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

Report by the Prisons and Probation Ombudsman for England and Wales

September 2008

This is the report of an investigation into the death of a man at HMP Leeds in June 2007. He was found hanging in his cell. He was 49 years of age, and had been in prison custody for less than three weeks.

My colleagues and I offer sincere condolences to the man's family and friends for their sad loss. I must also apologise for the delay in issuing this report.

This investigation has been undertaken by my colleague. I would like to thank the Governor of HMP Leeds and his staff for their participation in the investigation.

A doctor undertook a review of the man's clinical care on behalf of the local Primary Care Trust (PCT), and I also greatly appreciate his assistance.

During his time in police custody the man had been identified as at risk of suicide or self harm, and a suicide/self-harm warning form was opened by custody staff. On reception into HMP Leeds on 21 May 2007, the man was immediately placed on suicide and self harm monitoring and support procedures. The man illustrated a number of risk factors. He had a history of previous suicide attempts over the previous ten years, and had attempted suicide on the day of his arrest. He had allegedly murdered his partner. He also had a history of drinking to excess and depression for which he had been admitted to a psychiatric hospital four years previously. The man was seen by a consultant psychiatrist, a member of the Mental Health Inreach Team, and was also offered support to deal with his alcohol dependency.

My investigation highlights a number of concerns about the man's care and my report includes four recommendations.

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

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SUMMARY

In May 2007, the man was charged with the murder of his partner at his home on 15 May. He was detained in police custody for six days where it was noted that he had attempted suicide on the day of his arrest. He was supervised constantly and saw the Forensic Medical Officer. He was taken to hospital for treatment after banging his head against the cell wall.

When the man arrived at HMP Leeds on 21 May, the initial healthscreen noted that he had a history of coronary heart disease and depression. He had also taken an overdose of prescribed medication and drunk excessive alcohol on the day of his arrest. His history of depression had been ongoing for ten years and he had been sectioned under the Mental Health Act and under the care of a psychiatric hospital four years previously. However, he had not taken any anti-depressant medication for a month. He was said to be tearful and was expressing suicidal thoughts. The man was immediately placed on an Assessment, Care in Custody and Teamwork (ACCT) form. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.) The man was referred to the prison doctor for a secondary health assessment. He was also referred to see a registered mental health nurse (RMN).

The prison doctor saw the man the same day and again noted his history of alcohol dependence, depression and coronary heart disease. Later that day the man saw a Counselling, Assessment, Referral, Advice, and Throughcare (CARATs) worker to assess him for their programme. (The CARATs programme provides non-clinical treatment for prisoners who have substance misuse problems. CARATs teams assess prisoners and provide on-going support and referral to outside agencies.) He declined to join the CARATs programme as he did not take drugs.

The next day (22 May 2007), the man was seen both by an RMN from the Primary Care team and a mental health nurse from the Safer Custody Unit. The Safer Custody Unit nurse referred him for bereavement counselling. The man declined the safer custody programme. The RMN identified that the man was at high risk of suicide and referred him to the Mental Health Inreach Team (MHIRT). The RMN arranged to see him again on 24 May but there is no evidence that this happened. The man was seen by a consultant psychiatrist, part of the MHIRT, on 1 June. She confirmed that the man was depressed and prescribed medication for his depression.

The man was at high risk of harming himself. He had a history of previous suicide attempts over the previous ten years. He had allegedly murdered his partner of two and a half years. He also had a history of drinking to excess and of depression for which he had been admitted to a psychiatric hospital. He was monitored through suicide and self harm monitoring and support procedures throughout his time at Leeds. The man also regularly spoke to Listeners (prisoners who are trained by the Samaritans to give confidential emotional support to fellow prisoners). Sadly, he was found hanging in his cell on 8 June 2007. Resuscitation was attempted but to no avail.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.

2. A doctor was asked to carry out a review of the man's clinical care. I am grateful for this review being undertaken in a timely manner. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.

3. One of my family liaison officers contacted the man's former wife to inform her about my investigation and to offer her the opportunity to ask any questions. She was also invited to raise any concerns about the care he received whilst at Leeds that I could consider as part of my investigation. In the event, she asked whether the man had been monitored as a risk of self harm or suicide. She also raised concerns about the way in which his death had been communicated to her family. I consider that the first point is addressed within the main text of my report and as such I have not addressed it separately. The latter issue is addressed in paragraphs 40-41 under 'family concerns'. I hope my investigation and report will help the man's family to better understand what happened in the time leading up to his death.

4. My investigator discussed aspects of the man's treatment with staff at Leeds and with the clinical reviewer. (Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to contribute.) During the course of the investigation, 16 members of staff and two prisoners were interviewed. My investigator spoke too with the police in relation to their investigation. All statements taken by the police were shared with this office.

HMP LEEDS

5. Leeds is a category B local prison that accepts adult male prisoners from courts in West Yorkshire. Built in 1847, the prison has six wings, with 680 cells, plus room for 26 prisoners in the healthcare centre. A new gate complex opened in September 2002, providing better access and facilities for both visitors and staff.

6. Leeds has a maximum operational capacity of 1,254 prisoners. The prison always functions at or near this figure.

7. Leeds was last inspected by 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. Extracts from her report include the following:

   > “The prison had made considerable progress on detoxification since the last inspection. Between 220 and 250 prisoners were on a detoxification or medical maintenance programme at any given time.”

   > “ACCT process had replaced the F2052SH documentation of self harm in March 2005. Despite a training programme, understanding varied on the wings. The prison had a high level of substance dependency. We looked at half of the 17 ACCT forms open on the first day of the inspection. Generally, reviews were carried out within 24 hours of opening and weekly thereafter. Although multidisciplinary input was low at the initial assessment, there had been assessment interviews with the individual prisoners, who signed the form. All had caremaps, and most had management checks. Many entries continued to follow the clockwork regime of the old F2052SH, but later entries showed occasional detailed observations or critiques by senior officers. By comparison, entries on wing files of the review group were mainly uninformative.”

   > “There was a personal officer scheme but it was generally ineffective. However, in our survey 28% of respondents said that their personal officer was helpful, compared with the 19% benchmark … Staff told us that they did not have the time to undertake personal officer work. Managers told us that a revised scheme would come into effect through the performance improvement programme.“

8. Since April 2004, when I started investigating all deaths in prison custody, there have been 19 apparently self-inflicted deaths at Leeds (to date, 14 investigation reports have been completed by my office). There are common issues between this report into the death of the man and two of my previous investigations, to which I shall refer later.

KEY EVENTS

9. The man was arrested on 15 May 2007 on suspicion of the murder of his partner. He was strip searched and found to have an eight inch scratch from under his throat down his chest. He told police that he had taken an overdose of prescribed medication for his heart and had drunk one and a half litres of strong cider that day. The man said he had a heart attack in November 2006. He also said he suffered from depression but did not take any medication for the condition. He told police that he had harmed himself on a number of occasions over the previous ten years. He was stressed and had a dry throat. The police took him to a local Infirmary.

10. The following day, a police inspector reviewed the man at the Infirmary. The man said he had a history of self-harm over several years and had previously harmed himself by strangulation. He said he had been treated for mental illness at a hospital in Wakefield. The man was released back to police custody on 19 May. The hospital prescribed tablets for alcohol withdrawal and antibiotics believed to be for a throat infection. The man had a graze on his forehead that he told police he had caused by banging his head against a window ledge in hospital. He was examined by a police doctor who declared him fit for detention and interview. The man was placed on constant observation due to concerns that he would harm himself again. Constant observation continued until 21 May when he was transferred from police custody to HMP Leeds. The escort officer opened a suicide/self-harm warning form for the man and noted that he had been on constant watch in police custody and had harmed himself in the past by strangulation and taking an overdose. The form also indicated by way of tick boxes that the man was demonstrating bizarre behaviour and seemed depressed. The reception officer at Leeds signed the suicide/self-harm warning form at 1.00pm.

11. An ACCT was opened in reception by a Senior Officer (SO) at 1.40pm. The reasons noted were that the man had mental health issues. The SO was also aware from the police records that the man had previously tried to strangle himself. He said that he had nothing to live for and had harmed himself at the police station by banging his head against the cell wall, causing minor injuries. The man then saw an Acting Senior Officer in the First Night Centre (FNC). The Acting SO completed an ACCT immediate action plan at 2.40pm. He wrote, “Shared ‘safer cell’ initially. Half hourly documented observations (day and night). Documented handover. Phone and Listener access as and when requested on FNC.”

12. A cell sharing risk assessment was completed by two officer’s and a nurse. The man was considered a medium risk if sharing a cell with others. (That is, there was no immediate risk if he shared a cell, but the situation would have to be reviewed regularly.) The ACCT had already been opened. One of the officer’s noted that the man had “mental health issues. Immediate concerns about finding a suitable cellmate. He would prefer to share.”

13. Later on 21 May, a first reception healthscreen was completed by a nurse. The nurse noted that the man had a history of coronary heart disease for which he

was taking prescribed medication. She also noted that he had taken an overdose of alcohol and drugs on the day of his arrest. He also had a history of alcohol dependence. The man told the nurse that he had suffered from depression for ten years and had been under the care of a psychiatric hospital, having been sectioned under the Mental Health Act four years previously. The man said he had not taken his anti-depressants for a few months. The nurse referred the man to the prison doctor and registered mental health nurse (RMN).

14. After the healthscreen, a prison doctor examined the man and concluded that he had previously suffered a myocardial infarction (heart attack). He had ischaemic heart disease (narrowing or obstruction of the arteries causing insufficient blood supply to the heart). He also had a sore throat, said he was dependent on alcohol and had previously taken an overdose.

15. The man was seen by a CARATs worker at 4.00pm. He told her that he did not need to see a CARATs worker as he did not have a drug problem. The man spoke to the Samaritans at 6.00pm.

16. A second nurse noted in the man's ACCT at 7.35pm, "Seen by doctor in medical reception, disorientated and expressing feelings of guilt. Stated that he wanted to be strangled the way he deserves. Placed on supervised medication." The man was located in cell D1-16 overnight with Listeners due to the poor state of his mental health. ACCT observations were to continue hourly during the night.

17. On the morning of 22 May, an officer completed an ACCT assessment interview with the man. The first ACCT case review was completed by the Acting SO and this officer. They concluded that the man was a low risk of self harm. They referred him to see an RMN. This was a routine referral for prisoners charged with murder or manslaughter.

18. A mental health assessment was completed by the RMN on the same day. The man told the RMN that he had a ten year history of intermittent low mood. He had attempted to commit suicide on three separate occasions, ten years ago, four years ago, and before he was arrested the previous week. He denied any active suicidal intention but said he wished his last attempt had been successful. He described how he had met his partner around January 2005 and they had bought a house together two years later. On the day he allegedly murdered her, the man said she had threatened to leave him. He had been drinking heavily and had taken an overdose of prescribed heart medication. He told the RMN he could no longer see any point in living. He could not live without his partner and could not believe what had happened. He said he had been drinking heavily during the previous three months. The RMN identified that the man was a high risk of suicide and referred him to the Mental Health Inreach Team (MHIRT). He arranged to see him again on 24 May, although there is no evidence in the medical record that this actually took place.

19. Later the same day, the man was seen by a nurse who was a member of the Safer Custody Detoxification Unit. (The Safer Custody Detoxification Unit is a multidisciplinary team with prison officers, drug workers and mental health nurses. Officers go to see prisoners first of all and go through a scoring system.

The prisoners identified as needing help are then seen by the RMN or drug worker on duty. Officers can also identify individual prisoners they are concerned about.) The nurse interviewed the man as the duty RMN for the Safer Custody Detoxification Unit.

20. The nurse from the Safer Custody Detoxification Unit noted, “Referred for bereavement counselling. Declined safer custody programme. Seen today by Safer Custody RMN. Presented as anxious and distressed. I feel he would benefit from bereavement counselling and a safer custody programme, I will refer to chaplaincy. He has declined safer custody.” She explained that the man had already been referred to the MHIRT.

21. Again on 22 May, an officer completed the man’s induction. The officer noted that the man was quite distressed and seemed very remorseful about his situation. The man said he could not believe what drink could do. The officer wrote, “Took on board support mechanisms available and understands most of induction processes.”

22. The man also had an ACCT review and it appears that observations were reduced to two documented observations in the morning, afternoon and evening, with hourly observations throughout the night. It is not clear how risk was assessed during this or subsequent reviews. He was moved from D1 landing to cell D4-14 at 11.10pm.

23. The man was moved to F Wing on the morning of 23 May and was located in cell F5-45. He was allocated a personal officer. (The personal officer role is potentially very important. Personal officers are residential staff in daily contact with prisoners, and with the task of supporting them. They should be aware of prisoners’ individual needs and personal circumstances. Personal officers are expected to make detailed and relevant in prisoners' wing history sheets, and should provide input into important issues affecting them - for example, self-harm monitoring, and resettlement issues.) The personal officer does not recall that he met the man, possibly because of his shift patterns. The personal officer explained to my investigator that he works at Leeds every second Thursday, Friday, Saturday and Sunday of the month. Every prisoner is nominated a second personal officer who can assist if the original personal officer is unavailable. The man was allocated a second personal officer.There is no evidence from the paperwork that the second personal officer saw the man either.

24. On the same day (23 May 2007), an officer made a note in the man’s ACCT at 6.30pm. He wrote, “Samaritans came on the wing and [the man] spoke to them.” Later he wrote at 8.00pm, “Been with Listeners all association, his mood is average at the moment. Advised that there is the Samaritans phone and staff available if he wants to discuss anything.”

25. On 24 May, the ACCT records that the man spoke to a Listener, on the Listener’s initiative.

26. Another officer spoke to the man twice the next day (25 May). During the first conversation, the man said he was not feeling too bad but was drowsy, probably due to his medication for depression and alcohol detoxification. He told the officer that he had no thoughts of harming himself. The officer spoke to the man again later and the man told him he had had a legal visit. The officer noted, "Wasn't too chatty but said he was feeling fine. [The man] says that apart from feeling tired from his medication, generally he was feeling fine. Was a little bit more talkative than earlier."

27. On 28 May, the man spent an hour speaking to a Listener again at the Listener's request. The Listener told staff that the man was quite chatty.

28. The next day, the man again spoke to a Listener and then had an ACCT review. An SO wrote after the review, "Extremely remorseful and upset at what he has done. States that he is settling in on F Wing. But a further period of close supervision is necessary."

29. On 31 May, an officer increased the level of observations after a conversation with the nurse. The man's observations were increased to hourly documented observations. The man was seen by a consultant psychiatrist and member of the MHIRT, for a psychiatric review on 1 June. She noted:

    "Constant low mood since February 2007. Increased alcohol. Daily use over 20 units a day. Ruminations about his offence. Feels prison has reduced his sense of isolation. Sleep/appetite reduced, improved in prison. Feels life is meaningless/worthless. No current suicide ideation or suicidal acts. 10 year history of depression. Four/five previous overdoses, self strangulation. No Community Mental Health Team (CMHT) follow up. History of heart attack, November 2006. Most recent suicide attempt 15 May 2007 after alcohol at time of alleged offence. No regular psychotropic meds. Period of alcohol use a month ago. No history of memory loss. No alcoholic blackouts. History of sciatica. Closest relative step father. Father? committed suicide 12 years ago. No history of depression. "

30. The Consultant Psychiatrist confirmed that the man was suffering from depression and she prescribed medication.

31. The man spoke to a Listener for an hour on 4 June. The next day he had an ACCT review and his observations were reduced to two documented observations in the morning, afternoon and evening, with hourly observations throughout the night. The officer who increased observations noted in the man's wing history sheet that contact should be made with relevant staff regarding housing and the man should see MHIRT concerning mental health issues.

32. On 6 June, another officer noted in the man's ACCT that he had stayed in bed most of the day. The man told him that he had stomach ache all afternoon which was why he was resting. The officer wrote, "stayed in bed due to an upset stomach, otherwise said he felt right in the mind. Stayed in bed most of the day."

33. An officer told my investigator that on 7 June when he went to unlock prisoners for morning association, the man told him that he did not feel well and did not want to go to association. The officer left the man's cell door open and he again stayed in bed all day. Later in the day, at around 12.30pm a prisoner was moved into the cell with the man. The prisoner had the top bunk. In his interview with the police, he recalled that the man was asleep when he arrived but later that day they spoke about why they were in prison. The man told his cellmate that he felt he did not deserve to be alive after what he had done, and cried as he spoke. The man noticed that his cellmate had a bible and asked him if he was religious. The cellmate told the man that he was a Christian and he advised him to pray for forgiveness for what he had done and to move on with his life. The man told his cellmate that he wanted to take his own life but did not tell him how and when he would do so. The cellmate tried to console the man, but in interview he described how he was grief-stricken and would not stop crying.

EVENTS ON 8 JUNE 2007

34. At around 12.30am on 8 June, the cellmate and the man prayed together. The cellmate told the police that he was worried about going to sleep as he was concerned what the man might do to himself. The cellmate said he eventually fell asleep at 4.00am having heard the man crying. The cellmate did not tell any member of staff about his concerns for the man.

35. Later that morning, at around 8.00am, the cellmate and the man went to collect their medication. At 9.30am, the officer who unlocked for morning association spoke to the man. He was out of his bed and told the officer that he was feeling a lot better than he had the previous day. At around the same time his cellmate noticed that the man did not eat his breakfast. The cellmate failed to persuade the man to eat but successfully encouraged him to go to the exercise yard on association at around 10.00am. They returned to the cell at around 11.00am and watched television together.

36. A second Listener told the police that he had spoken to the man in his capacity as a Listener over a period of approximately two weeks before he died. The man had told him about his offence and said he could not cope with what he had done. The Listener said that the man often spoke to him generally about committing suicide, but after they spoke for a while, his mood usually improved. The Listener told police that he spoke to the man during association around 10.30 on 8 June. The man asked the Listener if he could stop taking his medication for his heart. The Listener told him, he should eat and continue to take his medication or he would make himself ill. The Listener told the police that the man seemed quite depressed and again spoke about suicide. The Listener told an officer around 2.00pm about his concerns that the man was not eating. However, he could not tell the officer anything else about his conversation due to the confidential nature of the Listener role.

37. The Listener was interviewed by my investigator in the presence of a Samaritan. He said he spoke to the man a lot as a Listener but understood that was still confidential information. He understood that he was to recount what the man told him in general, not when he spoke to him as a Listener. He told my investigator that the man was very down and told people on the wing that he was suicidal. His opinion was that the man was depressed. The man told the Listener that he had stopped eating and Officers were aware of that. He did not become friends with the man. The man asked if he could share a cell with the Listener but he was sharing with another prisoner. The Listener said that on the day he died, the man was worse than he had been previously. That was when he spoke to an officer and told him to keep any eye on the man. He said he told three officers that day to get the man moved to the Healthcare Centre. They said they couldn't, because they needed psychiatric reports. He confirmed that the rest of the information the man gave him was confidential. The Samaritans Nature of Service Policies states that Samaritans and Listeners will maintain confidentiality even after the death of a caller or contact and therefore the Listener should not have disclosed any of the information he did to the police.

38. The officer confirmed to my investigator that the Listener told him at around 2.00pm that he was concerned about the man. The man had told the Listener that he had not eaten for two days. The officer spoke to the man immediately but the man told him he was feeling better than the previous day. The officer asked the man why he had not been eating, he said he had a stomach problem but had collected a packed lunch. The officer checked with kitchen staff who confirmed the man had collected a packed lunch earlier. The officer said that the man appeared relaxed and coherent.

39. At about 3,00pm, two officers unlocked prisoners for association on landing F5. The first officer unlocked cells 1 to 26 and the second officer unlocked cells 38 to 48. The second officer unlocked the man's cell (45). His cellmate left the cell but the man stayed inside. According to the second officer, the man sat on the bottom bunk with his feet on the floor and his back upright. He was staring straight ahead and did not speak to the second officer or acknowledge him. At around 3.55pm, the first officer gave the warning to prisoners on F5 that they had five minutes of association left. He told my investigator that some prisoners made their way back to their cells and he locked a couple of prisoners back in their cells. The first officer noticed that the man's cellmate was standing outside the cell, waiting to go back in.

40. The first officer unlocked the cell door and opened it about 12 inches before he felt some resistance behind the door. He looked inside the cell, and saw the man lying face down across the door. The edge of the door was touching just above the man's left knee. There was a ligature around his neck that appeared to have been made from a torn towel. The first officer bent down to examine the man and noticed that the towel was wrapped twice around his neck with a knot tied at the end of the left side. In interview, the first officer described one part of the towel being above the man's Adam's apple and the other part behind it. It was wrapped tightly around his neck. The first officer untied the ligature. He did not notice where the ligature was attached. (A third officer, who arrived shortly afterwards, recalls that the ligature was attached to the bed frame.)

41. A fourth officer asked the first officer if he needed help. He told the fourth officer that he needed medical assistance. The fourth officer used his radio to contact healthcare and call a code blue emergency. (Code blue means there has been a hanging or a choking, potentially life threatening, which does not involve blood. Healthcare staff then know to bring the appropriate emergency equipment.) The Control Room called an ambulance. The first officer checked for a pulse but the man was cold to the touch and had no pulse. By that stage the third officer was at the cell and the cellmate was behind him. The cellmate was placed in the cell next door. The third officer is fully first aid trained and he took over from the first officer. The first and third officer's together turned the man onto his back and noticed that his face was purple in colour and that he was not breathing. The first officer undid a resuscitation mask for the third officer and applied this over the man's mouth. The third officer then performed cardiopulmonary resuscitation (CPR) until healthcare staff arrived at approximately 4.02pm.

42. To nurses relieved the third officer. The first nurse said in her interview with the police that the man was unresponsive. The second nurse administered oxygen

and located an airway. Both nurses attached a defibrillator to assess the progress of the resuscitation. The man remained unresponsive throughout. The paramedic arrived around 4.10pm and intubated the man (placed a breathing tube into his airway). The prison doctor arrived at 4.15pm. The doctor established intravenous (IV) access through a drip in the man's left arm and administered Atropine and Adrenaline. This had no effect and the prison doctor pronounced him dead at 4.25pm.

43. Staff involved were supported immediately by staff care and welfare and were also offered Samaritans support. Representatives from the prison (A Governor and the duty chaplain, the Imam) went to see the man's former wife and his son, shortly after the man's death to break the news. They were accompanied by police officers. They asked to speak to the man's son since he was noted as next of kin in the prison records.

ISSUES

Family concerns

44. The man's former wife spoke to my family liaison officer. She told the family liaison officer that she was unhappy with the way in which the prison informed the family that her ex-husband had died. She explained that the police and an Imam from the prison were at her house when she returned from work. They asked to speak with [incorrect name quoted]'. She asked them if they meant Mrs [the man's surname] and explained that she was formerly known by that name. She suggested they might mean her son. She then became concerned that something had happened to her son. She said they refused to tell her what had happened and wanted to speak directly with her son. While she tried to contact him, one of the attending police officers thought to clarify her son's age. It was eventually established he was just 15 years old. She was then informed of her ex-husbands death. She felt this could have been handled better and also questioned the appropriateness of sending an Imam to break the news when it was known the family belong to the Church of England. She was also concerned that uniformed police remained outside her front door in full view of her neighbours. However, the man's former wife felt the prison had generally been very helpful, particularly the family liaison officer, and she confirmed that the prison had paid towards the funeral expenses.

45. As noted, the man had named his 15 year old son as his next of kin. He had been separated from his mother for eight or nine years and had not had any contact with her since then. However, he did apparently maintain contact with his son. The prison was unaware of his son's age. The local guidance on family liaison, which is in line with the instructions in PSO 2710, 'Follow up to deaths in custody' states:

    > "The family should be informed face to face as soon as possible after the death. Wherever possible, this should be done by a dedicated family liaison officer working alongside the chaplain, or a governor or most senior individual available together with the chaplain. No member of staff should be deployed alone. The police should be told that the visit is to be made and, if judged necessary, should be asked to escort the team or remain nearby. If a dedicated family liaison officer is available for deployment, the duty governor can remain in charge at the scene."

46. I understand the family's concerns. In this case, however, I am satisfied that the Governor and the duty chaplain were the most appropriate members of staff available at the time to break the news, and I make no criticism of the prison about this. Nevertheless, I draw the Governor's attention to the family's preference for a chaplain of their own religion. The family was also upset at the attendance of police officers. Again, I make no criticism of the police attendance which was judged necessary by the prison. I note that the man had been charged with a violent crime and prison representatives did not know what to expect when they visited. I am pleased that the prison family liaison officer, another Governor, telephoned the man's former wife later on the same day. He visited her two days later.

ACCT/Clinical review

47. The Prison Service has various strategies to support prisoners at risk of suicide or self harm. Prisoners can be monitored by an Assessment, Care in Custody and Teamwork (ACCT) form. They can speak to a Listener. They also have access to Samaritans support over the telephone.

48. Prison Service Order (PSO) 2700, 'Prison suicide and self harm management,' recognises the following:

    > "Prisoners charged with homicide are a particularly high-risk group, and within this prisoners charged with homicide against a partner or family member are at an exceptionally high risk of suicide. Reception/first night staff must be made aware of the suicide and self-harm risks associated with prisoners who are charged with offences related to violence against a family member and/or homicide. Care of such prisoners will require close monitoring of trigger points, for example during any trial or around key anniversaries … Establishments must make provision for additional risk assessments and care to keep safe prisoners who have been charged with domestic violence and/or domestic murder/murder of a family member. Such provision must include ensuring a record is maintained to show what action has been undertaken."

49. In the man's case, he was known to have a history of depression with a recent suicide attempt related to his charge. He was assessed as being at high risk of harming himself and placed on an ACCT. He was seen by the prison doctor on 21 May 2007, the day he arrived at Leeds. The following day he was seen by a RMN and a member of the Safer Custody Detoxification Unit. A detailed assessment was undertaken and he was referred to the MHIRT. The RMN noted that he would see the man again on 24 May but there is no evidence in his medical notes that a follow up actually occurred. He was seen by a consultant psychiatrist (a member of the MHIRT) on 1 June. He does not appear to have had any further contact with healthcare staff until 8 June. The clinical review says, "[The man] does not appear to have been seen by healthcare staff following the consultant psychiatrist's assessment but it is not clear that this contributed to the final incident."

    The PCT should consider whether more frequent medical assessment and follow up is required following a review by a specialist consultant.

    This issue of more frequent assessment and follow up was raised in another of my investigations at Leeds (where I published my final report in September 2007). In that report, I recommended that: "The Governor and Head of Healthcare should consider the contents of the clinical review and potential changes that need to be made." The Prison Service responded, "Clinical care and re-design of services are a constant element of any healthcare organisation endeavouring to meet the requirements of the patient and constantly evolving guidance from NICE and other researched based information that is validated by both the service and the PCT." An update from the prison in February 2008

noted, “The department is NICE guidance compliant having recently audited the Depression treatment. Further improvements are being made:

- A system whereby GPs automatically make their own follow up appointments and electronic flags on EMIS for other follow up appointments.
- Automatic reviews and follow ups for those on ACCT for specific periods.
- The development of a national protocol.”

Another relevant recommendation in that earlier report was that: “Prison Healthcare should review the management of depression, including recording of symptoms, follow up and support arrangements and approach to monitoring progress.” The Prison Service replied, “We are currently piloting a new assessment tool for use in primary care mental health. We are also working towards the implementation of The Stepped Care Approach for Primary Mental health in line with current NICE guidance once funding has been secured to fund the extra staff required to implement the Stepped approach.” An update from the prison in February 2008 noted, “A full time equivalent worker will be employed from April 2008 to facilitate implementation of the Stepped Care Approach.”

The PCT Manager should ensure that any action regarding a patient’s care is taken forward appropriately and in a timely fashion to ensure all the patient’s needs are met.

This issue too was mentioned following an earlier investigation at Leeds (where I published my final report in December 2006). One of my recommendations in that report was that: “Healthcare staff need to actively assess the benefits of managing underlying long term conditions against the difficulties of short term stay in the prison, and record decisions.” The Prison Service replied, “This already happens, we endeavour to deal with all clinical conditions, irrespective of length of stay at HMP Leeds.” An update from the prison in February 2008 noted, “All prisoners are now assessed. This will be strengthened by a soon to be completed Health Needs Analysis which will identify any outstanding issues to be addressed via a Delivery Plan.”

50. As we have seen, the man’s level of risk was assessed by healthcare staff. The clinical reviewer concludes in his report that appropriate interventions appear to have been taken and that the man was quickly seen by the consultant psychiatrist. However, the clinical reviewer points out that it is not clear how the level of risk was assessed by healthcare staff when reviewing the ACCT. He recommends that the clinical team should undertake a review to see if a more structured assessment by the healthcare team was warranted. Nevertheless, he points out that it is difficult to see what further steps could have been taken by healthcare to prevent the man’s death.

    The PCT should review the process of assessment of risk by healthcare staff at ACCT reviews to see if a more structured procedure can be adopted.

Personal officer scheme

51. This investigation illustrates the need for effective personal officer schemes in prisons. During the investigation, my investigator discovered that the man's personal officer could not recall meeting him. Indeed, it could be that, due to his working pattern, he never actually met the man at all. The man was allocated a second personal officer to cover any absences of the first officer. However, there is no evidence that the second personal officer saw him either.

52. The public inquiry into the murder of a prisoner at Feltham Young Offender Institution in March 2000 highlighted weaknesses in personal officer schemes in the Prison Service. The report states:

> "The context in which the most effective work with prisoners can be done on a daily basis is the personal officer scheme … If an establishment does not have one, it must have what the relevant Prison Service Order called "a group officer scheme" or a shared working arrangement." No description of how they were supposed to work was given … I remain unpersuaded that it is not possible to operate a simple personal officer scheme even in a busy local prison. The high turnover of prisoners means that the time for personal officers to get to know the people they are responsible for will often be quite short. Inmates could be released or moved on elsewhere before they have been able to build up a relationship with their personal officer. But that should not prevent members of staff getting to know them while they are there …The other problem in busy local prisons is said to be that officers have so much else to do that finding time for personal officer work is a luxury they cannot afford ... I do not believe that no time can be devoted to personal officer work. A couple of minutes with a prisoner - perhaps a couple of times a week - to find out how things are going is all that is needed to let the prisoner know that there is someone there looking out for them … It is necessary for establishments to cater for times when the personal officer is not at work… The role of the personal officer needs to be spelt out so that everyone has a clear idea of what is expected of them. It is much more than a prisoner's first point of contact if they have a problem or want to raise something, though it is that as well. The role is a pastoral one, checking up on the prisoners in their care to see whether anything is troubling them, getting to know them so that they can sense when they are dispirited and need cheering up, and providing them with an outlet for getting things off their chest. "

53. While I appreciate the difficulties of running an effective personal officer scheme in any busy local prison, I note that the Prison Service accepted (in principle and subject to affordability) the following recommendations from the report:

- It should be mandatory for all establishments to have a personal officer scheme. That includes busy local prisons, although if time for personal officer work is limited, it should be used constructively.

- Personal officers should be assigned to individual prisoners, not to a group of cells. They should be members of a small team, so that when a

prisoner's personal officer is not on duty, the prisoner can approach another member of the team.

- The role of the personal officer should be clearly defined in each establishment's personal officer scheme. The Prison Service should publish a model scheme, which should be regarded as having been adopted by every establishment which does not produce one of its own.

- Before officers begin personal officer work, they should receive training locally on what the work involves.

54. The heading for the personal officer section of HM Chief Inspector of Prisons' inspection criteria, *Expectations*, also emphasises the need for effective personal officer schemes:

> "Prisoners' relationships with their personal officers are based on mutual respect, high expectations and support. We expect that personal officers are an initial point of reference for their prisoners, that they are aware of their individual needs and can help them access services, that they know prisoners' personal circumstances and can act as links with their families, that they make detailed and insightful entries in prisoners' wing history sheets, and that they provide input into all matters affecting their prisoners: sentence planning, IEP decisions, self-harm monitoring, and in particular resettlement issues."

55. The most recently published inspection of Leeds by HM Chief Inspector of Prisons in August 2005 identified failings in the personal officer scheme but there was an undertaking from the prison to review the scheme. This happened in 2007 and a pilot programme was developed that became a national programme. Training for this scheme was being undertaken around the time of the man's death. When my investigator interviewed the man's personal officer in September 2007, the revised personal officer scheme was underway at Leeds. I appreciate that, at the time of the man's death, the revised scheme was being rolled out and was new.

56. The prison's own document on the personal officer scheme before it was revised states:

> "Every prison should have an effective personal officer scheme. A fully integrated scheme helps to create a caring, trusting and supportive work place where respect and decency outweigh any malevolent undertones and help to promote a safer, secure and more purposeful environment for prisoners and all staff … Personal officers are alert to the needs of their offenders and which services they can access to help them should the need arise … support for offenders on a more personal level [is] particularly important for prisoners who struggle to cope … Personal officers should contribute to any IEP/ACCT reviews when available or nominate a second to represent the offender in their absence or when not practicable to attend."

57. I am disappointed that the man did not have a personal officer who could offer him this level of support as required. This is not a criticism of the allocated individual. Careful consideration should be given when allocating personal officers to ensure that they are available and can provide appropriate support for prisoners.

    The Governor should review the personal officer scheme without delay to ensure that personal officers are able to perform their role fully.

Conclusion

58. The man demonstrated a number of risk factors. He had previously tried to harm himself and had attempted suicide on the day of his arrest. He had been charged with the homicide of a loved one. He also had a history of drinking to excess and depression. In prison, his heightened risk was correctly identified and he was subject to special monitoring and support. However, while I have been critical of some aspects of his care, there is no suggestion that he confided in staff his intention to harm himself when he did.

RECOMMENDATIONS

1. The Chief Executive of the PCT should consider whether more frequent medical assessment and follow up is required following a review by a specialist consultant.

2. The Chief Executive of the PCT should ensure that any action regarding a patient's care is taken forward appropriately and in a timely fashion to ensure all the patient's needs are met.

3. The Chief Executive of the PCT should review the process of assessment of risk by healthcare staff at ACCT reviews to see if a more structured procedure can be adopted.

4. The Governor should review the personal officer scheme without delay to ensure that personal officers are able to perform their role fully.

1. **The Prison service has accepted the recommendations apart from 3 which has been partially accepted. The action plan is attached.**