Investigation into the circumstances surrounding the death of a man at HMP Leicester in June 2007

Report by the Prisons and Probation Ombudsman for England and Wales

September 2009

This is the report of an investigation into the death of a man at HMP Leicester in June 2007. The man was discovered suspended by a bed sheet from his cell window. Despite efforts to resuscitate him, he did not regain consciousness and was pronounced dead in his cell. He was 44 years old.

I offer my sincere condolences to man's family and to all those touched by his passing.

One of my Family Liaison Officers contacted the man's family to learn of the particular concerns they had about his death. I apologise for the delay in producing this report but I hope that it answers all of their questions.

The investigation was undertaken on my behalf by one of my Senior Investigators. On behalf of Leicester Primary Care Trust, an independent General Practice consultant and clinical assessor undertook a clinical review of the healthcare the man received whilst in custody. I would like to thank the Governor of Leicester and his staff for their help and co-operation.

The man's death, ten days after leaving HMP Peterborough, should be seen in the context of the problems that the prison system faces. He was vulnerable in that he had a serious mental illness, schizophrenia. He was recalled to Peterborough after being charged with further offences. He became settled after a month and was receiving appropriate medication. However, due to a court appearance, he found himself, unexpectedly, relocated first to a police station then to HMP Leicester under Operation Safeguard, the system for allocating accommodation to prisoners when prisons have reached capacity. I regret that Operation Safeguard did not live up to its name in this man's case. With the benefit of hindsight, it is clear that the man's risk of self-harm was substantially increased by this disruption.

The man had been prescribed medication at Leicester but he had not collected it for several days. Leicester's lack of clarity over whether it had done anything about this further highlights concerns expressed in previous PPO investigation reports about the quality of Leicester's healthcare provision.

The report makes nine recommendations which highlight the communication of healthcare information and accurate completion of Prisoner Escort Records in particular. The report highlights two areas of good practice.

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Deputy Prisons and Probation Ombudsman **September 2009**

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SUMMARY

In 1999, the man was sentenced to ten years imprisonment for attempted murder and possession of a firearm with intent. He had been diagnosed with schizophrenia in 1998. His condition was stabilised with medication. At times whilst he was in custody, he was severely mentally unwell. In 2003, he was monitored by staff after saying that he felt like harming himself. A document in his clinical record from 2005 said he had cut himself superficially at least twice and expressed suicidal ideas. He was released on licence in June 2005 but was recalled to prison six weeks later amid signs that he was not keeping appointments with medical practitioners and the probation service. He was released on conditional licence in December 2005. He was cared for in the community and his mental health was monitored at regular appointments with his mental health practitioner.

Following new allegations of threats to kill, the man was recalled to prison in April 2007. He was taken to HMP Peterborough where he remained until 22 May when he attended Peterborough Magistrates Court. The man's Prisoner Escort Record, a form which accompanies a prisoner whenever they leave an establishment, was not endorsed with details of his mental health condition or a request for him to return to Peterborough. As a result, he was taken to Daventry police station where he spent the night as there were no places at Peterborough. This was managed through Operation Safeguard, a system used by the Prison Service, police, courts and escort contractors, to manage the shortage of prison places by accommodating prisoners temporarily.

The next day, the man was taken to HMP Leicester. He was referred to the mental health in-reach team (MHIT) by the reception nurse. A nurse from MHIT did not contact Peterborough to obtain further information on the man but spoke instead to the community outreach team who had looked after him before and after his previous periods in custody.

As part of the reception process, the man underwent a Cell Sharing Risk Assessment (CSRA) which rated him as low risk. He shared a cell with two different prisoners in the First Night Centre where he stayed for seven days. Two days after his arrival, his risk was upgraded to 'high' and he was required to be in a single cell as a result of information received from Peterborough concerning his mental health.

At Leicester the man was prescribed Fluphenazine decanoate, a slow-release injectable anti-psychotic drug. He was also prescribed Olanzapine, an anti-psychotic drug but did not collect it for four days. The prescription chart in the man's clinical record was marked 'DNA' to indicate this. When his allocated nurse saw the man six days after he arrived in Leicester, however, he told her that he was taking his medication and he felt well.

The man moved from the First Night Centre to L4 landing on 30 May. He asked an officer whether he could have a cell mate because he was lonely but the officer explained that this was not possible due to his high risk level. The man repeated his request several times over the next two days.

When he was moved to L4, he had chatted and played table tennis with a prisoner he had shared a cell with in the First Night Centre. However, the next day, he did not collect his medication and he returned to his cell early, having told an officer that he did not like being in a crowd of people. The information that the man disliked being in a large group of people was in his record but was not known to landing staff. His cellmate told an officer that the man had sat with his head in his hands and would not communicate.

On 1 June, an officer spoke to the MHIT nurse just before lunch after noticing that the man was walking on the spot. The man said he would discuss whether he could have a cell mate with his MHIT nurse. After lunch, a prison nurse to the man’s cell to see him and found him suspended by a ligature. The man could not be resuscitated and was pronounced dead in his cell.

A clinical review was conducted on behalf of Leicester City Primary Care Trust. He found that the man was possibly in the early stages of a relapse of his schizophrenia. He made recommendations concerning the coding of medication not being collected on clinical records, staff protocols for following up uncollected medication and quick access to essential clinical information on a patient.

THE INVESTIGATION PROCESS

1. My investigator was given access to the man's prison records at Leicester and Peterborough including his medical record, statements from staff and other documentation.

2. Notices to staff and prisoners announcing the investigation were displayed around the prison. No responses were received. One of my investigators met representatives from the Independent Monitoring Board and the local branch of the Prison Officers' Association to offer them the opportunity to raise relevant issues.

3. The man's family was offered, and accepted, the opportunity to contribute towards the investigation process. One of my Family Liaison Officers, made contact with the man's family. They spoke positively of the kindness and support they had been shown by Leicester but had several concerns about the care the man had received at Peterborough in the past. The family expressed their concern that staff seemed unable to recognise from the man's behaviour that he had not been taking his medication. They had made several telephone calls to Peterborough in the past to find out whether the man was being prescribed and was taking appropriate medication. They queried whether healthcare staff were available to prisoners at all times.

4. The family also questioned the suitability of a prison environment for someone, like the man, with schizophrenia and asked whether prison officers would have been aware of the man's condition. They accepted that he had not given an indication that he was at risk of suicide so he was not subject to regular checks by staff. Nevertheless, they felt that due to his illness the man was subject to sudden and unpredictable changes in mood and behaviour which should have been taken into account. The family felt that the inability of prison staff to recognise changes in the man's behaviour was perhaps indicative of their general lack of understanding of his illness.

HMP LEICESTER

5. HMP Leicester is a local prison which receives adult men who have been remanded in custody or sentenced to imprisonment. It is a small city-centre prison dating from the 19th century which normally holds up to 392 prisoners mostly in shared cells but, like most local prisons, has experienced overcrowding. On the day the man died, however, there were 354 prisoners at Leicester. The main accommodation for prisoners is a four-storey cell block.

6. Her Majesty's Chief Inspector of Prisons inspected Leicester in 2003. An unannounced short follow-up inspection took place in August 2006. Her second inspection report summarised Leicester's performance as "disappointing", describing it as a microcosm which showed "some of the problems faced by an overcrowded and stretched prison system". The report expressed concern about the operation of the process for supporting prisoners at risk of self-harm. It also flagged up the deterioration of healthcare since the previous inspection.

7. The most recent published Independent Monitoring Board report (1 February 2006-31 January 2007) indicated nine areas of concern. This included concern about the high number of prisoners with mental health issues and the lack of sufficient staff to offer appropriate support. The report also mentions the numbers of prisoners arriving late in the evening due to overcrowding at other establishments, poor representation of staff who should be attending reviews on prisoners at risk of suicide or self harm and delays in receiving the results of my investigations.

8. Since PPO took over responsibility in 2004 for investigating all deaths in prisons, there have been nine apparently self inflicted deaths at Leicester. The Ombudsman has previously made a number of healthcare-related recommendations, some of which are relevant to the care the man received in respect to the issuing and monitoring of medication.

9. At the time of the man's death, Leicester City Primary Care Trust was responsible for commissioning healthcare services. Healthcare is divided into primary and secondary spheres. Primary mental healthcare at Leicester has been provided since February 2007 by Serco, a private company. Secondary mental healthcare services are provided by the National Health Service through the Criminal Justice Team of the local Mental Health Partnership Trust. The in-reach team consists of two full-time Registered Mental Health Nurses (RMN) who deal with referrals from the General Practitioner or nursing staff concerning prisoners who have been diagnosed as having a mental illness. They do not take direct referrals from prisoners themselves. The RMNs follow a process known as tracking, to locate the community mental health service which was looking after the prisoner before they entered custody, in order to obtain background information. The prisoner who has been referred is discussed at a weekly multi-disciplinary meeting and allocated to a particular RMN.

HMP PETERBOROUGH

10. Until February 2008, healthcare was provided by Peterborough Primary Care Trust. It is currently provided by Kalyx, the company that operates Peterborough and several other private sector prisons. Secondary mental healthcare is provided by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust.

KEY EVENTS

The man's imprisonment:1999 - June 2005

11. The man was sentenced to ten years imprisonment in 1999 for the attempted murder of his ex-wife's partner and possession of a firearm. It was his first period of long-term imprisonment although he had served several shorter sentences of a few months. He served his sentence in several prisons, ending up at HMP Peterborough in late 2004.

12. The man's schizophrenia was managed by medication. His mental health was maintained by taking 600mg of clopixol by a slow-release injection known as a depot every two weeks. The man had long periods of relatively good health but when he stopped taking his medication he would become psychotic. His illness would take the form of exhibiting delusions that there was a crystal in his head and coloured sand in his eyes. He would talk about seeing the devil and his, imagined, Jewish background. Indeed, several documents in his prison records give his place of birth, erroneously, as Jerusalem or Israel and describe him as a "foreign national".

13. Whilst the man's mental health remained relatively stable, there were occasions where he gave cause for concern. On 1 June 2003, he told an officer he had not taken his medication for three days. Houseblock staff called a member of healthcare staff due to his behaviour. He said he felt like smashing up his cell and harming himself. An F2052SH booklet was initiated by an officer. (An F2052SH is a booklet where prisoners at risk of self-harm or suicide can be monitored and supported. It has since been superseded by the Assessment Care in Custody and Teamwork process which is a system that supports and cares for prisoners who are at-risk of self harm or suicide.) On 9 August, a member of staff wrote in the man's Record of Events, expressing concerns about his general behaviour. He had been wearing the same clothes for two weeks and had noticeable body odour. On 24 October, the man said that he would take his own life when other prisoners were asleep.

14. A Local Risk Management Meeting took place in Peterborough on 27 January 2005 to discuss managing the man's risk on release. This was a multi-agency panel attended by representatives from the probation service, police, social services, and mental health practitioners. Parole had been refused in May 2004 due to the man writing letters to his ex-wife (who did not want contact with him). Whilst the letters did not appear directly threatening, one referred to "payback time". The meeting concluded that the man did pose a risk to his former wife and possibly to himself on release.

15. A psychiatric report was written by a doctor of Suffolk Forensic Psychiatry Services on 10 March 2005 for the purposes of preparing a care plan for the man's release. The plan was for the man to be admitted to a medical centre in Peterborough General Hospital on the day of his release. This would provide ongoing psychiatric treatment in a controlled environment and liaison between the local probation service and mental health team. The man was

thought to have demonstrated a good degree of insight and compliance regarding his mental health condition. He had been stable over the previous 12 months and was at low risk of re-offending.

16. On 27 April 2005, the Parole Board granted the man's application. It acknowledged that he would require "very close multi-agency supervision" and a robust release plan. He was released from prison on 27 June 2005 on parole licence.

In the Community: June 2005 - August 2006

17. The man's mental healthcare was transferred to the Peterborough Assertive Outreach Team which looks after clients in the community. A Care Programme Approach (CPA) report was completed by Cambridgeshire and Peterborough Mental Health Partnership NHS Trust on 29 November 2005. (The CPA is aimed at patients with complex mental health needs. There may be involvement by medical, social work, housing and mental health professionals. It requires multi-disciplinary assessments and care plans which are reviewed at regular intervals). The man was described as a complex individual who required an intensive care approach. It observed that he had reasonable insight into his illness yet had a tendency to stop medication with resulting relapses. It noted that when he stopped taking his medication, he had become psychotically unwell within a fortnight. The psychosis was characterised by distressing auditory hallucinations which told him to harm/kill himself. The CPA report said that the man had "cut himself superficially at least twice while unwell and expressed suicidal ideas." It described the man's early warning signs indicating possible relapse as increasing pacing, increase in agitation, smirking, pre-occupation, irritability, impulsivity, attitudinal hostility and wanting to write and send inappropriate correspondence.

18. The man remained well for several months and complied with taking his medication and keeping appointments with healthcare and criminal justice professionals.

19. On 7 June 2006, the man saw a visiting Consultant Psychiatrist. In the man's clinical record, his speech was described as bizarre and he stated that he was an illegal immigrant. On 9 June, the man saw a Community Psychiatric Nurse. He called her "Babes" and kissed her cheek. She said to him that his behaviour was unusual but he did not consider it to be so. He appeared distracted. His clinical record said he was "staring in sinister/intense manner – denied feeling he could heal with his eyes or was experiencing crystals or coloured sand in his eyes which are early warning signs for him." A Care Programme Approach Co-ordinator was going to contact the man's sister to let her know how he was. The man insisted he was Jewish and had arrived in Britain on a boat with his parents from Jerusalem. The Care Programme Approach Co-ordinator regarded the man as unwell.

20. The man co-operated with his release plan to monitor his mental health until 1 August 2006 when he did not attend an appointment with his probation officer.

21. On 3 August, he was not at home for a scheduled visit from the psychiatric services and failed to attend a planned appointment with his doctor. As his mental health was giving cause for concern and he was not available to receive medication, the decision was taken to recall him as he was not complying with his licence conditions.

Recall to Peterborough - 4 August 2006 to 22 December 2006

22. The man was recalled to prison on 4 August for failing to comply with the terms of his release licence. A prison doctor referred him to the in-reach team the day after his reception. The man was seen by the visiting Consultant Psychiatrist and an in-reach practitioner. The man's CPN from the Assertive Outreach Team visited him on 9 August. He appeared unkempt and pre-occupied with delusional beliefs. He was taking regular anti-psychotic medication by mouth and by injection but he was seriously mentally unwell even so, insisting he was "Jewish", a sign that his mental health was deteriorating.

23. The man was moved from healthcare to normal location in Peterborough with the understanding that, if he felt unwell, he could return to healthcare. He went to healthcare on 18 August to have his depot injection. The man had another depot injection on 24 August and stayed in healthcare as his mental health was in decline. The Consultant Psychiatrist from the Outreach team visited the man in Peterborough. He told the in-reach team that he had spoken to a doctor of the Cambridge Forensic Psychiatry Service at Addenbrooke's Hospital, looking into the possibility of the man being transferred to a hospital for treatment. On 31 August, the man was still insisting he came from Israel.

24. On 1 September 2006, the Parole Board considered the revocation of the man's licence. It concluded that recall had been appropriate. The man admitted missing appointments with his supervising officer and psychiatrist and not taking his medication.

25. The man moved from healthcare to an ordinary wing on 12 September. He settled down until 9 October when he went back to healthcare as he did not feel able to cope on normal location. He was pre-occupied by whether he would be transferred to a hospital on early release and was not able to concentrate on anything else. On 20 September, the Consultant Psychiatrist wrote to doctor at Addenbrooke's Hospital, asking whether he would be preparing a Mental Health Assessment for the Parole Board hearing on 20 October. In the event, the Consultant Psychiatrist provided a report for the hearing recommending release prior to his conditional release date on 22 December, but the matter was not resolved and the man was not admitted to hospital.

26. On 2 November, the man was admitted to healthcare as he said he was seeing the devil. This had left him quite distressed. He remained in healthcare for one month and on 2 December asked if he could go into a ward

with other patients. He moved into it the next day and appeared happy and more settled. The man asked to return to his own cell on 18 December. He was released on conditional release licence on 22 December 2006, which was the last date he could be kept in custody.

In the community - 22 December 2006 to17 April 2007

27. After the man's release for the second time, he continued to take his medication and stayed at the medical centre on a voluntary basis before being allocated a flat in the community. However, on 13 April, after pacing up and down the ward for much of the day, the man told the Consultant Psychiatrist that he felt suicidal and tense in the mornings and was lonely in his flat. He said he did not want to be admitted so it was agreed that he would attend the centre during the day over the weekend. The next day, the man arrived at the centre and asked to stay as an in-patient because he was increasingly being preoccupied by suicidal thoughts and had planned to hang himself from a door.

28. On 15 April, the man was arrested outside the centre. He was charged at a police station in Peterborough on 16 April with the offences of making threats to kill his ex-girlfriend, on 13 April and possession of a Class C drug (cannabis). He appeared at Peterborough Magistrates Court on 17 April to answer these charges and was remanded in custody. A Prisoner Escort Record (PER) accompanied the man from the police station to the court. A PER is a written document which highlights risks associated with particular prisoners. There are three main risk categories – medical, security and other – with tick boxes for the relevant risk. Under medical, the box "medical condition" was ticked, along with the security category boxes, "violence" and "conceals weapon". Under the section containing further information about risk, it said "poss of shotgun. Shot male, resist arrest, schizophrenic".

29. As a result of the further criminal charges, the man was formally recalled to prison. The reasons for the revocation of his licence were that he breached condition 5 (i) of his licence in that "you failed to be well behaved, not commit any offence and not do anything to undermine the purposes of your supervision, which were to protect the public, prevent you from re-offending and help you resettle successfully into the community".

30. During the reception process at Peterborough, Sections 1 and 2 of the Cell Sharing Risk Assessment (CSRA) were completed by a Prisoner Custody Officer (PCO). He ticked the form to indicate that he had seen the man's Prisoner Escort Record and warrant. The PCO ticked yes to the questions "Has the prisoner ever abused alcohol or drugs?" He ticked no to the question "Is there evidence of the prisoner having a previous F2052SH?" (a self-harm monitoring form). Having used the man's answers as his source, he assessed the man's risk as medium (that there was no immediate risk but the situation would need to be reviewed regularly) due to his previous convictions. Section 3 of the CSRA, which gauges whether a prisoner is at risk of harming others, was completed by a nurse of the Healthcare Team. The box "you feel that something is wrong" was ticked and the man's risk was assessed as high.

In addition the Healthcare nurse wrote that the man would need a single cell. In section 4, the duty manager decided that the man posed a medium risk but he should be monitored by wing staff.

31. The man's First Night Hourly Observation Record said that he seemed calm and collected. He asked for the observation flap on his cell door to be left open and this was done.

32. The man was seen by the prison doctor on 18 April. He was prescribed 100mg Fluphenazine decanoate, an anti-psychotic slow release medication every two weeks. On 19 April, he was seen by a Community Psychiatric Nurse (CPN) from the mental health in-reach team. After their consultation, she wrote in his clinical record:

> "Seen by in reach he is desperate to work so that he can get off the wing he does not want to return to healthcare advised that we do not want him in healthcare and we will support his application to work. Upset about allegations of threats to kill and that he was in possession of a gun. He said that he met a woman in a pub and they were together for six weeks and she fell in love with him and he broke it off which caused the recall. Compliance with his depot attended healthcare to have it."

33. A PCO wrote in the man's Record of Events on 20 April, "Seems ok on wing but asking for a job because he feels he will end up back in H/C if he's behind his door all day."

34. On 23 April, the man saw a nursing Sister in the healthcare centre. He asked for a letter he could give to his wing officer to allow him to get some work as he was becoming distressed without anything to do. The nursing Sister provided the man with the letter. On the same day, the Post Release Section of the Public Protection Unit faxed Peterborough a copy of the man's licence revocation order. It included the message "Please note that it has been brought to our attention that the man shows issues of vulnerability in custody in that: he has Mental Health issues in last sentence and will struggle with recall."

35. The man appeared at Peterborough Magistrates Court on 24 April, and was remanded in custody until 22 May. He signed a Confirmation of Disclosure of Recall Dossier/ Representations Against Recall form. He indicated that he wanted to make written representations against his recall through his legal representatives.

36. The man was moved to healthcare on 28 April as he had begun to feel fragile. An entry in his Record of Events (signature illegible) read "Seems ok but would like to double up because he is lonely." On the same date, a PCO wrote, "Admitted to H/care – explained to him that I am his personal officer."

37. On 30 April, the man had an appointment with his CPN. He told her his medication was giving him cramp and he wanted to remain in healthcare

because he could not cope on the wing. He also said he was seeing the devil on the wing. He was admitted to healthcare. On 4 May, he expressed the view to his CPN that he should be associating with other prisoners. It was agreed that he could return to wing once he had been seen by a doctor. When the man reported the same delusion to his CPN again on 8 May, she reassured him that he would not have to return to his wing. He remained in healthcare until 14 May.

38. On 5 May, the man made an application to be transferred to HMP Guys Marsh. His application read in part "I am a paranoid schizophrenic, the devil is in this prison plus Bullingdon and Grendon prisons … I would like to settle into one prison and be rehabilitated. Guys Marsh can sort me out."

39. The PCO wrote in the man's Record of Events booklet on 5 May that his television was removed from his cell for his own safety after he threatened to smash it. The next day the PCO made an entry in the Record of Events that the man kept saying the devil was in the prison and he wanted to be transferred. The PCO asked a nurse to contact in-reach to see the man.

40. The man was seen by his CPN on 7 May. She noted in his clinical record that he was very agitated, saying that the devil was on the wing. The man was reassured that he could stay in healthcare and he would not be moved back to the wing unless he wanted to. He received a reply dated 8 May from Peterborough's Observation, Classification and Allocation (OCA) unit that arranges transfers, "Unfortunately we do not allocate to Guys Marsh."

41. On 10 May, a Public Protection Panel meeting to consider the man's risk management took place. The names of the participants are not recorded. The meeting considered input from different areas of the prison and heard that the man had asked for a job. The man feared he would end up back in healthcare if he was locked in a cell all day (which had occurred) and he had asked to share a cell with another prisoner.

42. The man's probation officer commented that he was being managed well in healthcare but did not do so well when moved to a houseblock. Mental health in-reach said that the man came across as vulnerable and did not like large groups of people. The security department's contribution was that the alleged victim of the offence for which the man was recalled and remanded in custody was retracting her statement.

43. A PCO wrote in the Record of Events booklet on 10 May that the man said he was surrounded by the devil and had x-ray vision. He was pacing up and down and said it was all he could do when he was on a high.

44. On 12 May, a Cell Sharing Risk Review took place and a document with its findings was completed. It gave the man's current risk rating as medium. It mentioned his previous conviction of attempted murder. Under the question "Has the prisoner displayed any anti-social behaviour, bullying, threats, damage to property, aggression, hate-motivated behaviour, assaults?" The response read "Current offence threats to kill made threats to kill others April

07 because devil told him so + markers for possession of shot gun + resisting arrest."

45. In response to other questions on the form, it was noted that the man was suspected of using cannabis. The security department did not have any information which would affect the risk assessment. The question about whether there was a history of self-harm was not answered. The PCO wrote that healthcare information was that the man was known to the In-reach team as he said he saw the devil in his cell telling him to harm others. He was possibly a sufferer of drug-induced psychosis and staff should treat him with extreme caution due to his history of violence and current mental state.

46. The man met with his CPN on 14 May. They talked about the last time they had met on 11 May and how unsettled he had been. The man admitted that he had been feeling under stress but he believed he was now ready to try going back to normal location. After the meeting, his CPN discussed the man's possible move back with a doctor and officers on the houseblock to which he would return. It was agreed that he could be discharged from healthcare with the understanding that if he deteriorated, he could return there.

47. On 22 May, the man left Peterborough for a court appearance at Peterborough Magistrates Court. His CPN was on annual leave. The man's core record had been signed to say that he was fit to attend court. However, there was no record on System 1, the internal healthcare computer tracking system, to show that he had been fitted for court. He was accompanied by Prisoner Escort Record (PER) which is used to highlight any information of special importance about the prisoner being escorted.

48. Operation Safeguard is a system which came into operation in October 2006 and is used by the Prison Service, police, courts and escort contractors to manage the shortage of prison places for persons remanded in custody. It matches the availability of spaces with the demand and makes provision to accommodate 400 prisoners in designated police stations and court cells until prison spaces are available. In the event that prisons are unable to accept more prisoners because they are full, Operation Safeguard has a protocol which sets out which prisoners will be given priority for a prison place. These include young offenders, women, category A prisoners, those actively at risk of self harm or suicide and prisoners who have significant healthcare issues. In order for escort staff to be aware which prisoners fall into these categories if not apparent, Prison Service Instruction (PSI) 30/2006 states that their "PER forms <u>must</u> be endorsed 'RETURN TO DISCHARGING ESTABLISHMENT.'"

49. On the man's PER, the risk categories section of Part A was completed by a PCO on 21 May. The man's PER was not endorsed according to the PSI. Under "medical", the boxes for medical or mental condition were left blank and the box for "no known risk" was ticked. Under security, the boxes for violence and "conceals weapons" were ticked. Under "other", the box for drugs/alcohol issues was ticked. In the section "further information about risk", the PCO wrote "violence, threats to kill. Drug offences. Weapons, shotgun". The man

was remanded in custody to appear at Peterborough Crown Court on 22 June. Part B of the PER is a record of events. It shows that the man left Peterborough at 7.55am and arrived at court at 8.10am. He left court at 2.25pm and was taken to Daventry police station, arriving at 3.45pm. He spent the night there and was handed over to the escort contractors the next day at 12.35pm, arriving at HMP Leicester on 23 May at 1.35pm.

50. At Leicester, the man was seen on reception by an officer. The officer completed section 1 and 2 of a CSRA using information from the man's PER, court warrant and his answers to the set questions put to him. The officer did not have the man's medical record. The man's risk was assessed as low. The reception officer described him as polite and co-operative. The healthcare section of the CSRA was completed by a nurse assessed the man as low risk. In the man's clinical record on the form 'Further Reception Health Checks', under the 'Change in Circumstances' heading, the nurse wrote 'Rec[eived] HMP Peterborough'.

51. The man was taken to the First Night Centre for prisoners new to Leicester, which was located on the ground floor of the residential accommodation block. An officer interviewed the man in the First Night Centre. His low CSRA was noted and he was given £2.00 telephone credit, an envelope, writing paper and a visiting order. He was asked to read and sign several compacts concerning Leicester's policies, rules and routines. The man was given a free telephone call to his sister at 6.35pm to let her know he was in Leicester. They talked about arranging for her to visit. He was given cell L1-26 which he shared with another prisoner.

52. The next day, the man started the induction process. The facilities of the prison were explained and he was told how to access particular services such as arranging visits and having money sent in. The first night induction checklist gives a number of subjects that should be covered. None of them are ticked, however, and the signature of the officer who completed the form is illegible. The man remained in the same cell but was allocated a different cell mate.

53. The mental health in-reach team (MHIT) nurse wrote in the man's clinical record on 24 May that he was on an enhanced CPA with a diagnosis of schizophrenia. She had contacted the Assertive Outreach Team in Peterborough after receiving a referral from the nurse working in Reception who saw the man on his arrival. My investigator has been unable to find documentation detailing how the Reception nurse became aware that the man had mental health issues. The Reception nurse left Leicester in August 2007 and now works at HMP Gartree. My investigator interviewed her by telephone in October 2008. She said that she did not have a strong recollection of the circumstances of the man's arrival at Leicester or what he said to her that day. However, she did remember him having a distinctive face and eyes. She thought that she might have gleaned information about the man from his clinical record and made a referral to MHIT on that basis. The man's prescription chart in his clinical record showed that he had been prescribed 15mg of Olanzapine daily for 28 days.

54. On 25 May, Leicester's parole clerk was sent documentation concerning the Parole Board's review of the man's case three days earlier. The Parole Board concluded that his recall had been justified and a further review was scheduled for 22 November 2007. It indicated that the man's case would be reconsidered in the light of the outcome of his outstanding court cases, his progress whilst in custody, his psychiatric assessment and any proposed risk management plan to manage his mental health in the community. There is no indication, however, that the man was aware of his review date.

55. The man's cell sharing risk was reviewed on 25 May by a Senior Officer (SO). The man's risk was raised to high after information received from Peterborough suggested a history of mental health issues. The SO amended the CSRA completed on 23 May to reflect her concerns. As the SO has been on long-term sick leave, my investigator has not been able to interview her.

56. According to his Record of Events, the man was asked to complete his education induction but refused to attend. Disciplinary action was taken against him in the form of a "strike" or a written warning about his conduct.

57. The man's Medication Administration Record Chart in his clinical record indicates he did not collect his anti-psychotic medication, Olanzapine, on 26, 27 and 29 May and 1 June.

58. On 29 May, the MHIT nurse spoke to the man briefly at his cell door to introduce herself and find out whether he had any acute worries or concerns. She told my investigator that the man came across as pleasant and, apart from his "very stary eyes," appeared relaxed. She asked him if he was fine with his medication and he replied that he felt well and was taking his medication. She told him that he should ask for her if he needed to but she would arrange to see him more privately in Healthcare. The MHIT nurse wrote in the man's clinical record that she would see him again for a full interview. She described to the investigator the difficulties in securing a satisfactory interview room. The rooms in the First Night Centre were poorly designed and too small while the only interview room in the Healthcare centre was in constant demand and had to be pre-booked. The date of that interview was not specified.

59. In answer to my investigator's questions, the MHIT nurse said that she would not normally see a prisoner until she had digested their background information. She said that she could not remember whether she had actually contacted Peterborough in-reach team, but thought it was possible she did because there was extensive information about the man in his clinical record. She was asked whether in-reach at Leicester would follow up what happened to a patient if they did not return from court. The MHIT nurse replied that she would check on the computer system to see where they were. If it was unclear, she would ask the custody office, which manages prisoners' records, to check a national database and, failing that, she would contact the court which the prisoner had attended.

60. The MHIT nurse was not sure whether Peterborough's in-reach team had contacted her to confirm the man's whereabouts. Her feeling was that his stay at Leicester would have been brief given that he was due to appear in court in Peterborough. The investigator acknowledged that in MHIT nurse's role as a mental health nurse, she would not have expert knowledge of the prison service's arrangements for transferring prisoners. Asked whose responsibility she thought it would be to trace a prisoner and arrange for them to return to their original prison, she felt that both the sending and the receiving prison had equal responsibility. She added that she had contacted the Offender Management Unit at Leicester to find out whether the man was likely to remain in Leicester but his position was unclear.

61. The man's induction documentation was updated on 30 May when he was given four sentence planning targets to aim towards. They were to work with wing and healthcare staff towards sharing a cell, attend education or gain employment, engage with the personal officer scheme and work towards enhanced Incentives and Earned Privileges Scheme status. The form has a section to be completed by the man's personal officer but it was not completed, nor was the personal officer identified. An officer told my investigator subsequently who the man's personal officer was. The staffing roster showed that this officer was on annual leave when the man was allocated to her.

62. On 30 May, the man was moved from the First Night Centre to the landing for convicted prisoners. He was given cell L4-03 and his CSRA history sheet was marked to indicate that he was to be in a single cell. He did not collect his medication that day.

63. An officer wrote in a typed note after the man's death that the man had rung his cell bell several times on 30 May. The officer answered and the man asked him if it would be possible for him to have a cell mate because he wanted a companion in his cell. The officer discussed the man's request with a Senior Officer. On looking in the man's personal file, he noted the high risk CSRA, and the comments about assault on it. The officer saw that the man had not been given personal officer information or landing rules and information. The officer then went with a colleague to the man's cell, told him who his personal officer was and asked how he was feeling. The man said he wanted a cell mate because he was starting to feel funny. The officer said to the man that he would not be able to have a cell mate until his next CSRA review on 26 June. He asked the man if he knew why he was high risk and he said it was because he was a paranoid schizophrenic. As he talked to the officer the man began walking on the spot. As the officers left the cell, the man asked whether the observation flap in the cell door could be left open so that he could at least see other people. The officers agreed to this. The officer made a note of his conversation with the man in the wing observation book and discussed it with the SO who said that they should monitor him for the rest of the day.

64. The man made three telephone calls on 31 May at 7.55am, 9.03am and 9.06am which were retrieved from the telephone system (after his death) and

transcribed. His first call was a brief one to his sister, asking her to telephone his solicitor concerning how long he would have to serve now that he had been recalled from licence. The second call was to his former girlfriend. They discussed a statement she had made to the police but later withdrew, about the man's conduct, which had led to him being recalled. The man telephoned his sister again. He asked when she would be visiting him. On being told that she had tried but had been unable to book a visit, he said that she should wait to see the outcome of his court case in June before visiting. He asked whether she had redecorated his bedroom (he was due to live with her on his release) and after some affectionate chit-chat, they finished the call. The same day, the man was given another warning by for "constant misuse of cell bell." My investigator wrote to the officer who issued the warning asking him to provide more detail on the circumstances around the warning. Part of his reply said "in the case of the man misusing his cell bell system, he had not had any previous warnings so I thought it was best to inform him that he had broken a landing rule by reading to him and then issuing him with the written warning slip."

65. The mans prescription chart showed that he was prescribed 100 mg Fluphenazine decanoate, although his clinical record does not indicate whether it was actually administered.

66. The prisoner who was in cell L4-05, next door but one to the man and who had shared a cell with him in the First Night Centre, told an officer after his death that the man usually played table tennis with him and his cell mate. However, on the evening of 31 May, the man sat with his head in his hands and would not communicate. At interview, an officer told my investigator that the man had returned to his landing early from association. The man had said that he was not comfortable in the association room as there were a lot of people and he did not like being in a crowd.

67. The next morning, 1 June, the man did not collect his medication. He went out on the exercise yard with other prisoners. An officer told my investigator that this had surprised him, given that the man had returned to his cell early the previous evening after saying that there were many people in the association room. During the exercise period however, the man walked around the exercise yard with his head down, kicking the ground and would not speak to his cellmates. They assumed he wanted time on his own so they did not mention his behaviour to an officer. My investigator asked one of the men about the man's behaviour but he could not recall the encounter. He said that his cellmate was the one who used to speak to the man. The cell mate has been released from Leicester and, unfortunately, could not be contacted.

68. At lunch time on 1 June, an officer noticed the man walking towards him. The officer asked the man if he was okay as his eyes were "wide open like a rabbit caught in car head lights". The man replied that he was but just as the officer was about to shut his cell door, the man asked again if he could have a cell mate soon because he felt lonely. The officer commented to my investigator "he was just lonely … just kept telling me he was lonely all the time". The

officer repeated that he would have to wait for a review to take place. The man then said that he would be seeing some one from the mental health in-reach team in the afternoon so he would mention wanting a cell mate to them. The officer agreed that this was a good idea.

69. After shutting the man's cell door, the officer approached a nurse from the in-reach team who was walking up the landing, and asked her if she knew the man. The nurse replied that he was her colleague's patient. The officer said to her that the man was asking to see someone from in-reach especially concerning being able to share a cell. The nurse said she would pass what the officer had said to her colleague.

70. The officer went back to the man's cell to let him know that someone from in-reach would be seeing him. The man asked whether it would be that day. He thanked the officer, asked for his observation flap to be left open and continued to eat his lunch. The officer told my investigator that it was not his usual practice to leave an observation flap open but he felt the man's request came across as genuine. The man had said to him that if he did not have a cell mate, it would help if he could see other people going past his cell. About ten minutes later, another officer who was standing outside the man's cell, shouted across the landing to his colleague that the man was asking about seeing a member of the outreach team in the afternoon. The first officer said that he had already dealt with the matter and someone from the in-reach (not the outreach) team would hopefully meet the man that afternoon. The second officer relayed this to the man. The second officer said to my investigator that he was aware the man had been recalled on licence but even though he regularly encountered such prisoners, he did not know much about what it entailed.

71. At interview, the man's allocated in-reach team nurse said she did not normally work in the prison on a Friday but, unusually, she went to Leicester that day as she had some spare time. Just before midday, her colleague told her that the man wanted to see her but, as he was already locked in his cell, she decided to see him after lunch.

The discovery of the man's death and aftermath

72. After lunch on 1 June at about 2.00pm, the nurse told an officer who was in the staff office on L4, that she was on her way to speak to the man in his cell. Although an officer had left the flap covering the man's cell door observation panel open before he went off duty at lunchtime, the nurse told my investigator that when she reached the cell, the flap had been closed. She opened it, looked into his cell through the observation panel and saw him suspended from the window bars by a strip torn from a bed sheet. She unlocked his cell and went in, then touched him. She told my investigator that he was "not stone cold but pretty cool to the touch". She said she was not carrying a radio or a ligature-cutting tool as these are not issued to non-uniformed staff.

73. The nurse went to the cell door and shouted for staff assistance. However, she said that the wing was noisy and she was not sure whether she had made herself heard but she went back into the cell and tried to lift the man but he was too heavy so she came out of the cell and shouted for staff again. She said that officers probably arrived in less than a minute from the time she first raised the alarm.

74. An officer responded and ran to the man's cell, along with another officer This officer handed his ligature-cutting tool to the first officer who cut the ligature around the man's neck. The officer said the man was placed on the floor but he was very cold and he could not find a pulse.

75. The same officer began cardio-pulmonary resuscitation (CPR) until other healthcare staff arrived. Resuscitation was attempted by two officer's . A nurse arrived at the man's cell with an emergency response bag in response to a radio message for urgent attendance from a healthcare member of staff. Two further nurses also arrived. The man did not regain consciousness. An ambulance was called at 2.03pm and arrived at the prison at 2.06pm.

76. Leicester's General Practitioner arrived at the man's cell at 2.10pm. He could not detect a pulse or a heartbeat. The man's pupils were fixed and dilated and the General Practitioner pronounced his death at 2.20pm.

77. A hot debrief was held after the necessary administrative procedures following the man's death had been completed. The purpose of the debrief was to bring together all staff who had been involved in the immediate aftermath of finding the man. The hot debrief was chaired by the Deputy Governor, and was attended by all relevant staff and representatives of the Staff Care Team. It enabled the staff present to discuss how the man's death had been handled and air any issues that had arisen as a result.

78. After attending the hot debrief, Leicester's Prison Chaplain, and a Principal Officer left Leicester at 4.50pm to drive to London in order to break the news of the man's death to his family. They arrived at the family home at approximately 8.30pm.

79. The man's sister was very distressed at the news of his death. She told Leicester's FLO that her brother had telephoned her and did not give any indication that he intended to take his life. In fact after she had last spoken to him, she had telephoned her aunt to say that he sounded really well. Her brother had told her not to visit him at Leicester but to wait until his next court appearance as he believed he would return to Peterborough prison. She had agreed to do this. The man's family were grateful that staff had travelled from Leicester to London to tell them of the man's death in person.

80. The man's family were offered and accepted the opportunity to visit Leicester to meet prisoners and staff who had cared for him. His family were touched by the generosity of prisoners who organised a collection and raised £195. They were all the more appreciative of this mark of respect for the man's memory, given that he had only been at Leicester for a short time.

81. My investigator spoke to a member of the mental health in-reach team at Peterborough who had known the man during his time there. She said that after the man went to court on 22 May, she did not realise that he was in Leicester until she was told about his death, four days after it occurred. She added that the man was well-known at Peterborough and, if the in-reach team at Leicester had contacted her, she would have been happy to try to negotiate a return to Peterborough for him. She was mystified as to why Leicester in-reach had not contacted their Peterborough counterparts.

82. A post mortem examination was conducted on 5 June by a Forensic Pathologist. His report described the man's cause of death as hanging. Samples of the man's blood and urine were analysed for the presence of medicines, drugs and alcohol. My investigator discussed toxicology tests with a member of the forensic pathology team which analysed the man's samples. She asked whether the toxicology report would indicate if the man had actually taken the medication had been prescribed. He replied that, although no identifiable drugs (illegal or prescribed) had been found specific tests to identify particular medication might not have been carried out. This meant it was possible that medication was present in the man's body but did not register.

83. An operational review into the dispensing of psychotropic medicines in the Healthcare department at Leicester was conducted by Serco's Senior Investigations Officer. The report of his findings detailed that the man did not collect his medication on 26 and 27 May. The man was seen by a prison nurse on 28 May and advised to collect his medication. The nurse then referred the matter to the in-reach team and the man was seen by his personal nurse on 29 May. The report found that "although on interview the staff of the HCC stated that they do inform 'In Reach' when they have concerns with regards to a patient of his treatment … there is however a universal apathy to the recording of such information on Prescription Charts and IMRs and there is no managerial input or checks and balances and as a result there is no 'Audit Trail'." The Senior Investigations Officer concluded that although the fact that a prisoner did not appear is noted, it is left to individual nurses to follow up. He recommended that there should be managerial oversight of prescription charts and the whiteboard which is used for the recording of the dispensing of psychotropic drugs. My investigator was unable to discuss the SERCO report with the prison nurse due to the nurse's sick absence.

84. After the man's death, Leicester's Healthcare Manager issued a Notice to Staff on 4 June which read:

> "All qualified staff are reminded that it is their responsibility to investigate why someone prescribed anti-psychotic medication is not attending for their prescribed medication, simply documenting the fact that the patient has not attended is not sufficient. When you have discovered the reason behind the non-attendance this must be documented in the patient's medical record."

ISSUES

85. The man battled with schizophrenia for most of his adult life. He responded to treatment both in the institutional settings of hospital and prison and in the community. His risk to the public or particular individuals was managed in a multi-disciplinary setting by professionals who showed an in-depth understanding of his behaviour assisted by valuable input from his sister, who had maintained a close and supportive relationship with him throughout his years of imprisonment.

86. The man's condition was stabilised by a mixture of slow-release injections and daily oral medication and regular review under a recognised Care Programme Approach with skilled mental health practitioners. The man was vulnerable however, when he stopped taking his medication as his psychotic symptoms would return. Whilst serving his sentence, he rarely gave cause for concern that he would harm himself. On one occasion, in June 2003, an F2052SH self harm monitoring form was opened after he displayed disturbing behaviour and told staff he felt like smashing his cell and harming himself. Four months later, the man said he would take his life when other prisoners were asleep. The CPA report dated 29 November 2005 referred to the man cutting himself superficially on at least two occasions and expressing suicidal ideas. It is unclear, however, whether those events were historical or whether they took place in custody. Apart from these episodes, there is little documentary evidence that the man had expressed suicidal intent until he told the Consultant Psychiatrist on 13 April 2007 (shortly before being arrested) that he was preoccupied by suicidal thoughts and planned to hang himself from a door.

87. The man was recalled to prison on two occasions under the provisions of the Criminal Justice Act 2003 which, under Prison Service Order 6000, sets out conditions for the early release and recall of prisoners. The first time his licence was revoked was on 4 August 2006, 14 months after release on parole when he was not co-operating with the psychiatric services. He was released three months later on licence as he had served the full required period in custody.

88. After being arrested, charged with a serious offence and remanded in custody, it was perhaps inevitable that the man would have been recalled to prison. Given the nature of the original offence that he had been convicted of, allegations that he had committed an offence which had similar hallmarks had to be taken seriously.

89. When the man was taken into custody in April 2007, the Prisoner Escort Record that accompanied him from the police station to court on 17 April, contained information that he was schizophrenic. Despite his family's concerns about the care he had previously received at Peterborough, his mental health condition seems to have been acknowledged and appropriately handled. It was reasonable that an Assessment Care in Custody and Teamwork (ACCT) document was not opened at that point. The man was

allowed to have the observation panel flap open when he asked and he saw a doctor within 24 hours of his arrival. Medication was prescribed promptly and he was referred to and seen by the in-reach team.

90. However, in contrast to his previous period in custody, the man appears to have been anxious about being locked in a cell by himself without a job. He is variously described in his clinical record and Record of Events as desperate to work, upset, distressed, lonely and agitated. The Post Release Section of the Public Protection Unit drew Peterborough's attention to the man's vulnerability due to mental health problems and correctly predicted that he would struggle with recall to prison. The man talked on several occasions of the devil being in the prison and gradually he exhibited more of the trigger signs that his psychosis might be returning. He told staff he was surrounded by the devil, he was seen to be pacing up and down and he said he had x-ray vision.

91. At the time when the man attended court on 22 May, concern that prisons were unable to accommodate the number of people being sent to them was, as now, a pressing issue. Operation Safeguard was devised to co-ordinate where and how available spaces would be filled. In practice, it meant that in the quest to meet demand, prisoners could and were sometimes being located at short notice in prisons far from their homes.

92. Although the man's core record was signed on 21 May to say that he was fit to attend court, a lack of co-ordination meant that this was not recorded on System 1, Peterborough's healthcare tracking system. This meant that although the in-reach team should have been aware that the man had left Peterborough and was attending court, they were not. This was a mistake. The man was suffering from a serious and enduring mental illness, albeit under control. It was essential they knew of his whereabouts so that adequate follow up could be undertaken if he did not return.

I recommend that Peterborough devises a system to ensure that prisoners who attend court or leave the establishment are recorded on System 1.

I recommend that the Director of Peterborough reminds staff that signatures on documentation must be legible.

93. The question as to whether the man's PER should have been endorsed for him to return to Peterborough is a finely balanced one. With hindsight, it would have been desirable for him to return. Nevertheless, it might have been more acceptable for Peterborough not to endorse the PER provided that it showed all relevant information about the man. Clearly it did not. It was the failure to provide sufficient relevant detail about the man's mental health history combined with the absence of a request for him to return to Peterborough that left him vulnerable.

94. Peterborough did not have a specific system for requesting that prisoners who might be vulnerable due to mental illness are returned from court instead of

ending up in another prison. If the PER had been adequately explanatory, the relevant court staff would have been able to make an informed decision as to whether or not he should return to Peterborough. However, the failure to provide sufficient explanatory detail meant that the information which should have been immediately available to Leicester's staff was absent.

95. The man was not actively considered to be at risk of self harm, his symptoms had been stabilised by medication and the PER prepared by Peterborough did not mention his schizophrenia. Had the PER requested that he was returned to Peterborough, in all probability he would have been. However, in terms of priority for return to a prison after a court appearance rather than spending the night in a police cell, the man's PER did not flag up that he was a possible risk. This meant that instead of returning to Peterborough, where he lived and his mental health needs were addressed, he was taken to spend the night in a police station in Northamptonshire and then on to HMP Leicester the next day, where he was unknown.

I recommend that the Director of Peterborough devises a system to ensure that up-to-date healthcare information is included on PERs before each escort takes place.

I recommend the Director of Peterborough ensures that explicit requests for individual prisoners to return to Peterborough are made on PERs if the circumstances warrant it.

96. The man's telephone conversations with his sister give the impression that he was expecting to return to Peterborough after his court appearance. Indeed his personal nurse told my investigator she did not think he would spend long at Leicester and that he would have returned to Peterborough because he was due to attend court there. It certainly would have made sense for him to have returned there. Both the prison in-reach and the community outreach teams knew the man very well as he had been their patient for some ten years. He had worked with the some of the same practitioners for several years and they were familiar with his background.

97. One might well ask whose responsibility it was to arrange for the man to be returned to Peterborough. He, not unreasonably, assumed that he would be returned to Peterborough because he was due to appear in court. His personal nurse assumed that he would be returned in due course. His allocated personal officer was on leave and his former CPN at Peterborough was unaware of his location. There is no clear policy on the responsibility to initiate a transfer in such circumstances. Perhaps if the man had made a formal request to return, then the ball would have begun to roll, but there is nothing to suggest that he did. He had only spent a week at Leicester and was still feeling his way. Peterborough in-reach told my investigator that if Leicester had approached them for information rather than contacting the Assertive Outreach Team in the community, arrangements could have been made for the man to return.

98. Due to the slight expansion of prison places since the time of the man's death, Operation Safeguard has not been re-activated for some time. Regrettably, however, the prison system is still experiencing the twin phenomena of increasing turnover of unconvicted prisoners between prisons and an increase in absolute numbers of prisoners. This puts prisoners in the vulnerable position of being liable to be moved around the country in an effort to overcome the geographical imbalance between spaces available and their location. This is not good for prisoners or prisons.

99. The man's Cell Sharing Risk Assessment (CSRA) at Peterborough assessed him as being medium risk, which meant that there was no immediate risk but the situation would need to be reviewed regularly. When he arrived at Leicester, he was assessed as low risk, despite the existing CSRA. The man shared a cell with two different prisoners before his risk was reviewed on 25 May and upgraded to high, following which he was placed in a single cell. I have not seen documents that show he had assaulted other prisoners in the past. Nevertheless, the issue of whether or not to allow a prisoner with a raised risk assessment to share a cell raises important questions of how one deals with prisoners who could pose a risk to others balanced against the risk such prisoners pose risk to themselves. I accept that such assessments are an essential tool for prison staff and I support their use. The difficulty in this man's case is that his high risk status gave rise to the unintended consequence of him missing human contact. It is unclear whether he had possessions at his disposal such as a radio, television, reading material or other means to be able to stave off the loneliness he was experiencing.

I recommend that the Governor of Leicester assesses the needs of high risk CSRA prisoners and devises means to alleviate the effects of isolation.

100. The man remained in the relatively sheltered environment of the First Night Centre for a week before moving upstairs to L4 landing on 30 May. Having had the opportunity to share a cell, albeit inadvertently, it is striking that there is a constant thread of him asking several times if he could have a cell mate because he was lonely. As an officer commented, the man spoke of feeling lonely all the time. When he had the opportunity to mix with other prisoners, initially he had played table tennis with his cellmate and chatted. By the next day, however, he appeared to have retreated into himself, returning to his cell early after telling an officer that he was uncomfortable socialising with a large group of prisoners. Ironically, the information that the man did not like large groups of people was provided by Peterborough's in-reach team in the minutes of the Public Protection Panel (PPP) meeting which took place on 10 May and were in the man's prison records. If contact had taken place between the two in-reach teams, crucial facts about the man could have been handed over promptly rather than Leicester having to tease them out from a thick file which was not readily available to landing officers. Awareness of such information could have enabled officers to understand the significance of the man's behaviour. Unfortunately, the fact was buried in his records.

101. On the day the man died he asked, not for the first time, for his observation panel flap to be left open so he could see people passing outside his cell. This was done, although the flap appears to have been closed by the time his personal nurse reached his cell. The man told an officer that he intended to raise the issue of cell sharing with his in-reach nurse. He was suffering from schizophrenia, he had been recalled to prison after serving a sentence for a serious act of violence, he was facing further charges which, if proven, could have resulted in a lengthy prison term, he was in an unfamiliar prison, his family had been unable to arrange a visit and he spoke repeatedly of feeling lonely. This combination of factors, in retrospect, meant that the man was more vulnerable than was realised. However, they were not facts that any one member of staff had been able to pull together. An officer's interaction with the man revealed an understanding and caring approach which reflected well on him. I appreciate that busy local prisons are not the easiest of environments for staff to get to know those in their care especially in only one week but it is possible that if the man had been able to spend some time with his personal officer, these apparently disparate strands could have been drawn together.

I recommend that the Governor reviews and strengthens the role of the personal officer at Leicester.

102. A clinical review of the medical treatment the man received in custody was conducted by a doctor on behalf of Leicester City Primary Care Trust. His report said that there were no indicators that the man was becoming psychotic whilst in Leicester apart, possibly, from the observation by an officer that he was walking on the spot in his cell. The man did not express delusions about the devil or his religion but it was possible that he was in the early stages of relapse. He stopped collecting his Olanzapine medication after being transferred and he may not have taken it even on the days he did collect it. The doctor said that on first examining the man's prescription charts, he had wrongly assumed that the initials DNA next to certain dates denoted the member of staff who had issued the medication that day. It was only sometime afterwards that he realised DNA in fact stood for 'Did Not Attend'. He makes the point that on looking at the charts, this error is all too easy to make. The review continues:

> "If the fact that the man had stopped collecting his medication had been carefully analysed it might have triggered an early mental health assessment, which might possibly (although I would not put it any higher than this) have picked up signs of distress. Support might then have been able to be given to the man that might have prevented any self-harming actions. It is, however, worth noting that the man had not exhibited major self-harming behaviour in the past and his fatal self harming action might have been an impulsive gesture in response to the stress of the charges he was facing. Such impulsivity might have increased by his decision to stop taking his Olanzapine".

103. The clinical reviewer notes that the man's clinical record contained information that he was known to be at risk of rapid relapse into psychotic illness if he

stopped taking his medication. Whilst a care team who were familiar with him would have known this, it was not flagged up to Leicester who had to rely on combing through his "voluminous" files to extract pertinent information.

104. The Clinical Reviewer made several recommendations including:

> **"I therefore recommend that prison primary and specialist healthcare services should work to identify prisoners whose health, physical and mental, is known to be at risk of rapid deterioration and to ensure that such information accompanies the prisoner, in real time, around the prison system. This will require negotiation with prisoners in respect of confidentiality of information."**
>
> **"I recommend that the primary healthcare service at HMP Leicester considers updating its coding system so that the entry representing the fact that a patient has not collected his medication cannot be mistaken for an entry that represents the fact that he has collected it."**
>
> **"I recommend that the primary healthcare service at HMP Leicester considers drawing up a protocol to ensure that if a prisoner decides not to take prescribed medication the matter is brought to the attention, in a timely manner, of a healthcare professional with sufficient knowledge and skills to decide what action (if any) should be taken. Such a decision should be documented in the patient's clinical record."**

105. The clinical review raised a number of important questions about the healthcare the man received at Leicester. The clinical reviewer focuses on whether the man was becoming psychotic, the clinical information available about the man and the systems at Leicester for recording whether medication had been administered.

106. The Clinical Reviewer's report says that there were no indicators that the man was becoming psychotic apart from, possibly, when the officer observed him walking on the spot in his cell. He acknowledges that the man appeared to be becoming more stressed a week or so before he arrived in Leicester.

107. On five of the nine days that the man spent at Leicester, he did not collect his medication. His prescription chart was marked 'DNA' when he failed to appear. SERCO's investigation report says that a nurse informed the in-reach team about this and left it to them to take forward. The man's personal nurse appears to have been unaware of this and said the man told her that he was taking his medication and felt well. There appears to be some confusion as to who knew what. The toxicological analysis of the man's blood and urine did not reveal traces of identifiable medication but specific tests to show their presence may not have been performed. The man's clinical record showed that he had missed several doses but I have not seen any written

documentation to indicate that the in-reach team were aware that he was not taking his medication.

108. It may be that the man decided not to take his medication or he might have failed to collect it for some other unexplored reason. Unlike in the local community, the free movement of prisoners is limited and it is the prison's responsibility to enquire. It is important that there is adequate follow up especially when the medication is for a mental health condition. In a previous report on the death of a prisoner at Leicester who died in January 2007, I made a recommendation concerning the importance of following up any prisoners who have missed their medication. I concur with the clinical reviewer's recommendations in this regard.

109. The man was known by Peterborough to be at risk of rapid relapse into psychotic illness if he stopped taking his medication. A care team who were familiar with the man would have known this, whereas Leicester had to comb through the many documents in his clinical record to extract the relevant information. If the man's personal nurse had examined the man's most recent Medication Administration Record Chart before she went to see him, she would have seen that the man had missed his medication for several days. Whilst there is a reference by a nurse in the man's clinical record to contacting the outreach team, I have seen nothing in the man's records to indicate that contact between Leicester's and Peterborough's in-reach teams did in fact take place. Peterborough told my investigator that Leicester did not contact them and his personal nurse could not recall if anyone at Peterborough had spoken to her. Clearly, this was unsatisfactory. There is no way of knowing whether the man might have taken his life at Peterborough at some point in the future rather than at Leicester, but close liaison between the in-reach teams would have helped minimise the risk that vital information between the two would be lost. This is also an example of relevant information that could have been written on his PER. I concur with the clinical reviewer's recommendation in this regard.

I recommend that prison primary and specialist healthcare services should work to identify prisoners whose physical or mental health is known to be at risk of rapid deterioration and to ensure that such information accompanies the prisoner around the prison system.

Good Practice

110. It was good practice for the prison Reverend and a Principal Officer from HMP Leicester to travel the 103 miles to London to tell the man's family personally of his death rather than asking the police or a governor at a prison nearer to the family home. This showed care and consideration for the man's family and is in keeping with previous deaths I have investigated where Leicester's impressive family liaison has been praised.

111. It was good practice for the man to be able to move easily between healthcare and his houseblock at HMP Peterborough according to the state of his mental

health. This appears to have been well managed, with houseblock staff aware of his situation.

RECOMMENDATIONS

To the Director of Peterborough

I recommend that Peterborough devises a system to ensure that prisoners who attend court or leave the establishment are recorded on System 1.

After consideration of the draft report, the Prison Service accepted the recommendation and responded, "All prisoners transferred from HMP Peterborough to court or to another HMP establishment will have their records on System One updated by a suitably trained person and a copy of the System One record will be placed with the IMR in the transfer envelope." It gave a target date for completion as October 2008.

The six month follow-up action plan progress report said "All staff have now been trained on System One and ongoing support is in place. All records are input on to System One by trained nurses.

I recommend that the Director of Peterborough reminds staff that signatures on documentation must be legible.

The Prison Service accepted the recommendation. The six month follow-up action plan said "All staff will be reminded by way of a notice about the importance of legible signatures, printed name and designation on documentation. This will also be raised during induction of operational and non-operational staff. Registers of names, designations, signatures and initials will be maintained for all staff (healthcare, permanent and agency and custodial) based in male and female healthcare." It gave the target date as October 2008.

The six month follow-up action plan progress report said "A signature register is now in place."

I recommend that the Director at Peterborough devises a system to ensure that up-to-date healthcare information is included on PERs before each escort takes place.

The recommendation was accepted. The Prison Service responded "Staff completing Healthcare information will receive adequate training to ensure all information is documented prior to an escort. An information folder will also be provided for staff which details how the documentation should be completed." A target date of October 2008 was given.

The action plan progress report said "Registered Mental Nurses are now based in reception. They sign all PERs and input required information on to the system."

I recommend the Director of Peterborough ensures that explicit requests for individual prisoners to return to Peterborough are made on PERs if the circumstances warrant it.

The recommendation was accepted. The Prison Service responded "Requests for a prisoner to return to HMP Peterborough on medical grounds will be noted on the PER prior to discharge." A target date of October 2008 was given.

The action plan progress report commented "This is ongoing. A list of prisoners on medical hold is available to the doctor on a spreadsheet. The doctor is aware to print the sheet daily and share the information as required.

To the Governor of Leicester

I recommend that the Governor of Leicester assesses the needs of high risk CSRA prisoners and devises means to alleviate the effects of isolation.

The recommendation was accepted. The Prison Service commented: "There is a robust weekly risk assessment process in place that reviews all prisoners who are high risk and require a single cell. The CSRA review process will be amended to include a plan to minimise the isolation of prisoners who are potentially vulnerable or are displaying mental health or other concerns."

The progress reported that the recommendation had been completed and the weekly CSRA meeting is "now embedded, this meeting reviews all High Risk single cell prisoners.

I recommend that the Governor reviews and strengthens the role of the personal officer at Leicester.

The Prison Service accepted the recommendation and commented: "There was a full review of the personal officer scheme at Leicester in June 2007. The new process is now fully embedded and the recent HMCIP inspection acknowledges that although basic, the scheme was effective.

The progress report said that the recommendation had been completed. "The residential Principal Officer now conducts a weekly management checks on a random sample of personal officer entries, this helps to ensure staff make appropriate and meaningful entries of interactions with prisoners.

The Governor and the primary healthcare provider: SERCO

I recommend that the primary healthcare service at HMP Leicester considers updating its coding system so that the entry representing the fact that a prisoner has not collected his medication cannot be mistaken for an entry that he has collected it.

This recommendation was partially accepted. The response read "The coding used at HMP Leicester is common to most prisons in the UK so a decision to change coding would need to be taken at a higher level.

The progress report commented "System One, the healthcare medical records system has a generic coding system built in. When a patient does not collect their

medication free text is also entered on the system against that prisoner, this process was audited in January 09 and found to be 98% positive.”

I recommend that the primary healthcare provider at HMP Leicester devises a protocol to ensure that if a prisoner does not collect their medication, the matter is brought to the attention, in a timely manner, of a healthcare professional with sufficient knowledge and skills to decide what action (if any) should be taken. Such a decision should be documented in the patient’s clinical record.

The recommendation was accepted. “Staff information notice issued as evidenced in the report. Management and pharmacy checks carried out on a regular basis.” The follow-up action plan said that “management checks instigated June 2007 and on-going.”

The progress report commented “Healthcare staff complete omit code checking and this was recently audited as above. A notice to staff was issued, and a reminder notice to staff is to be re-issued to ensure continued compliance.”

The Governor and the PCT Prison Health Lead

I recommend that prison primary and specialist healthcare services should work to identify prisoners whose physical or mental health is known to be at risk of rapid deterioration and to ensure that such information accompanies the prisoner around the prison system.

The recommendation was partially accepted. The action plan commented “The PCT has commissioned SERCO to provide co-ordinating role. The PCT will work with SERCO to devise a new protocol and risk management tool using principles of the Offender pathway. This will be an agenda item for the SERCO performance management meeting on 8 October 2008.

The progress report said “The Clinical Governance committee now have a formal review process in place for all of SERCO’s working protocols. A review of the mental health provision has been completed, the PCT have agreed a new contract giving increased mental health cover for HMP Leicester and this will be effective from 1/6/2009. All relevant health information accompanies a prisoner if they move around the prison estate.

GOOD PRACTICE

It was good practice for the prison Reverend and a Principal Officer to travel the 103 miles to London to tell the man's family personally of his death rather than asking the police or a governor at a prison nearer to the family home. This showed care and consideration for the man's family and is in keeping with previous deaths I have investigated where Leicester's impressive family liaison has been praised.

It was good practice for the man to be able to move easily between healthcare and his house block according to the state of his mental health. This appears to have been well managed, with house block staff aware of his situation.

No comments were received concerning good practice.