided by the police indicated that he had made previous attempts and had mentioned self-harm while in their custody. He left no letter explaining the reason for his actions and it is unclear why he decided to take his life. However, the realisation of his position regarding his relationship and the impossibility of contact, together with the worry regarding disclosure of his offences within the prison are likely to have been contributory factors.

RECOMMENDATIONS

1. The Governor should issue reception staff and internal probation staff with clear instructions on the actions they are expected to take when information on a prisoner's welfare is received from the police, court or other outside agency.

   This recommendation was accepted by the Prison Service who have said:

   A staff information notice will be produced to set down action that must be taken by all individuals when welfare information is received by any member of staff from partner agencies. This will be drafted and circulated by the Safer Prisons Team. This will also be circulated globally to all staff via e-mail. Reception and Probation managers will be informed when welfare information is received to ensure that they are aware of its content and are able to check that appropriate action has been taken. The target date for this action to be completed is July 2011.

2. The Head of Healthcare should ensure that nursing staff who are conducting the initial healthscreen have access to the Person Escort Record in all cases and any other risk assessments relating to medical concerns, completed prior to a prisoner's arrival into custody.

   This recommendation was partially accepted by the Prison Service who has said:

   As it is not clear that staff had the PER or risk assessments at the time of the assessment,

   New cell sharing risk assessment has a tick box for healthcare that asks 'assessed medical records?' this will be replicated on systmOne as follows:

   Healthcare will include a tick box on SystmOne that will indicate that staff have PER at time of assessment. In addition another tick box will be added with free text that indicates any other risk assessment documents seen by the nurse making the health assessment. Process will be set up to be auditable.

   If a prisoner arrives at medical reception without any accompanying documentation the nurse will actively request PER from officers.

   If there is no PER or other documentation with the prisoner, healthcare will make an assessment based on the information they are given by the prisoner at the time. Follow up information is requested from the prisoners GP the following day.

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3. The Head of Healthcare should carefully evaluate the training, experience and expertise of the healthcare team to ensure that they fully understand the serious implications custodial care can have on a prisoner's mental well-being and, where concerns are raised, are able to make timely referrals to the mental health team.

   This recommendation was accepted by the Prison Service who has said:

   In order to prevent confusion, healthcare changed the 'TASK' function to Mental Health Team and removed Mental Health In-Reach Team from task functions, ensuring that all referrals or requests reach the correct team in a timely manner. This has been completed.

   Training will be developed and delivered to healthcare staff by the primary healthcare team that aims to provide generic health care staff with a framework to better understand how patients are presenting and therefore what options they have i.e. ACCT, referral to primary care mental health signposting, security issues, GP, IDTS, no further action etc. Target for this to be implemented is September 2011.

   Actions in point four will ensure that all healthcare staff understand the serious implications custodial care can have on a prisoners well being. Target date July 2011.

4. The Governor and Head of Safer Custody must ensure that any member of staff who has not been trained to carry out ACCT procedures are prioritised for this training and that it is provided at the earliest opportunity.

   This recommendation was accepted by the Prison Service who has said:

   A 2 hour Health Care training package and programme is being designed to ensure all health care staff receive ACCT training and facilitate regular refresher training. To begin 1 September 2011.