Investigation into the circumstances surrounding the death of a man at HMP Leeds in April 2006

Report by the Prisons and Probation Ombudsman for England and Wales

April 2008

This is the report of an investigation into the death of a man that was found hanging in his cell at HMP Leeds on 19 April 2006. The man was 25 years of age.

I would like to express my condolences to the man's family and friends for their loss. I hope that my report addresses any concerns they may have. I must also offer my apologies for the delay in completing this report.

The investigation into the man's death was carried out on my behalf by one of my investigators. A clinical review was conducted by Leeds West Primary Care Trust. I would like to thank the then Governor of Leeds, and his staff, in particular the principal officer, for their co-operation and assistance with my investigation.

The man was received into custody at HMP Leeds on 8 February 2006. On 18 April, he was located in the segregation unit for disobeying an order to transfer to HMP Ranby. The man self harmed but, although attended to by healthcare staff, he was not placed on an Assessment, Care in Custody Teamwork (ACCT) document. The man was found hanging by a ligature the following evening.

My report highlights a number of concerns with regard to the segregation unit at Leeds and the care that was afforded to the man whilst there, and I have made a significant number of recommendations. I would add that I have raised some of these concerns in previous investigation reports.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2008**

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SUMMARY

The man had served a number of custodial sentences before being received into HMP Lincoln in October 2003. The man's long history of self harm was recorded by staff. In November, the man was transferred to HMP Hull, returning to Lincoln later that month. In December, the man was moved to HMP Durham, before being transferred back to Lincoln. Healthcare staff at the prisons recorded his history of deliberate self harm and he was assessed on several occasions by a psychiatric nurse. Whilst at Lincoln, the man's medication was reviewed by the prison doctor.

In May 2004, the man was transferred to HMP Stocken where he became more settled. In March 2005, he was released on licence but was breached and recalled to HMP Doncaster in May. Staff at Doncaster recorded that the man was a prolific self harmer and he was placed on an F2052SH. (The F2052SH was a document which was used to assess and observe prisoners at risk of self harm. This has now been replaced by the Assessment, Care in Custody Teamwork (ACCT) process.)

In June 2005, the man was transferred to HMP Ranby. Staff at the prison recorded that the man had used threats of self harm to manipulate staff and had no qualms about carrying out such threats. During January 2006, the man was again released on licence from HMP Stocken. However, the next month he was arrested and was received at HMP Leeds on 8 February.

At Leeds, the man was assessed by nursing staff. They recorded that he suffered from depression. An ACCT booklet was opened to monitor and support his self-harm risk. The man's history of drug and alcohol abuse was recorded and he was put on the drug detoxification programme. Over the subsequent weeks the man continued to be monitored by healthcare staff.

The man's behaviour deteriorated towards the end of February and he smashed his in-cell television. He was placed in the segregation unit, but was moved back to his own cell the following day.

On 18 April, the man was told that he would be transferred to HMP Ranby. He told staff that he would not transfer as he was in debt. He refused to return to his cell and told staff to take him to the segregation unit. On arrival in the segregation unit the man was placed in a cell with little furniture and with no personal possessions. He was seen later that day by healthcare staff and a member of the Independent Monitoring Board (IMB).

That afternoon the man was charged with disobeying an order, and told that he would be adjudicated upon the following morning. The man was given his evening meal and staff reported that he had little to say. At around 9.30pm, the man asked an OSG for a newspaper. The OSG told the man that none was available. However, an hour later he gave the man a supplement from his own paper. The man then asked the OSG to see the nurse, explaining that he had made cuts to his arms.

At around 10.30pm, the man was seen by a nurse who treated the wounds. The nurse recorded that the man had made approximately 20 superficial scratches to both of his arms. The OSG and the nurse completed an F213SH (a form on which any act of self harm is reported). None of the staff present that evening opened an ACCT document. The nurse made a record of the man's self harm in the healthcare observation book. No record was made by the OSG in the segregation unit observation book.

On the morning of 19 April, at the daily briefing of staff in the segregation unit, the man's act of self harm was not discussed. Applications in the segregation unit were taken from prisoners at the regular time of 7.30am during the governor's rounds. The man refused to talk with staff at this time.

The man was seen by a mental health nurse, as a consequence of a referral made by nursing staff the previous day. Although the mental health nurse was aware of the man's actions the previous evening, she said that the man had no signs of mental illness. The mental health nurse did not open an ACCT booklet.

The man was considered fit for adjudication and this took place later that morning in front of a governor. The governor was not aware that the man had self harmed the previous evening. The man refused to attend the adjudication and the governor proceeded in the man's absence. Finding him guilty, the governor gave the man a punishment of 20 days cellular confinement.

That afternoon the man was notified of the adjudication's outcome. A second nurse saw him and passed him fit for cellular confinement. The second nurse said that she noticed the scratches to the man's arms, but said that he did not appear to be withdrawn or depressed at the time. That evening the man was given his tea and was later heard throwing his plastics (eating utensils) around his cell. Soon afterwards, staff removed his cup and bowl from his cell but appear to have left his plate and a fork.

Two of the three officers on duty in the segregation unit that afternoon were called to other areas of the prison in order to assist with other discipline duties. A prison officer was left in charge of the unit. The prison officer started his final check of prisoners and equipment on the unit at about 7.55pm. The prison officer said he completed the checks at 8.00pm, although he did not sign the man's hourly cellular confinement log. The prison officer reported the prisoner numbers for the final roll check and then left the prison.

At about 8.30pm, the OSG began his first check of the segregation unit. The last cell to be checked was the man's. Failing to obtain a response, the OSG raised the alarm. Discipline and healthcare staff responded and on entering the cell they found the man hanging. They removed the ligature and commenced cardio pulmonary resuscitation (CPR) immediately. Staff continued to give CPR to the man until instructed to stop by the prison's Medical Officer. Paramedics from West Yorkshire Ambulance Service

attended and the man was pronounced dead.

In the early hours of 20 April, staff from Leeds informed the man's mother, and then father, of their son's death. A Family Liaison Officer from the prison, represented the Prison Service at The man's funeral.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my Deputy Ombudsmen but then conducted by an investigator from my office. My investigator was assisted by two further colleagues when interviewing staff at Leeds. Notices were issued to staff and prisoners informing them of the investigation and inviting them to contact the investigators should they wish.

2. The investigators visited Leeds and were given full access to the segregation unit and the cell in which the man apparently took his life. They met with the Governor as well as representatives of the Independent Monitoring Board (IMB) and with the Police Liaison Officer. They also made themselves known to a representative of the local branch of the Prison Officers' Association.

3. The investigators reviewed the man's prison and health records in addition to other documentation. Interviews were conducted with a number of staff who had had contact with the man. I would also like to thank the Police Liaison Officer at Leeds and the principal officer, for their assistance to my investigators.

4. I commissioned a clinical review from the Leeds West Primary Care Trust (PCT). A Doctor completed this on behalf of the PCT.

5. West Yorkshire police confirmed that they had no concerns with regard to the circumstances of the man's death.

6. One of my Family Liaison Officers made contact with the man's family to explain the purpose of my investigation and invite them to raise any concerns they wish to be considered and addressed as part of the investigation. The family chose not to engage in this process at this time.

7. However, in early 2007, the family contacted another of my Family Liaison Officers and requested a visit from my office. My family liaison officer and my investigator visited the family at their home in Hull on 28 February 2007. During the visit the family raised a number of issues, some of which the family liaison officer and my investigator were able to address during their meeting.

8. Other issues raised by the family are addressed within this report and include:

    - Why was the man in the segregation unit?
    - Was the man on 'suicide watch' around the time of his death?
    - What time had the man apparently taken his life and could this have been a cry for help, had it happened around unlock time?

- Was the man tested regularly for drugs?
- When the family saw the man at the funeral directors he appeared to have some bruising in the middle of his forehead. (My investigation has been unable to establish why this was.)

I hope this report helps his family better understand what happened to the man in the time leading up to his death.

HMP LEEDS

9. HMP Leeds is predominantly a Victorian prison. The four original wings (A, B, C and D) were built in 1847. Two more wings (E and F) were opened in 1994, together with new kitchens, gymnasium and healthcare centre. It is a category B local prison for adult male prisoners from West Yorkshire.

Segregation

10. The segregation unit at Leeds is known as S1. It has 22 single cells. These include two special cells and two cells equipped to deal with prisoners on dirty protest. The first of the special cells is used as a holding cell. Prisoners are first located here when transferred to the segregation unit. Here they are searched and asked to change into standard issue prison clothing. The second special cell is a normal cell. This cell, along with the holding cell and the two dirty protest cells, is fitted with closed circuit television. Twelve additional cameras continuously film the landing and are monitored in the segregation unit office. At the time of the man's death there were no segregation unit cells which met the Prison Service's definition of a safer cell. However, steps were being taken for some to be altered to meet this standard.

11. None of the cameras in the segregation unit at Leeds, either in the special cells or on the landing, were in operation at the time of the man's death. Although my investigators enquired on a number of occasions why the cameras on the unit were not working, they were unable to establish precise details.

12. When prisoners are first located in the segregation unit they should be given an information booklet about the unit's rules, the daily regime, and how to make applications or a complaint. The booklet also acts as a compact between them and the unit staff. This sets out the agreed and accepted levels of behaviour and entitlements. The booklet should be given to prisoners within 24 hours of their arrival on the unit.

13. It is a mandatory requirement of the Prison Service that all prisoners held in a segregation unit are visited daily by the duty governor, chaplain and doctor. The visits are to ensure that prisoners are being treated fairly and decently, and to give them an opportunity to raise any concerns.

14. In Leeds, prisoners in the segregation unit are expected to be up and dressed by 7.30am when they are unlocked briefly and are allowed to make applications. (Applications are written requests by prisoners to access services or an item.) Prisoners not adhering to this rule are unable to make applications later in the day. Those in the segregation unit have to apply for items available as a right for other prisoners, including telephone calls, showers and exercise. Prisoners who arrive on the unit half way through the day are not formally given the chance

to make an application until the following day.

15. Whilst in the segregation unit, prisoners can ask to talk to the Listeners (selected prisoners trained by Samaritans to offer support for prisoners at risk of self harm.) and use the Samaritans mobile telephone at any time. This applies to all prisoners regardless of their reason for being on the unit.

16. Meals are brought to prisoners in the segregation unit at midday and during the early evening. Food is left at the cell door, together with a flask of hot drinking water. Each door is opened in turn to permit the prisoner to collect his meal tray, and the routine is repeated when the used plates and flasks are removed. Prisoners are given a breakfast pack at the same time as they are given their evening meal.

17. During the night, as in other parts of the prison, staff have a routine known as pegging which requires them to go to pre-determined parts of their wing at pre-set times to log their presence. The purpose of the pegging routine is to ensure that all parts of the wings are patrolled regularly through the night. There are two pegging points in the segregation unit.

18. The staffing levels in the segregation unit remain the same regardless of the number of prisoners in the unit. During the day, the unit is managed by a senior officer and six prison officers who are all specialist staff and have been through a selection interview. At the time of the man's death, at night time, unlike other wings which are staffed by prison officers, the segregation unit was staffed by an operational support grade (OSG) rather than a specialist on the unit. The OSGs do not have specialist knowledge of the requirements for a segregation unit and are not selected for the role. During the day their duties are often in other parts of the prison and the only time they work on the wings is at night. Their knowledge of the prisoners and what has been happening in the unit that day is obtained from the wing staff when the OSGs take over.

19. As well as looking after prisoners in the unit, segregation staff are responsible for the administration of adjudication hearings including preparation of paperwork, collecting and returning prisoners to and from cells, and being in attendance throughout the process.

Inspection

20. Leeds was last inspected by Ms Anne Owers, HM Chief Inspector of Prisons, in August 2005. She identified that the prison faced a number of difficult challenges because of chronic overcrowding and a high turnover of prisoners. Ms Owers said in her report that:

> "We also had concerns about the management of the segregation unit, and the support and management of prisoners

at risk. The unit was run in a militaristic fashion: there was an over use of the special cell, without proper recording, and sometimes as a punishment for relatively minor disciplinary offences by prisoners already segregated."

21. Ms Owers also reported that segregation unit staff made three written entries, on average, in the prisoner's history sheets. She said that: "These were extremely superficial and usually consisted of single lines merely stating that the prisoner was ok…"

Suicide and self-harm

22. Prisoners who are considered to be at risk of self-harm whilst in prison are placed on an Assessment, Care in Custody and Teamwork (ACCT) document. This is used to assess and observe and support prisoners. It highlights the problems and possible trigger points of a prisoner at risk of self harm and delivers a multidisciplinary plan to give support and help through a period of crisis.

23. Before the introduction of ACCT, staff used a booklet called the F2052SH to monitor those prisoners at risk of self harm.

The adjudication process

24. An adjudication is a prison disciplinary hearing. It is a requirement of Prison Service Order 2000 that healthcare staff are given sufficient time to raise any concerns with regard to a prisoner's fitness to attend an adjudication. However, the final decision as to whether or not the accused is fit to face the hearing rests with the adjudicating governor. If a prisoner is found guilty a range of punishments can be given.

25. Examples of punishments that can be given at adjudication include the forfeiture of particular privileges, lost earnings, and cellular confinement. (Cellular confinement is a punishment whereby a prisoner is locked in a cell for most of the day and, apart from exercise, is not allowed to mix with others. Prisoners who serve a period of cellular confinement are sometimes not allowed access to radio, television or to some or all of their own belongings as an additional part of the punishment.)

Incentives and earned privileges (IEP)

26. The IEPS scheme is intended to encourage and reward good behaviour by allowing prisoners access to such privileges as in-cell television, wearing of own clothes and more time out of cell. There are three levels: basic, standard and enhanced, dependent on behaviour. The scheme continues when prisoners are located in the segregation unit. As a standard regime prisoner, the man would have been entitled to the same regime as he had whilst on normal location and was

permitted personal possessions in his cell subject to security clearance.

KEY FINDINGS

Background

27. The man's antecedents (police records) show that he received numerous custodial sentences. His final period of custody began in August 2003. In March 2004 he was released on licence only to be recalled to prison two months later. The man was released on licence for the second time in January 2006, before being arrested for a burglary in Leeds. He was received into custody at Leeds on 8 February.

28. The man was received at HMP Lincoln on 15 October 2003 as a convicted un-sentenced prisoner. During the reception process his long history of self harm was immediately recorded by staff and as a consequence he was placed on an F2052SH. The man was seen by the prison doctor and put on the prison detoxification programme. On 27 October, his F2052SH was reviewed and closed.

29. The man remained at Lincoln until a court hearing at York Magistrates' Court on 7 November. Due to an adjournment the man was told that he would be sent to HMP Hull. The man told staff that he was known to other prisoners at Hull and would self harm if he was sent there. However, the man was in fact transferred to Hull and staff opened an F2052SH.

30. On 19 November 2003, the man returned to Lincoln. During reception it was again recorded that he had a history of self harm, but no F2052SH was opened. The man was assessed by the prison doctor. He reported that the man was suffering from depression, but did not appear depressed in mood. The doctor noted that the man had apparently been on the antipsychotic drug chlorpromazine, but questioned the need for this medication.

31. On 1 December, the man was transferred to HMP Durham. He told staff that he had been waiting for a mental health assessment. The man's medical record said that he had a history of deliberate self harm and a mental health referral was made. On 9 December, the man received a mental health assessment by a community psychiatric nurse (CPN) from the Mental Health in Reach Team (MHIRT).

32. On 10 December 2003, the man was transferred back to Lincoln and healthcare staff recorded that he should be seen by a CPN. On 6 January 2004, he was assessed by a nurse from the MHIRT. She recorded that the man had no evidence of an enduring mental illness and that his desire to receive the antidepressant amitriptyline instead of venlafaxine was perhaps in order to obtain a "buzz". On 30 January, the doctor at Lincoln agreed to stop the man's prescription of venlafaxine and begin a course of amitriptyline.

33. On 28 April 2004, there is an entry in the man's medical record recording that the effects of his amitriptyline had begun to wane and that he had been adding extra doses (up to 250mg) from other prisoners.

34. On 20 May 2004, the man was transferred to HMP Stocken. The man continued to be prescribed amitriptyline. In an entry dated 14 June, the prison doctor noted that the man was very talkative, even charming, but said that he was a skilled manipulator who only wanted drugs. He added that the man wanted to come off amitriptyline.

35. On 21 July, The man indicated to staff that he wished to address issues connected with his drug taking and offending. However, on 11 October he was removed from the drug treatment programme due to non attendance. On 10 December, it was reported in his medical record that his prescription of amitriptyline should be reviewed with a view to it stopping.

36. On 24 March 2005, the man was released on licence. However, he was breached and recalled to prison on 16 May. The man was sent to HMP Doncaster. During the reception process a member of healthcare staff recorded on his Cell Sharing Risk Assessment (CSRA - a form used to assess the risk that a prisoner would present to others when sharing cells) that he was a prolific self harmer, and that he felt he would self harm if not given detoxification and protection. Due to these concerns staff, immediately opened an F2052SH. A note on his medical record says that he told healthcare staff that he did not feel like self harming that night, but would if not given detoxification medication or a television. Later that evening, the man was taken to the healthcare centre after making a number of superficial cuts to his left forearm.

37. During an F2052SH review on 17 May, The man told staff that he had self harmed because his detoxification was not working. He said that he wanted to be signed off his detoxification programme and to be put on amitriptyline. The reviewer recorded that the man was:

> "… tearful at times, asking why he cannot have a new cell mate or television. He implied that this is stressing him and therefore would cause self harm."

38. On 19 May, the man's medical notes record some confusion with regard to his prescription of amitriptyline. He had a "temper tantrum" at not receiving it. He was prescribed the drug later that day.

39. The man's F2052SH was reviewed before being closed on 31 May. The reviewers recorded that he had no further thoughts of self harming now that his detoxification had been completed and his medication had been sorted out.

40. On 21 June 2005, the man was transferred to HMP Ranby. The CSRA recorded that he was a prolific self harmer and that he:

> "Had used threat of self harm to manipulate staff, nevertheless has no qualms about carrying out these threats."

Entries in the man's wing history sheets indicate that over the coming months he settled into the regime at Ranby, although his behaviour deteriorated towards the end of his time at the prison.

41. The man was transferred to HMP Stocken on 5 December 2005. The healthscreen indicated that the man was currently receiving amitriptyline for his depression. On 14 December, the man submitted a complaint form saying that he had been given no reason by the prison doctor for having his amitriptyline stopped. In response, the practice manager wrote that the amitriptyline had been withdrawn as it was not on Stocken's list of approved medicines. The practice manager told the man that a period of one week must elapse before another anti-depressant could be given. He advised him to make an appointment with the doctor in order to discuss an alternative treatment. No notes about the withdrawal of the man's medication at Stocken were made in his medical records.

42. On 13 January 2006, the man was released on licence from Stocken. However, he was arrested for offences of robbery and burglary in the Leeds area and remanded into HMP Leeds on 8 February. It was later learnt by the prison that the man was a recalled prisoner, and his licence was revoked on 23 February.

43. On 8 February, a reception officer at Leeds completed the CSRA. The man told the officer that he had a history of drug and alcohol abuse and had previously been placed on an F2052SH.

44. A reception nurse carried out a first night reception healthscreen on the man. The reception nurse noted that he consumed three litres of strong cider a day, took cocaine, heroin and cannabis daily, and amphetamines "now and again". The reception nurse indicated that the man suffered from depression, had previously seen a psychiatrist and had been prescribed amitriptyline from 2002 to December 2005. The man said that he had self harmed in the past by cutting both wrists.

45. Part of the man's healthscreen involved him giving a urine sample for drug testing. The sample tested positive for opiates, benzodiazepines and amphetamines.

46. The man was received at Leeds while the Leeds West PCT and Leeds University were conducting a trial which involved researching the effectiveness of buprenorphine, more commonly known as Subutex, and Methadone. The man met the criteria for taking part in the trial.

He was, at random, prescribed Subutex as opposed to Methadone in order to detoxify from opiates over a 20 day period. The man received his first dose of Subutex on 9 February and attended daily for the medication. However, he failed to collect his last two doses. This non attendance was not followed up by staff.

47. The urine of a participant in the trial was sampled, confidentially, eight days, one month, three months and six months after the last dose of Subutex had been administered. No referral to discipline staff was made should prisoners test positive for opiates. Nursing staff not involved in the trial would also be unaware if prisoners returned positive urine samples.

48. The man was given his first post trial test on 7 March, eight days after the trial had ended. The Drug Therapist and Evaluation Co-ordinator of the trial at Leeds, explained to my investigators that at this point he should have tested negative for all drugs including Subutex. However, the man's sample was positive. The Drug Therapist and Evaluation Co-ordinator confirmed that the sample taken a month later, around 8 April, also tested positive, suggesting that the man may have been obtaining the drug illegally from the wing. At the time of the man's death, the toxicology results from the post mortem were negative.

49. As well as the healthscreen, the reception nurse also completed a self harm assessment. This is done by scoring prisoners by asking a number of questions. If a prisoner scores more than ten out of a total of 22, he is considered to be at risk of self harm and an ACCT document is opened. During the assessment the man scored ten points and the reception nurse opened an ACCT booklet. The man was placed on hourly observations. The reception nurse told my investigators that, because of his history of depression, she referred the man to the mental health clinic.

50. On 9 February, as part of the ACCT process, an assessment interview was completed by an assessment officer. The assessment officer said that when the man was told of the assessment, he swore at the officer, saying that he would not talk to anybody until seen by the doctor. The assessment officer recorded that the man's only problem was that he had not received his detoxification, but would be seeing the doctor that morning. He added that the man had last self harmed two years previously as a coping mechanism, and had no suicidal intent at that time. It was recorded that the man had a supportive family and friends with whom he said he would keep in contact.

51. After the man's assessment interview, a senior officer chaired the initial case review along with the assessment officer. The man was also present. The senior officer recorded that the man was:

> "…not suicidal or feeling like self harming. Has now been written up for a detox and has now settled into prison regime. In

> our opinion this ACCT now has served its purpose and can now be closed."

The date of the post closure interview was set for 16 February but this never took place.

52. On the morning of 9 February, the prison doctor saw the man. He recorded his history of drug and alcohol abuse and that he had been accepted onto the detoxification trial. The prison doctor recorded that there was no deliberate self harm or intention, and that the man had a history of depression and amitriptyline prescription. The prison doctor noted that the man would require a mental health evaluation.

53. Whilst on the first night induction centre, the man was given a short induction to prison life at Leeds. He was seen by a member of the chaplaincy team, education department, and by a Counselling, Assessment, Referral, Advice and Throughcare worker. (The CARAT team deal with prisoners with drug problems and can offer counselling, support and referrals to rehabilitation centres during sentence and on release.) A referral was made for the man to attend a Drug Intervention Programme in York on his release. On 16 February, the man's CARAT worker undertook a substance misuse assessment.

54. On 18 February, an unidentified officer introduced himself to the man as his personal officer. On 20 February, another officer also introduced himself as the man's personal officer and recorded in his wing history sheets that the man had no problems to date.

55. On 20 February, the man was adjudicated upon for refusing to obey a lawful order. A note in his medical record by the mental health nurse indicates that he was fit to attend the adjudication.

56. On 28 February, the man was seen at the mental health clinic by the mental health nurse . She recorded in his medical record that the man had:

> "No evidence of mental illness present. Does have issues with low mood, this appears to be related to his drug abuse and alcohol abuse. Advised he will be seen in the substance misuse clinic."

57. On 1 March, the man was sentenced to two years and four months imprisonment at Leeds Crown Court.

58. On the evening of 5 March, the man smashed his TV and was placed on report (a process which marks the start of the adjudication process), and was removed to the segregation unit. It is a Prison Service requirement that all prisoners who are moved to the segregation unit must been seen by a registered nurse within two hours of their arrival. The assessment is recorded on a Segregation Safety Algorithm which

is intended to be a ‘snapshot’ of the prisoner’s condition at the time of the screen.

59. The algorithm was completed by a third nurse. She advised that there were no healthcare reasons why the man could not be segregated. A second governor authorised the man’s segregation at 8.30pm.

60. On 6 March, The prison doctor visited the man in the segregation unit and noted “no probs” in his medical record. Officers on the unit recorded in the man’s segregation history sheets that he had a poor attitude and could not be bothered to get out of bed for lunch. The man appeared to be in a much better mood that evening.

61. On the morning of 7 March, after visiting the man in the segregation unit, the prison doctor again recorded that there were “no probs” in his medical record. Staff in the segregation unit that day noted that the man was seen by the second governor for applications. The man was reported as having no issues. It was recorded later that day that the man was moved to C wing.

62. My investigator failed to find any documentation informing the man why he had been located in the segregation unit from 5 to 7 March. Although this period of time in the segregation unit had no bearing upon the man’s death some weeks later, this lack of paperwork is raised again later in my report.

63. On 8 March, the man made an application to work in the prison’s clothing exchange store. However, an officer noted in his wing sheets that he would not be suitable at that time.

64. The last entry in the man’s wing history sheets was made on 23 March. It said that the man had been issued with a warning for refusing to attend work because he had a headache. The officer added that the man lay in bed ignoring him and that he had a surly attitude.

Events of 18 and 19 April 2006

The man's refusal to transfer and return to his cell

65. At approximately 9.30am on 18 April, the man was taken from his cell to see a member of staff from the Observation, Allocation and Categorisation unit (OCA) on B1 Landing. (Staff who works in OCA are primarily responsible for the categorisation and allocation of prisoners. They have responsibility for assessing the needs and requirements of prisoners, and establishing which prison would be most appropriate for them to be transferred to). The man was advised by OCA staff that he would be transferred to Ranby the following day.

66. Before a transfer can take place a prisoner is 'fitted' for travel by a member of healthcare staff who has access to the medical record. A fourth nurse who 'fitted' the man for travel that day, explained that prisoners are informed of their transfer before being assessed by healthcare staff. The fourth nurse said that prisoners were assessed behind a screen, but in the same room that they are seen by OCA staff. The fourth nurse said when the man was told of his transfer to Ranby, the man told the officer that he did not want to go because of debt. The man told him that he could not go, and would not go. However, because there was no medical reason preventing the man's transfer, the fourth nurse recorded in the man's medical record: "Seen prior to transfer, fit and well. No medical issues. Fit to travel."

67. At approximately 9.50am, after being seen by allocation staff, a second prison officer asked the man to return to B1 holding room. The second prison officer said that the man refused to go, saying: "I'm staying here, I'm not going to Ranby, you'd better get me down the block." The second prison officer contacted a second principal officer who told him to take the man straight to the segregation unit.

The man's location in the segregation unit

68. The man walked to the segregation unit, escorted by the second prison officer. An entry in the man's Record of Events, F2052A, on the segregation unit (more commonly known as prisoner history sheets) records that he:

> "Walked to Seg from B1 after refusing to return to his wing due to debt. Very obnoxious refused to talk with nurse or staff a very angry young man."

The man's segregation unit history sheets record that he was placed in the segregation unit under Prison Rule 55 (the rule that allows staff to keep a prisoner located in the segregation unit in order to serve a punishment of cellular confinement).

69. Although there is no written record of what exactly happened to the man when he arrived in the segregation unit, staff confirmed that he would have been placed in the "strip cell" and searched before being moved to a normal cell on the unit.

70. During interview, a fifth nurse explained that, at about the time the man was being brought to the segregation unit, she had been asked to attend the unit to see two other prisoners. She said that whilst there she was told that the man was on his way. The fifth nurse was asked if she would mind waiting so that she could carry out the required Segregation Safety Algorithm assessment.

71. At 10.10am, the fifth nurse completed the man's assessment. She indicated on the form that the man had not self harmed in the current period of custody, was not taking any psychotic medication and was not showing signs of being acutely unwell. She concluded that the man would be able to cope with a period of segregation. The fifth nurse also recorded: "Will refer to RMN [mental health clinic] re antidepressants but not acutely unwell."

72. In her police statement, The fifth nurse said that she had asked the man if he had any injuries, to which he said no. She added that none was visible. During interview with my investigators, the fifth nurse said that when she saw the man in his cell he did not look at her and came across as very angry. During her medical assessment the man had complained that he should have been prescribed amitriptyline as he had been prescribed the drug before coming into prison. The man denied any suicidal or self harm intent and, with his agreement, she referred him for an assessment with an RMN. The fifth nurse confirmed with my investigators that when completing the segregation safety algorithm in the segregation unit, nursing staff would not always have access to either the prisoner's medical record or to their electronic medical record (EMIS).

73. The man was placed in cell S1.31, a regular cell on the segregation unit. The cell had integral sanitation and contained a standard single iron bed with mattress, sheets and blanket. The only other furniture was a cardboard chair.

74. An entry by a segregation officer in the segregation observation book (a book in which all major movements and incidents on the unit are recorded) says that the man was held in the segregation unit under rule 53. (Rule 53 allows the Prison Service to hold prisoners in the segregation unit who have been charged for breaking a prison rule and who are pending an adjudication.)

75. At around this time the man was also seen by the prison doctor. He again recorded in the man's medical notes that there were "no probs". The prison doctor told my investigators that part of his job as a medical officer was to visit all the prisoners in the segregation unit at about

11.00am each day to establish if they required his services or not. The prison doctor said that:

> "it is a brief 'good morning', how are you today, how you feeling today, any medical problems and that is it."

He said that he very rarely entered a prisoner's cell due to the strict security on the unit. The prison doctor told my investigators that he did not really look at the prisoners' medical records before attending the unit, adding, "I don't know who I am going to see until I get there".

76. At 10.15am, a third governor approved the man's segregation under Rule 53. At 11.00am, as required, the Independent Monitoring Board was informed of the man's location on the segregation unit.

77. At some point that morning, the man signed the segregation unit compact. On the second page of the compact prisoners are informed what prison rule they are being held under and an explanation of the rule is provided. The last page of the compact is where the prisoner signs indicating that they agree to the unit's rules and what is expected of them. Although staff at Leeds were able to provide my investigators with the back page of the man's compact, they were unable to provide the front page which would have informed the man of the reason for his location on the unit.

78. Applications in the segregation unit are made at 7.30am. The man arrived in the segregation unit at approximately 10.00am and therefore missed the governor's daily round at which applications are made. Staff explained that it was still possible for prisoners located on the unit after 7.30am to make applications, although this was dependent on the type of request and other factors such as time and staffing levels. There is no record that the man made any applications or requests on 18 April, or that he was invited by staff to make any.

79. A request was made by segregation unit staff for the man's property to be removed from his cell on C wing. At 11.05am, officers removed a number of items. These included letters and cards, playing cards, legal papers and toiletries. Although these items were removed at the request of the segregation unit staff, they were not taken to the unit to be given to the man. Segregation unit staff did not follow up the request when the man's property failed to appear. A second senior officer confirmed that, as a prisoner on the standard regime, the man would have been entitled to personal possessions in his cell, subject to security clearance. The first governor said that prisoners would normally let staff know that they wanted their property.

80. An entry in the Segregation Observation book states that the man put his "plastics" (eating utensils) out after lunch. When asked by a third prison officer, the man said that he was ok.

81. At 2.35pm, the man was seen by the IMB. The IMB recorded that the man was:

> "In bed. Either ½ (or ¾) asleep or feigning well. Grunts for replies to questions and on 3rd turned over & covered himself & back to sleep."

82. At approximately 4.30pm, the man was given his evening meal and breakfast pack for the following morning. The third officer recorded: "he didn't really have nothing to say when asked if ok."

83. The third officer issued the man with his adjudication charge sheet at 4.47pm. The charge sheet informed the man of the charges laid against him, for refusing to return to his cell earlier in the day, and told him that the adjudication would be heard by the adjudicating governor at 9.30am the following morning.

Events during the evening of 18 April

84. On the evening of 18 April, The OSG commenced work as usual at about 7.30pm, although his night shift duties did not officially start until about 8.15pm. The OSG explained that he would start early in order to get ready for the night ahead and to be briefed by other staff. In his police statement The OSG said that he recalled checking the man some time between 8.00pm and 8.30pm as the man "… was subject to cellular confinement". However, the man had not been adjudicated upon and therefore was not subject to any punishment at this time, including cellular confinement.

85. The OSG said in his police statement that the man had first asked for a newspaper at about 9.30pm. He said that the man was still "ok" when he checked again at 10.00pm. At about 10.30pm, The OSG gave the man a supplement from his newspaper along with a pen. He told my investigators that:

> "I think he was banging on his door, you know, asking for a paper, and I explained to him that I couldn't give him a paper because there were none there to give him. So he kept banging, banging, then he sort of settled down. A bit later on I noticed that I had a supplement in my paper, so I offered him that, it was crosswords and things like that he could do. So I went to his cell door, called him, no reply, I called him again, without any reply and so I just said to him, 'well you don't want this then', then he replied to me, 'well what is it?' I said, well I have got a supplement you can have, it's crosswords, I will give you a pen you can, he reacted to me then, you know and he said, 'oh yes please', he put on his light and I gave him the paper and he was actually quite happy."

The OSG said that before giving the man the crosswords he had had

nothing else in his cell. He added:

> "…once I gave him the paper he said to me, 'can I see the nurse', so I asked why, and he said, 'well I have been cutting myself', so when I looked there was no blood there or anything like that."

The OSG explained that the man had a number of wounds. He did not know which were fresh and which were old.

86. At around 10.30pm, the OSG summoned assistance from a nurse, who was based on A wing, the landing above the segregation unit. He said that she requested the night orderly officer who carried keys to also attend the segregation unit. (During the night neither OSGs nor Nurses hold an emergency cell key.) However, the night orderly officer said that he believed the call to attend the segregation unit came from The OSG himself. The OSG told my investigators that the night orderly officer and the nurse:

> "… opened the door and asked the man to come out onto the landing so they could see properly and the nurse said, 'well there is nothing there, there is nothing to dress'. You know. There was no blood; there was no weeping skin or anything like that. She just said, 'I can't dress anything that you haven't hurt.'"

87. The night orderly officer said he had been told that a prisoner had self-harmed or threatened to self-harm if he did not get some reading material. On attending the segregation unit The OSG told the night orderly officer that the man had now been given something to read and appeared to be okay. The night orderly officer said that the man's arms "didn't look too bad at all". He said that the nurse applied some antiseptic spray and the man was allowed to go back into his cell.

88. The OSG said that the nurse asked the man what he wanted her to do. The man asked for a couple of Paracetamol tablets to take the pain away. The nurse gave the man the tablets and he "was quite happy".

89. The nurse told my investigators that she was alerted by an officer that she was required in the segregation unit as a prisoner had made cuts to his arms. She first went to A wing to collect a dressing pack. In her statement to police she said that she arrived on the segregation unit at 10.35pm. The nurse said that when the man was unlocked he came to the cell door. She asked him what he had done and it was then that he showed her his arms. The nurse said:

> "There were scratches on his arms, not consistent with, I thought at the time, well it is not consistent with a razor blade, because they were not really cuts, they were more like raised red areas across his arm, I could see old scarring from other

> marks that had been made previously, how old, I don't know, I couldn't really say accurately. There was no blood coming from his arms at all, wounds weren't bleeding, they were more like raised welts …"

In her statement to police the nurse said that the marks on the man's arms were "numerous but very minor". She believed that it was not a serious attempt by the man to self harm, but a protest about not getting a newspaper.

90. The OSG told my investigators that the nurse asked the man why he had cut himself. The OSG thought the man said that he had only done it because he could not get a newspaper. During her interview the nurse said she had asked the man:

> "…'well, what is wrong, what have you done it for.' He said, 'well I wanted a newspaper.' I said, 'well I can't help you with that either."

The OSG said he visited the man on a couple of further occasions that night to check on the man's welfare.

91. The night orderly officer was asked if he was sure whether the man had self harmed or not. He said:

> "Me personally I am not sure whether he did or he didn't, it looked to me as though he hadn't because there was no fresh marks there at all."

The night orderly officer went on to say :

> "I believe the officer down there filled in a 213SH, but as far as I could see there was no evidence as to any self harm at all, it seemed as though the self harm threat had been taken care of by handing over the reading material."

92. The OSG completed a Report of Injury to Inmate Form F213 and recorded that:

> "This inmate requested to see the nurse after he scratched both his forearms. The nurse attended at 22.30hrs along with Oscar 1 and the inmate requested he just wanted painkillers."

The nurse wrote on the form that she had examined the man at 10.35pm:

> "Many (approx 20) superficial scratches seen on both arms – not bleeding, dressing inappropriate as they were very small and hardly broke skin surface."

93. The OSG also opened an F213SH, Self-Harm / Attempted Suicide Form. (This is a form on which any act of self harm must be reported. It is set out in a questionnaire format and, as with the F213, part of it is completed by the medical officer.) The OSG left both forms on the nurse's desk for completion.

94. The nurse told my investigators that she did not feel the man was at all suicidal. (As noted above, she told the police that it was a protest about a newspaper.) She told us that a prisoner's location in the segregation unit would not influence her decision on whether to open an ACCT document or not.

95. When asked if he had considered opening an ACCT document, the night orderly officer said:

> "…the reason he said he was going to self-harm was because of the reading material and when I went down there and got an overview of all of the picture and he had been given the reading material … there was no problem, he had got his material whatever it was, magazine, there was no reason to open an ACCT document."

96. During interview, The OSG said that the man's injuries were minor and were not a serious attempt at self harm. He had accepted the nurse's decision not to open an ACCT document.

97. The OSG said that, although he would normally have expected to record the attendance of the nurse and orderly officer in the observation book, on this occasion he had not. No entry was made in the man's history sheets either.

98. The nurse was asked whether a note of her attendance was made on EMIS, the electronic medical record. The nurse said that it was not because "the injuries were exceptionally minor." She said:

> "…I could spend my entire night putting on EMIS that, 'oh he has cut his finger with a razor blade [or] while sharpening a pencil', I could spend my entire night doing that and some nights it could be exceptionally busy."

Although no entry of the man's injuries was made in his medical record, the nurse did make an entry in the healthcare observation book before going off duty. She wrote that the man had: "made superficial scratches to both arms – no dressing required".

99. In his police statement, the OSG said that he checked the man again at 11.00pm. He asked him what had caused the injury. The man passed him a small piece of black plastic which he put in the bin. The OSG said that he checked the man during the rest of the night. At

some point during the night the man smashed his hot water flask.

100. The nurse was asked by my investigators about nurses on night duty handing over healthcare responsibilities to nurses coming on duty the following morning. The nurse said that the fourth nurse would have been there. She said that during the handover everything that had happened through the night and was in the observation book was explained.

101. The fourth nurse told my investigators that he started work on 19 April at approximately 6.30am. He said that as part of the handover routine he would have gone straight to A wing, where the nurses base themselves at night, to see if there were any problems. The fourth nurse said that the handover involved reading any notes made in the healthcare observation book. When asked if he was aware of the "superficial scratches" that The man had made to his arms The fourth nurse said:

"I was aware of that when I spoke to [the nurse], it was made clear that he had done it because he wanted a newspaper overnight. Therefore it was not a deliberate self harm, to kill himself, it was not manipulated but a way of getting something from somebody."

102. In his police statement, the fourth nurse said: "I did not see the nurse who had been on nights. I did however receive a 'handover' from another nurse. I can't recall who."

Events of 19 April

103. At 7.30am, the second senior officer led the daily staff briefing in the segregation unit. The OSG told my investigators that told staff that the man had been seen by a nurse during the night after having made scratches to his arms. He could not remember whom he told. However, from interviews with segregation unit staff who were on duty that morning, I know that the man's self harming was not discussed at the segregation unit morning meeting.

104. The first governor told my investigators that at 7.30am on the morning of 19 April she did her usual morning rounds with the chaplain. She said that the man's cell was opened up for daily prisoner applications and the governor's check at approximately 7.45am. The governor said that the man refused to speak to her. On completion of her rounds she left the unit, not returning until about 9.30am to start adjudications.

105. It was at this time that the man handed back the damaged flask. The third prison officer wrote in the man's history sheet, "handed his flask back which he had smashed up. Placed on report." A fourth prison officer told my investigators that, "during applications, first thing in the morning, the man did not get out of his bed, or want to have any

interaction with staff."

106. The prison doctor also visited the man in the segregation unit that morning, noting once again in his written medical record that there were "no probs".

107. At approximately 10.00am the mental health nurse and healthcare manager at the prison, saw the man in the segregation unit as a consequence of the referral made by the fifth nurse the previous day. The mental health nurse recorded in his medical record:

> "… denies any suicidal intent at this time. No evidence of any florid psychotic symptoms at this time. Will see again for assessment. Located in the seg unit at present time. Made superficial scratches to both his arms last night. No treatment required. He needs to be advised to request to see the doctor regarding a medication review."

The mental health nurse completed a Mental Health Referral Form, noting that the man had previously been treated for depression and that he had said he had been on amitriptyline.

108. In her statement to police, the mental health nurse said that she was aware from the entry by the first nurse in the healthcare observation book that the man had been seen in the night following an act of self harm. She said that she "knew that neither the first nurse nor the fifth nurse had seen fit to open one [an ACCT booklet]."

109. The mental health nurse said that she believed the man was not suicidal when she saw him at that time. She told my investigators that, when she asked the man why he had scratched his arms, he said it was because he had not been given a newspaper. She said that the man had no signs of mental illness at all and had "laughed" the incident off. The mental health nurse described the scratches on the man's arms as like those from a bramble or a cat. She said she did not bring the scratches to the attention of staff as they had happened the night before and she presumed the issue had been dealt with. The mental health nurse said she did not consider opening an ACCT because there were no obvious signs of self-harm or suicidal ideation. However, had she been the first to attend the man the previous evening, she probably would have done so.

110. In her statement to police, the mental health nurse said she told the man that she:

> "… would see him again after he came out of the segregation unit to do a full assessment of his mental state and medication."

She was not aware that the man had been given 20 days cellular confinement. In her opinion:

> "… the self harm incident[s] of the previous night were token gestures, made in an effort to get his own way."

111. The first governor said that two of the adjudications that morning involved prisoners who were in the segregation unit. The man was one of them and his adjudication was one of the last to be held although it was completed before lunch time. (All adjudications at Leeds take place in the segregation unit.)

112. The fourth nurse explained to my investigators that since the introduction of PSO 2000, The Prison Discipline Manual, a new screening tool had been devised for medical staff to fit prisoners for adjudication. At Leeds this information is recorded on a document called Adjudication Concern Screening. He said that staff in the segregation unit send the medical clerk a list of all prisoners who are to be adjudicated on that day. Nurses check the medical records of prisoners to see if there were any concerns. He said that, although he noted the entry by the fifth nurse the previous day entitled mental and behavioural problems, he believed the man would have understood the adjudication process. The fourth nurse recorded that there were no concerns which the adjudicator should be aware of before the start of the hearing.

113. The fourth nurse confirmed that he had not seen the entry by the mental health nurse, made that day. He said he did not record the scratches the man had made to his arms the previous evening on the adjudication screening form because:

> "Personally I had no issue because one, he didn't show that he was going to try and kill himself and two, he was fit to sit in front of the Governor to be adjudicated."

In his police statement, the fourth nurse said:

> "I collected all the inmate medical records in respect of inmates located on the segregation unit from the medical records office together with a list of names. I then checked all the records with regard to any mental or medical issues each individual might have. I ticked the form 'no' on each name which indicated that there were no issues of note. I then went to the segregation unit with the completed form. Which I signed and gave it to an officer on the unit. I had no knowledge of any incidents that occurred through the night in respect of any names on the list."

He also said in this statement:

> "I did not know the man had self harmed. Even if I had, I would not have altered my opinion that he was fit for adjudication. But I would have documented the brief details of

the incident on the column marked ‘details’.”

114. The fourth prison officer and a fifth prison officer had been assigned adjudication duties that morning. The fourth prison officer told my investigators that he went to collect the man for the adjudication but the man said he did not want to attend.

115. In her police statement, the first governor explained that the adjudication proceeded without the man. She said that she read out the evidence of the second prison officer as recorded on the Notice of Report. The second senior officer read out the man’s conduct report. It is unclear whether the charge against the man was for refusing to transfer to Ranby or for refusing to return to his cell. However, the governor said that it was clear in her mind that the charge stood as the man had refused to transfer to Ranby. This conclusion was drawn from the officer’s evidence and what she had been told about the reasons for the man’s presence in the segregation unit. The governor found the charge proved and the man was given a punishment of 14 days cellular confinement. A previously suspended punishment of six days cellular confinement was added, giving the man 20 days cellular confinement.

116. The governor told my investigators that this was only the second time she had carried out adjudications. She was not aware that the man had self-harmed the previous evening. The governor thought none of the segregation unit staff knew either, as nothing had been entered in the unit observation book. The governor explained that she would not necessarily know if a prisoner was on an ACCT before an adjudication. However, she said that she would check before sanctioning the use of cellular confinement, expecting to have been informed by the nurse who carried out the algorithm.

117. The fourth prison officer took the paperwork informing the man of the outcome of the adjudication and punishment to his cell. In his police statement, the fourth prison officer said that the man said nothing. He believed the man remained in his bed and appeared not to be bothered by the punishment. It was at this point that the fourth prison officer noticed a number of superficial marks on the man’s arms that appeared to have been self inflicted.

118. At 12.10pm, the second nurse was called to the segregation unit in order to assess the man’s fitness for cellular confinement. (A punishment of cellular confinement cannot be imposed unless a medical practitioner or nurse has completed an assessment.) The second nurse told my investigators that when she saw the man she noticed the scratches that he had made to his arms and asked him about them. The marks appeared to be consistent with self-harm. The man confirmed that he had self-harmed. She recalled that the man did not really want to talk. He was “stroppy” and in quite a “bad mood”, but was not personally abusive. The second nurse said that when she left

the man:

> "…he turned over on his bed, he was resting on his bed, turned over on his bed with his back to me, which was kind of like, 'yeah I don't want to talk to you anymore'."

The second nurse said that when she saw the man he did not appear to be "…withdrawn or depressed or acutely unwell…" Although she could not remember telling any one specifically about the scratches to the man's arms, there were two officers present who would have heard her conversation. The second nurse recorded on the algorithm that the man had self harmed during his current period of custody. She added that his mental state would not deteriorate significantly if segregated and that he showed no signs of being acutely unwell at the present time. She said at interview:

> "… his behaviour seemed normal to me, as a Registered General Nurse, there was nothing about his behaviour that struck me as abnormal or unusual … [He] also denied to me, having any further wishes to self-harm or commit suicide, so from that point of view I was satisfied".

The second nurse told my investigators that she was not aware that a period of segregation should be noted in the prisoner's medical record or that an ACCT booklet should be opened after an act of self harm.

119. The first governor signed the segregation safety algorithm at 12.20 am. She recorded that the man was suitable for cellular confinement and should be segregated as per the adjudication punishment. In her police statement, the first governor said she only became aware that the man had self harmed after he had died.

120. In his police statement, the fourth prison officer said that the nurse did not mention anything about the marks on the man's arms which could be clearly seen. The fourth prison officer said that he was "quite disturbed by this". The second nurse told the police she did not make any entry on the man's medical record as she felt that the algorithm explained it all.

121. That afternoon, an officer wrote in The man's history sheet that he:

> "Got out of bed to put his plastics out, wouldn't speak to staff when asked if ok."

122. At 5.00pm, the first prison officer had issued the man with an F1127B, Notice of Report form, for having "smashed" up his flask the previous evening.

123. The fourth prison officer told the police there were no incidents of note that afternoon. The man was on hourly checks because of his cellular

confinement. At about 5.30pm, the man was heard to be kicking or throwing his cup and bowl around his cell so they were removed. The fourth prison officer told my investigators that the man seemed a very angry person. The fourth prison officer said he was later asked to give assistance to colleagues on D wing.

124. In his statement to police, the first prison officer said the man's cell door was opened at about 5.30pm and he was given his tea. The man asked about having a flask of hot water for the night but was told there was not one to give him because he had smashed his previous flask the night before. The first prison officer said that the man swore at staff, and began to shout and make a lot of noise. The man's cup and bowl, which he was throwing around, were then removed. I note that although these items were apparently removed from the man's cell, at the time of his death a plastic plate and fork were present.

125. The last entry in the man's history sheets was made by the first prison officer. He recorded that the man:

> "Took tea meal, [the man] became abusive to staff because he had not been given a flask."

During his interview with my investigators, the first prison officer was unable to recall the exact details of the contact he had with the man that afternoon. He could remember that he had given the man the notice of report and that the man had been abusive when not given his flask.

126. In his police statement, the first prison officer said that he believed that he had done the evening checks, but did not sign the entry for 8.00pm on the man's hourly watch cellular confinement record. However, the first prison officer said he did check the man's cell and recalled that he saw him lying on his bed. The man was on his side and just looked at the first prison officer before looking away. The man did not give him any cause for concern at that moment.

Events leading to the man's discovery

127. The fourth prison officer told my investigators that it was probably between 6.15pm and 6.30pm when he left the segregation unit to assist other staff on D Wing. At about the same time the sixth prison officer was ordered to assist with a hospital escort. The first prison officer was left working alone in the segregation unit.

128. At about 7.30pm, The OSG arrived in the segregation unit to prepare for his nightshift. Only the first prison officer was on duty when he arrived. The first prison officer briefed him that, if the man asked why he did not have a flask, it was because he had broken one the previous day. Apart from this, the first prison officer said that it had been a quiet day. The OSG told police that after telling him about the smashed

flask, “the first prison officer then went and opened the fire hydrants and relevant gates as per night patrol conditions.” The OSG said, “I don’t know whether he did his last checks of the prisoners as I didn’t see him do it.”

129. The OSG said that after the first prison officer did his final round he returned to the office at about 8.00pm. The first prison officer told the OSG that he was going to the centre of the prison in order to report segregation unit numbers for the final roll call. After giving in the numbers, the first prison officer returned to the segregation unit, collected his things and left.

130. The first prison officer told my investigators that he commenced his final checks of the segregation unit at around 7.55pm. This included opening gates, unlocking the fire hydrants and counting the prisoners. The first prison officer said that he gave his numbers for the final roll check just after 8.00pm, before returning to the segregation unit, collecting his bag and leaving via the First Night Centre.

131. The OSG told my investigators that, once the day staff had left, he would check the doors and locks to the cells himself, as well as checking the number of prisoners on the unit. The OSG began his checks at 8.05pm. The last cell he checked was the man’s. Although the cell light was off, The OSG could see a silhouette at the back of the man’s cell. He tried to get the man to respond.

132. Failing to get any response, The OSG tried to summon Oscar 1 on his radio, but the battery was dead. He then went to the office to get a spare battery, but that too was flat. (My investigators were told by the OSG that he would often have to change the batteries in his radio two or three times a night.) He then phoned the control room and asked for Oscar 1 (the orderly officer) to attend the segregation unit immediately.

133. The Duty Governor, and the principal officer attended. The OSG shouted to the officers congregating at the centre of the prison waiting to go home for further assistance. The OSG then went to the office, collected the ligature scissors and returned to the man’s cell. The man had already been cut down. The OSG took no further part in the efforts to revive him.

134. At 8.00pm, the principal officer was located on the prison centre to start the process of confirming the prison roll. This takes 10 to 15 minutes. the principal officer said that, at about 8.10pm when the roll call was still in progress, the alarm was raised over the radio for Oscar 1 to attend the segregation unit. He and the duty governor who was standing behind him at the time, immediately walked down the stairs leading from the centre to the segregation unit. The principal officer said he was told by the OSG that he could get no response from the prisoner in cell S1 31, and that he was unable to turn the light on. The principal officer checked and saw that the man was motionless at the

back of his cell.

135. The principal officer immediately opened the cell door. He described the cell as being, "… a very sparse cell, nothing much in there at all". He said that the man was hanging with a ligature around his neck, and was suspended from the window bars. The duty governor then activated his personal alarm.

136. The principal officer took the weight of the man's body by lifting him and shouted for a pair of ligature scissors. The fourth prison officer, the second person to enter the cell, assisted in supporting the man. The ligature was then cut by the seventh prison officer. The principal officer said that the man was still warm and flaccid when he was placed on the bed. The Fourth prison officer immediately checked for a pulse and chest compressions were started. The principal officer said that a nurse quickly attended and checked the man's airways before commencing full cardio pulmonary resuscitation (CPR). The principal officer said that there were a number of nurses in attendance at this point. An automatic external defibrillator (a machine used to assist in restarting the heart) was attached to The man, but it advised not to shock.

137. In his police statement, the fourth prison officer said that whilst on the centre at about 8.05pm he heard the call for assistance from the duty governor. He said he ran down to the segregation unit and saw the duty governor and the principal officer standing outside the man's cell. The fourth prison officer said that he followed the principal officer into the cell and assisted him in taking the man's weight. The seventh prison officer cut the ligature from around the man's neck with a ligature knife (a safety blade used to cut ligatures quickly), and the man was placed on the bed. The seventh prison officer took no further part. The fourth prison officer said that he continued to assist nursing staff with CPR until told to stop by the prison doctor.

138. The fifth nurse was cleaning the medical centre when the alarm was raised. The fifth nurse and the sixth nurse were told by an officer that a prisoner had been found hanging in the segregation unit. The fifth nurse attended immediately. On her arrival at the cell she found an officer giving the man cardiac massage. The fifth nurse checked for vital signs and prepared to carry out mouth to mouth resuscitation. She said that the man's body was still warm to the touch.

139. At this point, three other nurses attended, bringing with them emergency equipment. Chest compressions continued whilst staff attempted to get air into the man. One of the nurses said that CPR had commenced by the time of her arrival. She said a defibrillator had been attached to the man and that the third nurse was trying to fit an airway. Another nurse also assisted the nursing team with CPR.

140. The prison doctor told my investigators that at 8.17pm he was informed by an officer that he was required urgently in the segregation unit. The prison doctor arrived on the unit at about 8.20pm to 8.25pm. He said he found members of medical staff and non medical staff in attendance, administering CPR to the man. The prison doctor said he felt the man had been dead for some time as he was not warm to the touch. However, he let staff continue to administer CPR. This was confirmed by the principal officer who told police that the prison doctor entered the cell when staff were administering CPR to the man. He said that the prison doctor had said the man was dead, but to carry on with CPR until the paramedics had confirmed death. However, shortly before the arrival of paramedics, the prison doctor told staff to discontinue.

141. Paramedics arrived at 8.30pm. One of the Yorkshire Ambulance Service paramedics, confirmed that CPR had ceased when he arrived at the man's cell. The paramedics left the prison when it was clear that death had occurred.

142. The first prison officer told my investigators that he had gone off duty by the time the man was found in his cell. The first prison officer said the man "was fine" when he left the unit at 8.00pm. He said:

> "… I was there 'till eight o'clock, I went down, I checked on everybody before I left, looked through to make sure, obviously for the roll count and everything and put the numbers in and left."

143. When the night orderly officer came on duty around 8.20pm, staff were still waiting to be released from the centre. He said that Oscar 1 would give permission for staff to leave early if they had good reason.

Events after the man's death

144. The OSG remained on duty in the segregation unit and was not asked to complete a report about his involvement or to attend the hot debrief. Incident reports from a number of healthcare and discipline staff were also not completed.

145. A second Family Liaison Officer at Leeds, was contacted and informed of the man's death at 9.00pm. Accompanied by four police officers, the second Family Liaison Officer and the duty governor and Sister from the chaplaincy visited the man's mother at about 2.15am on the morning of 20 April to inform her of her son's death. The man's father was told at 3.00am.

146. The Family Liaison Officer, attended the man's funeral on behalf of the prison. Leeds made a contribution of £1,000 to the costs of the man's funeral. However, it was a number of months before the funeral

expenses were finally settled by the prison.

147. West Yorkshire Police attended the prison. The Scenes of Crime Officer took photographs of the man and the cell in which he had died. A number of photographs show around 20 cuts to each of his forearms. Some of the cuts are up to four centimetres in length and indicate a recent act of self harm.

Toxicology, Post Mortem and Clinical Review

148. The post mortem report completed by a forensic pathologist, recorded that the man had:

> "...multiple recent superficial parallel incised wounds on the back of the right forearm extending down from the elbow towards the wrist, and there were a couple of marks also on the back of the wrist. Much older scars were present on the inner aspect of the forearm extending down from the ante cubital fossa to the wrist, again parallel marks. All these appear to be marks of self harm."

149. The forensic pathologist noted that on the man's left arm there was:

> "… virtually exactly the same pattern of distribution of self harm marks with much more recent ones present on the outer aspect of the forearm and older ones present on the inner aspect".

150. He concluded:

> "The pathological findings are those of hanging, consistent with the bed sheets used. The appearance and distribution of the ligature mark are typical of being self inflicted. There was evidence on the deceased of previous attempts at self harm."

151. Toxicology tests completed on the man returned a negative toxicological screen.

152. A Clinical Review was conducted by a Director of Public Health at Leeds West Primary Care Trust. In his review, the doctor concludes that both written and electronic medical notes relating to the man were clearly recorded.

153. The clinical reviewer draws attention to the difference in timings recorded by different participants. He comments that timings in such situations should be recorded as carefully as possible. The clinical reviewer judges that the medical care provided during the attempted resuscitation of the man was entirely appropriate.

154. With regard to the injuries the man inflicted on himself, the clinical reviewer says:

> "The man was seen by a nurse in segregation after he had superficially injured his arms. Although this was recorded on an F213SH no entry was made in the IMR or EMIS [The man's medical records]. It is important that all clinical interactions are recorded in the clinical records. However, there is no evidence to suggest that failure to record some information led to inappropriate care."

155. The clinical reviewer observes that the man was seen by the doctor on each occasion he was admitted to the segregation unit. However, he highlights that the recording of such contact was not particularly clear and that EMIS was not used. The clinical reviewer says:

> "The GP is required by Prison regulations to see a prisoner in segregation every 72 hours. Segregation is a difficult environment within which to work and a 'superficial chat' from the cell door is not a particularly effective means of assessing a prisoner. It could provide false re-assurance and is not an effective use of medical time. All interactions by healthcare staff with prisoners must have a clear context in terms of identifying and meeting needs. A more systematic assessment of physical and mental health needs could be undertaken and recorded in EMIS by the nurses and referral made to the GP if necessary. This should include unwillingness of the prisoner to take part in the assessment as well as describe constraints on the assessment process."

The clinical reviewer makes two recommendations:

Healthcare staff should review the purpose of assessing prisoners in segregation. A more systematic process of assessment and recording of results needs to be developed. This should be done on the basis of the most effective use of staff skills and competencies.

Healthcare staff should be reminded that all clinical interactions with prisoners must be recorded in the IMR and preferably on the EMIS system.

156. I concur fully with the clinical reviewer's recommendations. However, it is apparent from my investigation that on many occasions healthcare staff are asked to attend the segregation unit at short notice. As a consequence, they appear not to have access to prisoner's health records when completing assessments. The man had significant contact with healthcare staff when in the segregation unit. However, most was never formally recorded on his medical records, either electronically on EMIS or manually. The lack of access to the EMIS system by healthcare staff would be one contributing factor. I make the following recommendation in respect of access to medical records:

The Prison Health Partnership should consider the possibility of providing a terminal linked to the EMIS system either in the segregation unit or nursing station in the main prison.

157. The clinical reviewer says that the man's assessments by medical staff were mindful of his needs and he concludes there were no significant omissions in his care. The clinical reviewer notes that it is not possible to say if the man's behaviour was related to the illicit use of Buprenorphine (Subutex) and the potential transfer to Ranby.

158. During the investigation, my investigator contacted the clinical reviewer on a number of occasions. He asked the clinical reviewer to look at the man's prescription of amitriptyline over the previous five years, and the effect this may have had upon him. In response, the clinical reviewer said that the man was not on amitriptyline when he went to Leeds and there was nothing in his clinical assessment to suggest that he should have been. He said that the policy at Leeds was not to use the drug because of its toxic profile in overdose situations. The clinical reviewer said that the man's main concern at this stage was to get on the detox regime.

159. My investigator asked the clinical reviewer to look at what action staff took when the man missed the last two doses of Subutex which he was receiving as part of his detox programme. The clinical reviewer said that missing the final treatments of his detox regime was unlikely to have had a significant impact on the man. Prisoners had a personal responsibility for their health. Failure to turn up for medication usually did not warrant follow up unless staff had particular concerns. The clinical reviewer said that this had to be seen in the context of some 7,000 prescribing interactions per week.

160. The clinical reviewer was asked to explore healthcare staff's awareness of the man's history of self harm and depression and the RMN screening on the day of the man's death. My investigator asked the clinical reviewer whether adequate consideration had been made with regard to the man's suitability to remain in the segregation unit on 19 April. The clinical reviewer said that the mental health assessments of the man were undertaken by a qualified and experienced member of staff. The recording of information was sufficient to convey the outcome of the assessment undertaken. The clinical reviewer noted that:

> "Delay of 20 days between closure of the ACCT on the 9th and being seen in the review clinic is longer than staff would like but not inappropriate in a routine situation. It compares well against NHS waiting times.".

The clinical reviewer concluded that the review and suggested follow

up were not inappropriate.

161. The clinical reviewer was asked to comment with regard to the considerations taken by healthcare staff in deciding whether to open an ACCT after the man's self harm on the evening of 18 April. Although not included in his initial report, in his e-mail response to my investigator on 22 August, the clinical reviewer said:

> "I agree an ACCT should have been started on the 18th but my understanding is that this should [have] been undertaken by the person finding the injuries. This has to be seen in the context of on average 2 episodes of self harm per day in the prison (inflicted for a variety of reasons)."

162. I am very grateful to the clinical reviewer for his assistance. However, I recall that following the death of another prisoner at Leeds in August 2004.he wrote to me saying that his investigation into clinical care could not be independent as Leeds West Primary Care Trust employed a number of staff at HMP Leeds and he was the line manager of the Head of Healthcare at the prison. I drew this concern to the attention of the PCT at the time and must repeat it here.

Leeds West Primary Care Trust should ensure that any apparent conflict of interest is minimised when appointing a clinical reviewer.

ISSUES

The man's movement to the segregation unit

163. On the morning of 18 April 2006, the man refused to return to his cell on C wing, having explained to officers that he would not transfer to Ranby because of debt. The man told staff they should take him to the segregation unit.

164. Given the man's refusal, staff had little choice but to escort him to the segregation unit. The segregation unit observation book and segregation safety algorithm record that the man was located in the segregation unit under Prison Rule 53, pending adjudication. Staff recorded in his history sheet that it was under Rule 55, cellular confinement.

165. The man's history sheet records that he was placed in the segregation unit under Rule 55, cellular confinement. It is possible that Rule 55 was recorded by staff in error. However, on 18 April, the OSG appears to have been under the impression that the man was serving a period of cellular confinement. He told police that he had checked the man between 8.00pm and 8.30pm as the man was subject to cellular confinement.

166. The reason for the man's transfer to the segregation unit had no direct bearing on his death. However, it is of concern that some staff at Leeds were uncertain as to which prison rule applied. It is also disappointing that, for both occasions that the man was segregated, staff have been unable to provide my investigators with the paperwork informing him of the reason.

    The Governor should ensure that all staff and governors, in particular those working in the segregation unit, are aware of the prison rules which relate to the authorisation of a prisoner's transfer to the segregation unit, ensuring that the correct and appropriate rule is applied to individuals.

167. The man arrived in the segregation unit at approx 11.00am. Applications by prisoners on the unit had already been made at 7.30am. As already explained, this is the one time each day when prisoners can formally make applications on the unit.

168. I draw attention to the inspection report on Leeds by HM Chief Inspector of Prisons. Ms Owers describes the segregation unit as being "run in a militaristic fashion…" and the applications process may provide an example of this. However, I do note that the first governor told my investigators that staff had discretion whether or not prisoners were allowed to make applications after 7.30am. She added that the ability to make applications was dependent on the individual's

circumstances and the time he arrived.

169. Staff in the segregation unit at Leeds were unable to provide my investigators with any record that the man either made any applications during his first day on the unit, or that he was invited by staff to do so. I appreciate that, subject to staff discretion, prisoners are able to make applications in the segregation unit after formal applications are made at 7.30am. However, I make the following recommendations.

The Governor should review the way in which applications are made by prisoners in the segregation unit and consider introducing formal procedures which allow prisoners, when appropriate, to make applications after 7.30am.

Conditions of cell

170. On 18 April, the man was placed in a regular cell in the segregation unit. This contained nothing more than a bed and a cardboard chair. PSO 1700 on Segregation states that normal cells in segregation units should be:

> "… well lit and equipped to a standard similar to that found on normal location within the prison (this includes integral sanitation, in-cell electrics and TV aerial points). Any restriction of facilities (e.g. cardboard furniture, no in possession lighter) is supported by a risk assessment."

Staff at Leeds were unable to provide a risk assessment outlining the justification for there being just one cardboard chair in the man's cell.

171. At the time of the man's death, nearly all the furniture contained within the cells in the segregation unit at Leeds was cardboard. However, my investigators told me that, when they visited Leeds during the course of their investigation, cell furniture on the unit was gradually being replaced by furniture similar to that found in other areas of the prison.

172. When the man was moved to the segregation unit he had not been charged with breaking any prison rules. As such, he was entitled to the same level of privileges as he was whilst located on C wing. The man was not treated in this way.

173. The cell the man occupied on C wing had been cleared of his possessions as the consequence of a request by staff in the segregation unit. However, the few possessions that the man had were not passed onto him. He had nothing to occupy him in his cell in the segregation unit. He was given no TV or radio (to which he would have been entitled as a standard prisoner), no reading material, pen, paper or indeed any of his own possessions. At the time of his death, there was nothing in the man's cell other than his bed, cardboard chair, plastic plate and what appears to have been the remainder of his

breakfast pack.

174. It is clear to me that on 18 April, the day on which the man self harmed, he was serving what can only be described as a period of cellular confinement without privileges. This is very disturbing.

The Governor should ensure that all cell furniture in the segregation unit is comparable with that found in cells on normal location. Cardboard furniture should only be used when supported by a risk assessment in line with PSO 1700.

The Governor should ensure that those prisoners transferred to the segregation unit are provided with any possessions and activities to which their privilege level entitles them.

The man's attempt at self harm on 18 April

175. As noted, on the evening of 18 April, the man was located in a cell containing only a bed and cardboard chair. It may be that in order to alleviate the boredom that he requested a newspaper. The OSG advised the man that there was none to give him, although I understand that a small library is available to prisoners on the segregation unit. At 10.30pm, The OSG gave the man a supplement from his own newspaper. It was at this time that the man drew the OSG's attention to the marks he had made to his arms.

176. The nurse was called to see the man. She said that the man's injuries were "numerous but very minor". As there was no blood or weeping skin, she advised the man that she was unable to dress his wounds. The nurse told my investigators that she could see on the man's arms, "… old scarring from other marks that he had made …" the night orderly officer said that he had been called to the segregation unit because a prisoner had self harmed or had threatened to self harm.

177. Given the evidence presented to my investigators, and having had the opportunity to view photographic evidence from West Yorkshire Police, it is clear to me that the man had self harmed on the evening of 18 April. This had been acknowledged by staff themselves in the completion of an F213SH. I am therefore very surprised that not one of the three members of staff, one a trained ACCT manager, opened an ACCT document. This was despite the fact that the man had made many cuts to both his arms, was to all intents and purposes serving a period of cellular confinement, had a history of self harm and was located in the segregation unit.

178. I am also troubled by some of the responses of the nurse to my investigator's questioning. I believe they may reveal insufficient understanding of the needs of prisoners in vulnerable situations. In one response she said that the man's attempt to self harm was not serious but a protest about not getting a newspaper. I believe that the

night orderly officer also showed a lack of judgement in believing that the man had not self harmed.

179. The Prison Service definition of self harm as outlined in PSO 2700 Suicide and Self Harm Prevention, 3.1.1 is that:

> "… 'self harm' is any act where a prisoner deliberately harms themselves irrespective of the method, intent or severity of any injury".

Paragraph 3.1.2 goes on to say:

> "An act of self harm should always be taken seriously. Even if the prisoner appears to be using self harm as a means of gaining something, it is still a desperate act and the prisoner should be helped to find constructive ways to meet the underlying need."

180. Prison Service Instruction 18/2005, says at appendix C, section 2:

> "In the event of any incident of self-harm, or whenever a member of staff believes a prisoner/trainee is at risk of suicide or self-harm, they must (where there is not one open already) open an ACCT plan."

Leeds's own policy document on self harm clearly reflects this guidance. It says, "An ACCT will be opened in respect of any prisoner who self-harms."

181. I believe that the staff who responded to the man on the evening of 18 April made a serious misjudgement in not opening an ACCT document.

182. I would add that the man was seen by a number of staff the following day. These included the prison doctor, nurses and discipline staff. Some were aware of the man's self harming or had been informed of it by the man himself. Although some gave consideration to opening an ACCT, none thought it necessary.

The Governor of Leeds should remind all staff of their obligations under PSO 2700 to open an ACCT on any prisoner who self harms.

183. I draw attention to my report into the death of a prisoner in the Leeds segregation unit in August 2005. In that report my investigators established that the ability of staff to detect those prisoners at risk of self harm was limited because of the nature and restrictions imposed by the unit. I said that staff had few meaningful interactions with prisoners and recommended that the Governor should take advice from the Prison Service's Safer Custody Group (the part of the National Offender Management Service (NOMS)). This was to ensure that self

harm training included awareness of issues arising from an individual's circumstances and location especially in the segregation unit. Whilst I make no formal recommendation, I draw this to the attention of the current Governor**.**

Staff Handover

184. The nurse said that, during her handover to nursing staff on the day shift, she had explained everything that had happened through the night, making reference to the healthcare observation book. The nurse said that the fourth nurse would have been present at the handover.

185. The fourth nurse said that he was aware of the 'superficial scratches' that the man had made. In his police statement, he said that he did not see the nurse who had been on nights, but received the handover from another nurse whose name he could not recall.

186. My investigators have been unable to establish conclusively who was present during the healthcare handover, or what information was provided to nursing staff on the morning of 19 April.

The Prison Health Partnership must ensure that nursing staff are aware of their duties during shift handovers. When nursing staff hand over a shift, a record of the handover should be made in the healthcare observation book.

187. Additionally, no record was made by the OSG in the segregation observation book, or in the man's history sheets, that the man had self harmed or that an F213SH had been completed. The OSG said that he did tell staff that the man had been seen by a nurse in the night, but could not recall to whom he spoke. Staff told my investigators that the man's attempt to self harm was not discussed at the segregation unit morning meeting on 19 April.

188. It was unsatisfactory that the man's actions were not recorded appropriately by discipline staff. Significant events, such as attempts of self harm, must be discussed and recorded appropriately.

The Governor should remind segregation unit staff of the need to keep accurate and comprehensive records. Additionally, the Governor should remind night staff of the importance of providing staff coming on duty with significant information.

Adjudication

189. The man was fitted for adjudication by healthcare staff in accordance with Prison Service instructions and guidance. However, the fourth nurse did not record that he had self harmed the previous evening. He wrote that he did not know of any reason why the man's adjudication should not proceed. He did not draw to the governor's attention the

man's act of self harm the previous evening despite having been made aware of this during the shift handover.

190. The man's adjudication took place late on the morning of 19 April. The first governor told my investigators that she had been unaware of the man's actions the previous evening. She said that, had she been aware of the man's attempt to self harm, she would have considered it prior to the adjudication. The first governor agreed that the man's adjudication had not been conducted in the appropriate manner.

191. The first governor told my investigators that 19 April was only the second time that she had conducted adjudications. I have studied the adjudication record made by the first governor and note that there are some significant procedural flaws. These include not completing section 12 of the record indicating the man's plea, and not adhering to the guidance laid out in chapter 4.3 of PSO 2000 on how to conduct an adjudication in a prisoner's absence. Additionally, the officer who had laid the charge was not summoned to give evidence in person.

192. None of us is on top of any task the second time we carry it out. And I intend no personal criticism of the first governor. However, the evidence may indicate that she had not received adequate training in order to conduct adjudications. I recommend that:

The Governor should satisfy himself that all governors have received adequate training before conducting adjudications.

Discovery of the man

193. After his adjudication on 19 April, the man was checked hourly by segregation unit staff because he was on cellular confinement. These checks were recorded by staff on a cellular confinement watch sheet. At about 6.30pm, two of the three officers remaining in the segregation unit were asked to complete alternative duties elsewhere. The first prison officer was left alone in charge of the segregation unit. At 7.30pm, the OSG arrived. At around 7.55pm, the first prison officer commenced his final checks of the unit and reported his final numbers for the roll call just after 8.00pm, before returning to the unit to collect his bag and leave. The first prison officer did not sign the man's hourly watch sheet confirming that he had checked the man at 8.00pm. However, he did tell the police and my investigators that the man was fine when he left the unit at that time.

194. The OSG did not see the first prison officer make the final checks on the segregation unit. However, The OSG conducted his own check at 8.05pm during which he discovered the man hanging in his cell. At this time, the first prison officer was leaving the prison although the final roll had not been confirmed.

The Governor should remind all staff that, unless given the

authority to do so, no member of staff should leave the establishment until the final roll has been confirmed.

195. I concur with the clinical reviewer's finding that the medical care provided during the attempt to resuscitate the man was entirely appropriate.

Communication

196. My investigators have reported to me on the quality of record keeping in the segregation unit. Entries on the wing history sheets were generally of a poor quality. It would also appear that only the required standard three entries are being entered on a daily basis. As mentioned, staff were unable to provide my investigators with requested information. I also understand that staff visiting the unit are not regularly signing in and out as required by PSO 1700.

The Governor should remind segregation unit staff of PSO 1700 and the importance of keeping auditable, accurate and comprehensive prisoner and unit records.

197. My investigators were frustrated by the lack of information provided by Leeds as to why the CCTV cameras in the segregation unit were not in operation at the time of the man's death. Staff were unable to clarify when the camera's had stopped working. They were unable to say why this had occurred or confirm when the cameras were reinstated.

The CCTV cameras should be checked by a governor on a regular basis. A record of these checks should be kept and entries made if the cameras are not operating.

198. Upon discovering the man, the OSG went to use his radio to summon assistance. The batteries were flat, as was a second set he tried to use. The first governor told my investigators that she was not aware of the problems with regard to flat radio batteries. Neither had any staff drawn the problem to her attention.

199. During my investigation into the death of a prisoner who died in the segregation unit at Leeds in August 2004, I was told that the failure of officers' radios was a regular occurrence. I understood that the matter was being discussed at a high level within the prison. In my report I recommended the Governor ensure that staff have functioning radios. I repeat that recommendation.

The Governor should review procedures to ensure staff have fully functioning radios in all parts of the prison.

200. Staff in the segregation unit said that, because the man had been kicking his plastics around his cell, they were removed on the afternoon of 19 April. It would appear that some plastics were

removed. However, photographs indicate that a plate, and what appears to be a fork, were left in the cell. However, what is certain is that the man was left with nothing from which to drink.

201. At the time of the man's death, the segregation unit was patrolled by an OSG who was based solely on the unit. When necessary, support was sought from other officers in the prison. The OSG told my investigators that this had now changed, and that for most of the time during nights an officer is on duty in the segregation unit in addition to having responsibility for A wing. This issue was also raised in my report into the segregation unit death in August 2004.

    The Governor should ensure that at least one officer is routinely detailed to work and is based in the segregation unit at night.

202. I also note that during the early evening on 19 April one officer was left in charge of the segregation unit. I appreciate there are times when officers have to be redeployed to other areas of the prison. However, I would ask the Governor to give careful consideration when redeploying staff from the segregation unit.

Action taken after the man's death

203. The second prison family liaison officer, the Sister from the chaplaincy, and the duty governor broke the news of the man's death to his mother at her home in Hull. During her meeting with my staff, the man's mother explained that being told of the man's death was obviously upsetting and had not been helped by having four police officers present in addition to Prison Service staff,.

204. The OSG remained on duty after the man was discovered and he was not asked either to attend the hot debrief or to submit an incident report. In my report into another death in August 2004, I reminded the Governor that all staff should be seen for a hot debrief before going off duty.

    The Governor should ensure all staff involved in the death of a prisoner submit an incident report form, and should attend the hot debrief before going off duty.

205. Although the majority of staff felt that their welfare needs had been addressed, a number said that approaches from the staff welfare team had been unsatisfactory, and that management at the prison had not thanked them for their efforts. I draw this to the Governor's attention.

RECOMMENDATIONS

Healthcare staff should review the purpose of assessing prisoners in segregation. A more systematic process of assessment and recording of results needs to be developed. This should be done on the basis of the most effective use of staff skills and competencies.

No Response - Response from HMP Leeds to follow.

Healthcare staff should be reminded that all clinical interactions with prisoners must be recorded in the IMR and preferably on the EMIS system.

Accepted – Full response from HMP Leeds to follow.

The Prison Health Partnership should consider the possibility of providing a terminal linked to the EMIS system either in the segregation unit or nursing station in the main prison.

Accepted – Full response from HMP Leeds to follow.

Leeds West Primary Care Trust should ensure that any apparent conflict of interest is minimised when appointing a clinical reviewer.

No Response - Response from HMP Leeds to follow.

The Governor should ensure that all staff and governors, in particular those working in the segregation unit, are aware of the prison rules which relate to the authorisation of a prisoner's transfer to the segregation unit, ensuring that the correct and appropriate rule is applied to individuals.

Partially Accepted – HMP Leeds responded that PSO 1700 and PSO 2000 authorised segregation under Rule 53 from the time of the offence pending adjudication. A copy of each PSO is held in the segregation unit. The principal officer in charge of the unit will affix posters to remind staff of relevant rules and paragraphs for segregation.

The Governor should review the way in which applications are made by prisoners in the segregation unit and consider introducing formal procedures which allow prisoners, when appropriate, to make applications after 7.30am.

Accepted – Full response from HMP Leeds to follow.

The Governor should ensure that all cell furniture in the segregation unit is comparable with that found in cells on normal location. Cardboard furniture should only be used when supported by a risk assessment in line with PSO 1700.

Accepted – Full response from HMP Leeds to follow.

The Governor should ensure that those prisoners transferred to the segregation unit are provided with any possessions and activities to which their privilege level entitles them.

Accepted – Full response from HMP Leeds to follow.

The Governor of Leeds should remind all staff of their obligations under PSO 2700 to open an ACCT on any prisoner who self harms.

Accepted – Full response from HMP Leeds to follow.

The Prison Health Partnership must ensure that nursing staff are aware of their duties during shift handovers. When nursing staff hand over a shift, a record of the handover should be made in the healthcare observation book.

Accepted – Full response from HMP Leeds to follow.

The Governor should remind segregation unit staff of the need to keep accurate and comprehensive records. Additionally, the Governor should remind night staff of the importance of providing staff coming on duty with significant information.

Accepted – Full response from HMP Leeds to follow.

The Governor should satisfy himself that all governors have received adequate training before conducting adjudications.

Accepted – HMP Leeds responded that no adjudicator is allowed to undertake adjudications without having attended the relevant course. However, arrangements are being put in place to better support adjudicators new to the role by shadowing more experienced members of staff as part of their induction.

The Governor should remind all staff that, unless given the authority to do so, no member of staff should leave the establishment until the final roll has been confirmed.

Accepted – Full response from HMP Leeds to follow.

The Governor should remind segregation unit staff of PSO 1700 and the importance of keeping auditable, accurate and comprehensive prisoner and unit records.

Accepted – HMP Leeds say that a copy of each PSO is held in the segregation unit. The principal officer in charge of the segregation unit will affix posters to remind staff of relevant rules and paragraphs for segregation.

The CCTV cameras should be checked by a governor on a regular basis. A record of these checks should be kept and entries made if the cameras are not operating.

Not Accepted – HMP Leeds propose that a manager checks the CCTV, and not specifically a governor grade.

The Governor should review procedures to ensure staff have fully functioning radios in all parts of the prison.

Accepted – Full response from HMP Leeds to follow.

The Governor should ensure that at least one officer is routinely detailed to work and is based in the segregation unit at night.

Accepted for Review – HMP Leeds said that an exercise is underway to identify the resource implications of this recommendation.

The Governor should ensure all staff involved in the death of a prisoner submit an incident report form, and should attend the hot debrief before going off duty.

1. **Accepted**