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

Report by the Prisons and Probation Ombudsman for England and Wales

July 2007

This is the report of an investigation into the death of a man who was found hanging in his cell at HMP Leeds in July 2006. He had been recalled to prison on 7 June. He was 48 years of age.

I extend my sincere condolences and those of my colleagues to the man's family and friends for their loss. I know that the man came from a close family and that he will be sadly missed.

The investigation into the man's death was carried out on my behalf by one of my investigators. A clinical review was conducted by a doctor from the local Primary Care Trust. I am most grateful to the then Governor of Leeds and his staff for their cooperation and assistance with my investigation.

As a consequence of an increase in the number of prisoners who are recalled, the Release and Recall Section of the National Offender Management Service has seen its workload increase substantially. It seems likely that a delay the man experienced in receiving his recall paperwork, and uncertainty over his release date, preyed on his mind and may have been a contributory factor in his death.

My investigation has established that the man had probably been dead for some time when he was discovered by staff at Leeds. However, I have been saddened to learn that his body was then left suspended for some time.

My report makes a number of recommendations reflecting my concerns about the delay in forwarding the man's recall appeal paperwork, and the response by staff when he was discovered in the early hours of 6 July. More generally, I wonder if the assessment tool currently used to help medical staff judge a prisoner's risk of self harm sufficiently reflects the particular needs of prisoners who have been recalled to custody. It has become increasingly clear to me that recalled prisoners are an especially at risk group. It is therefore of the greatest importance that the procedures of the Release and Recall Section of the National Offender Management Service are as efficient as possible.

Stephen Shaw CBE
Prisons and Probation Ombudsman

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SUMMARY

In September 2004, the man was remanded into custody at HMP Leeds. He was monitored as being at risk of self harm on several occasions, and was seen a number of times by a member of the Mental Health In Reach Team (MHIRT) at the prison.

The man was transferred to HMP Lindholme on 24 February 2005. His records show that over the coming months he experienced a number of emotions, from being high in spirits to feeling depressed.

On 15 September, the man was found in his cell with a ligature around his neck and was taken to hospital for treatment. He told staff that he had heard voices in his head. Later that day, the man was transferred to HMP Moorland, before being sent back to Lindholme on 19 September. On 5 October, the man was seen by a mental health nurse at HMP Wealstun who noted that there were no concerns at that time. The man was released on licence from HMP Wealstun on 9 December 2005.

After his release from prison, the man moved into a flat. He made good progress in the community. He attended meetings with his Probation Officer regularly, and undertook a number of courses addressing his offending behaviour. During this time, the man and his girlfriend began to experience relationship problems. In May 2006, he was arrested for allegedly driving whilst under the influence of alcohol. As a consequence of his behaviour, his Probation Officer made a recommendation to the Release and Recall Section of the National Offender Management Service that his licence should be revoked and that he should be recalled to prison.

The man was returned to HMP Leeds on 7 June. During the reception process the man was screened by healthcare staff. He gave no indication that he was at risk of self harm. Within days of his arrival at Leeds the man was seen by a Registered Mental Nurse and a member of the MHIRT. The Registered Mental Nurse had been in professional contact with the man previously. Over the coming weeks, the Registered Mental Nurse saw the man on a number of occasions. On 16 June, he noted that the man appeared more settled, and during a meeting on 30 June he reached the view that the man was not at risk of self harm or suicide.

When the man was recalled to prison, the Release and Recall Section should within 24 hours have sent him documentation outlining the reasons for his recall and information explaining how he could appeal. However, the necessary paperwork was not sent until 27 June, nearly three weeks after his return to prison. A further delay in forwarding this documentation occurred at the prison, with the man eventually receiving part of his recall paperwork on 3 July.

The man's prison record says that he was notably upset, and was extremely frustrated about not receiving all of his recall paperwork on time. He threw the paperwork over the landing and paced his cell in an aggressive manner.

However, the man received assistance from an Officer who submitted a wing application on his behalf in order to seek an explanation for the delay.

On 5 July, the man received the remainder of his recall paperwork. He told the Officer who delivered it that he wished to appeal against the recall decision. That evening, the man spoke with his mother, telling her that a prison officer had told him that he would not be released until March 2007. In reality, the man would have been released on his licence expiry date (LED) which was 26 July 2006. During the conversation with his mother, the man told her that he had nothing to live for.

In the early hours of 6 July, the man was found hanging in his cell.

THE INVESTIGATION PROCESS

1. The investigation into the man's death was opened by one of my senior investigators. Another of my investigators, took the lead in the investigation and was further assisted by the opening investigator when interviewing staff at Leeds.

2. Notices announcing the investigation were issued to both staff and prisoners, informing them of the investigation and the terms of reference. These were displayed around the prison and invited staff and prisoners to contact the investigators should they wish.

3. My colleagues visited HMP Leeds and were given full access to all areas of the prison. My investigator met with the then Governor, the Independent Monitoring Board (IMB), and made himself known to a representative of the local branch of the Prison Officers' Association. The investigators obtained documentation relating to the time that the man spent at Leeds and records relating to his previous period of imprisonment. Interviews were conducted with a number of staff who had had contact with the man at the prison.

4. I commissioned a clinical review from the Primary Care Trust. My investigator spoke with the local police who confirmed that they had no concerns with regard to the circumstances of the man's death. I would like to thank the Police Liaison Officer and Principal Officer (PO) for their assistance to my investigators. A copy of this report will be sent to the Coroner to assist him with his enquiries.

5. My investigator and one of my Family Liaison Officers, met with the man's parents and family at their home on 24 August 2006. During the meeting, the family raised a number of questions with regard to my investigation, including:

    - Why was the man recalled to prison, and was his ex-girlfriend involved in the decision to recall him?
    - Who informed the man that his release date was to be changed?
    - Was the prison aware of the man''s history of mental health problems, and did they have access to his medical records in order to provide him with the most appropriate care?

    I trust that my report will answer these and other concerns raised by the man's family.

HMP LEEDS

6. Leeds is a category B local prison and 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.

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

8. 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.

9. Since April 2004, when my office started investigating all deaths in custody, there have been seven apparently self-inflicted deaths at Leeds.

KEY FINDINGS

13 September 2004 to 9 December 2005

10. On 13 September 2004, the man was sent to Leeds on remand awaiting trial. In December, he was convicted of possessing a firearm with intent to cause fear of violence. He was sentenced to two years six months imprisonment.

11. After arriving at Leeds on 15 September 2004, an F2052SH booklet was opened as a consequence of the man's low mood and thoughts of self harm. The booklet was closed eleven days later. (The F2052SH is a document which was then used to assess and observe prisoners at risk of self harm. The F2052SH has now been replaced by the Assessment Care in Custody and Teamwork (ACCT) document. This document carries out a similar function to the F2052SH, but additionally highlights the problems, and possible trigger points of a prisoner at risk of self harm, and develops a multi disciplinary plan to give him support and help him through a period of crisis.)

12. On 18 November, the man was seen by a Registered Mental Nurse. The Registered Mental Nurse told my investigators that his contact with the man during this time was fairly positive. He said that the man spoke honestly and openly.

13. On 27 January 2005, shortly after being sentenced, the man was again considered to be at risk of self-harm and staff opened another F2052SH. The booklet recorded that he was low in mood as a consequence of being given a longer sentence than he had anticipated and the loss of his home. Over the following days, the man was seen a number of times by the Registered Mental Nurse. During these meetings, the man reiterated his intention to take his own life.

14. On 8 February, the man's F2052SH booklet was closed. The review board, attended by two members of the mental health team, recorded that the man had made a vast improvement in his mood and that a positive frame of mind shone through. A transfer request to HMP Lindholme was approved. The man was looking forward to this transfer, believing that the worst was now over.

15. The man was transferred to Lindholme on 24 February. On 29 March, he approached an officer at the prison, telling him that he was mentally ill, had run out of medication, and was having suicidal thoughts. As a consequence the man was again placed on an F2052SH. This booklet was closed, with the man's agreement, on 6 April.

16. On a number of occasions over the coming months, staff noted in the man's wing history sheets that he was experiencing a mixture of emotions. A number of entries state that he was settled and high in spirits. However, other entries over the same period record that he was

very depressed and not taking his anti-depressants. In an entry of 28 August, it was noted that he: "keeps his distance from staff, is either up or down, there doesn't appear to be any middle ground with him."

17. On the morning of 15 September, the man told his mother that after his release he was to be sent to a hostel. He said that he was very depressed and that he had voices in his head telling him to kill himself.

18. At approximately 2.00pm that afternoon, the man was found in his cell with a ligature around his neck and with cuts to both his wrists. After receiving emergency medical treatment, he was taken to hospital. At the hospital, the man told staff he was disappointed that he had failed to take his own life and that the thought of leaving prison frightened him. He said that he was following the voices in his head, and it was the devil who told him to do terrible things to himself. An F2052SH booklet was immediately opened. Due to staff shortages on the healthcare centre, the man was transferred to HMP Moorland later that day before being transferred back to Lindholme on 19 September. Ten days later, during a review of his F2052SH, the man acknowledged that when feeling depressed he would use the support mechanisms available to him. The man recognised that he was a manic depressive and said that he had no intention of self-harming at that time. It was agreed by those present to close his F2052SH.

19. On 5 October, the man was transferred to Wealstun. On 17 October, he was seen by a member of the mental health team who noted that there were no concerns at that time. He was released on licence from Wealstun on 9 December.

December 2005 – May 2006

20. After his release from Wealstun, the man moved into a new flat. During a home visit from his Probation Officer on 13 December, the man talked about his offending, alcohol problem and his determination to make a fresh start. At a further meeting on 30 December, the Probation Officer recorded that the man had had a good Christmas. He spent New Year with his girlfriend but, because of his mood, he left early, afraid that he might get into an argument and start drinking. In early January 2006, he started an anger management course and decorated his flat. During this time, he continued to have contact with mental health services.

21. Towards the end of January and at the beginning of February 2006, the man and his girlfriend experienced relationship problems. The man apparently became low and depressed. During this period, his doctor prescribed mild anti depressants. The man continued to see his girlfriend once or twice a week, and told his Probation Officer that they were both happy with the arrangement. However, at the end of February the man's relationship with his girlfriend ended.

22. Towards the end of February 2006, the man's ex-girlfriend made a complaint against him, saying that she felt harassed by him. However, the Probation Officer believed that the accusations made against the man did "not add up". During a discussion with the Probation Officer, the man's Community Psychiatric Nurse (CPN), agreed that the man did not appear to be harassing his ex-girlfriend. Both were of the impression that he genuinely wanted to get on with his life. However, the man was advised not to have any further contact with his ex-girlfriend. The Probation Officer advised the man that, if his ex-girlfriend were to present herself at his flat, he should call the police and not let her in.

23. During March 2006, the man continued to make good progress, coming to terms with the end of his relationship. However, towards the end of March, the man's ex-girlfriend made it known that she intended to obtain a letter from her solicitor barring any further contact by him. However, it was pointed out to her by her own caseworker that this action might be seen as provocative, and that it would be inappropriate if the letter were to be sent to the man's support network.

24. At the beginning of April 2006, the man became upset at an Alcoholics Anonymous meeting and went drinking. The Probation Officer explained to him that this might not mean a relapse, and that he need not throw away everything for which he had worked so hard. At the end of April, the man received a letter from his ex-girlfriend's solicitor, barring contact with her. The CPN felt that the letter was counterproductive and damaging, and noted that the man took the news harder than he had initially admitted to, missing an appointment with his doctor due to a drinking binge.

25. Towards the end of April 2006, the man suffered a loss of money from his bank account for which he blamed his ex-girlfriend. It was recorded on his probation record that he was very upset, angry and "down" as a consequence. However, the man did not let his feelings get the better of him, and it was felt by his Probation Officer that he had handled the crisis well and not turned to alcohol.

26. At the beginning of May 2006, his Probation Officer reported that the man was very well. She noted that he had decided to leave his ex-girlfriend and money issues behind him, enjoying the good weather and his motorbike rides instead.

27. During the investigation, my investigator spoke with the man's solicitor. The Solicitor forwarded a copy of an attendance note that he had made during a visit to the man on 23 June. In the note, he records that the man had told him that on the morning of 20 May he had awoken with deep depression. He had gone out shopping on his motorbike, skidded, and fallen off. Instead of returning home, he went to the pub for a drink, before going onto another pub for further drinks. After leaving the pub he went to the home of his ex-girlfriend, in order to establish why she

was behaving the way that she had been. He shouted through her letterbox, but there was no response. The man said that he returned home, buying more alcohol on the way. After the man had been recalled to prison he admitted to the CPN that he had made a mistake in knocking at his ex-girlfriend's door.

28. On the evening of 20 May, the man was arrested on suspicion of driving his motorbike whilst over the prescribed alcohol limit. The arrest was made in order that the man could undergo further tests at the police station, and to allow for the effective investigation of the alleged offence. The alleged offence had been witnessed by a member of the public at a pub in which the man had been drinking.

29. Whilst at the police station, the man became verbally abusive and physically aggressive, attempting to punch one of the officers present. The following day he was bailed until 5 July.

30. On 22 May, the man contacted his probation office expressing concern that his actions might cause his recall to prison. On 25 May, the probation service learnt that the man's ex-girlfriend had said that he had attended her home, although the police said that there had not been any witnesses and it was not recorded as a crime. At a meeting on 26 May, the Probation Officer advised the man that he would be recalled to prison. The Probation Officer explained that the recall would only be until the end of his licence in July. The man agreed for the Probation Officer to call his mother to explain the situation.

31. On 31 May a Senior Manager from the appropriate Probation Area, made a recommendation to the Release and Recall Section that the man should be recalled to prison.

The man's recall to Leeds

32. My investigator obtained the man's recall file. It records that his recall had been agreed on 6 June. In a memorandum to New Scotland Yard on the same day, a request was made for the police to arrest the man and return him to custody. He was arrested and taken to HMP Leeds on 7 June.

33. A first night reception healthscreen was completed by a nurse. The First Reception Nurse wrote that the man was a diagnosed alcoholic, who avoided alcohol unless he lapsed, and that he had been doing very well for the last few months. She recorded that he had been diagnosed with depression and had self harmed in the past, having made several attempts on his own life. She added that he found it difficult to cope with being in prison and that his mood was up and down. The Clinical Review Doctor notes that the man's suicide screen score was only four. (The suicide screen is a number of questions relating to a prisoner's mental and physical well being. These questions are put to all prisoners during the first night reception healthscreen, and are scored.

Any score of ten or more means an ACCT document must be opened.) The man's score of four did not trigger an ACCT document to be opened.

34. The First Reception Nurse told my investigators that the man gave her no indication that he was likely to self harm at that time. The First Reception Nurse wrote on his Cell Sharing Risk Assessment (CSRA) that she had no concerns. (A CSRA is a document used to gauge the level of risk that a prisoner may pose to other prisoners if sharing a cell.) She said that, had she been concerned, she would have considered opening an ACCT document. The First Reception Nurse had little further contact with the man, other than when issuing his medication.

35. The man spent his first night at Leeds in the first night centre. Whilst there, the CSRA was completed by an Officer. The CSRA Completion Officer told my investigators that she could not recall her interview with the man. However, she said that as he was a recalled prisoner she would have been reliant on him to provide her with personal information when making her assessment. She added that she would only have had access to a limited amount of recorded information at the time. As a consequence the Officer indicated on the CSRA that the man was not on an open F2052SH/ACCT, or that there was any evidence that he had been on one previously. (When a prisoner is transferred from one prison to another, they should be transferred along with their complete prison and medical records. If a prisoner is recalled to prison, and therefore arrives without any old prison records, a request is later made for the records from the prison where an individual was released from. Although there is no record as to when the man's record was requested by Leeds it was received by the prison on 6 July 2006.) The man's old prison record would have contained his previous F2052SHs. However the Officer was not aware of these when she completed the CSRA.

36. On 7 June, the man was prescribed tablets for backache, cream for his dermatitis and escitalopram for his depression by the Locum Medical Officer. However, no notes were made in the man's continuous medical record. The First Reception Nurse explained to my investigators that locum doctors sometimes had a problem in accessing the computer system (EMIS) that holds the electronic medical records of prisoners at Leeds, as they might not have access to the necessary passwords. I conclude that this is the most likely reason why no record of the consultation was made on the man's electronic medical record.

37. On 8 June an administrator in the discipline office at Leeds, faxed a request for the man's recall paperwork to the Release and Recall Section (RRS) at the National Offender Management Service. The administrator made a note of the request in a log book at the prison.

38. When a prisoner's licence is revoked and he is recalled to prison, a request is made by the receiving prison to the RRS for his recall

paperwork. The recall paperwork sent to a prisoner is called the Representations against Recall Dossier and is more commonly known as the “reps pack”, “recall dossier” or simply “dossier”. The reps pack must be issued within 24 hours of the RRS being notified of a prisoner’s return to custody. The pack is made up of a number of documents and information, and primarily advises a prisoner as to the reasons for his recall to prison. This includes information from the probation office giving details for the recall. Annex A of the reps pack is a section that sets out a prisoner’s right to appeal to the Parole Board against recall to prison. This includes a form which prisoners must return to the RRS within five days, should they wish to appeal against the decision to recall them to prison.

39. The same day (8 June), the man was moved from the first night centre to E4 36, a single cell on E wing. Here he was seen by a nurse, a CPN at the prison. She wrote in his medical record that he experienced auditory hallucinations, and was presently very frustrated at being recalled as he had just got things sorted out for himself. The prison CPN noted that the mental health team would be informed that day, adding that the man denied any thoughts of self-harm. However, the man told her that he felt very depressed and had difficulty queuing. He had refused to pick up his medication that morning.

40. On 9 June, the Senior Psychiatric Nurse with the MHIRT, made contact with the man again. During his interview with my investigators, the Senior Psychiatric Nurse said that the man was quite reactionary, and saw his recall as being unfavourable to himself. He said it was:

    “… a case of seeing [the man] just to re-introduce myself as a familiar face, because we’d already got a very good established relationship, and it was a case of trying to allay any anxieties that [the man] may well have at that time.“

The Senior Psychiatric Nurse noted in the man’s prison record that he was: “Somewhat disappointed and angry at his recall saying that it was due to him ‘having a drink’ and posing a risk to people as a result.” He said that the man went on to say how well things had gone for him during his time out of prison, and that now it just felt like he had lost everything. The Senior Psychiatric Nurse told the man he would see him again the following week.

41. On 15 June, the man was visited by a Probation Officer who was covering for his usual Probation Officer whilst she was on leave, and the CPN, his community CPN. During the meeting the man expressed anger and frustration, admitting that he had made a mistake in knocking at his ex-girlfriend’s door. The CPN told the man that the mental health team at the prison were fully aware of the effects on his mental health that his recall to prison was likely to trigger.

42. The Senior Psychiatric Nurse saw the man again on 16 June. He said the man was “looking a little more settled”, and was expressing a lower degree of anger about his recall. Due to time restraints, the Senior Psychiatric Nurse was unable to discuss matters at length with the man, but promised to see him again the following week. The Senior Psychiatric Nurse had no concerns that the man would self-harm at that time, saying: “[The man] was able to work things out for himself in terms of anger, reasons for anger, [and] reflect on that a little bit for himself.”

43. An entry in the man’s RRS, National Offender Management Service file, dated 23 June, simply records, “proceed”.

44. On 23 June, the covering Probation Officer wrote in the man’s probation records that he had completed the risk management plan requested by RRS. He wrote as follows:

> “We rang the RRS section earlier this week, they have a backlog and are unable to process anything at the moment. In the meantime the man stews in prison. This is the first chance I have had to complete this despite the fact it should have been sent a week or so ago, I think”

45. On 23 June, the man also received a visit from his Solicitor. In his attendance note, the Solicitor noted that the man had been told that his sentence expiry date (SED) was 10 March 2007. The man was concerned that this would be the date of his release. The solictor advised the man that, under “the old legislation”, the expiry date for his licence was 26 July 2006. He assured the man that he would make representations to the Parole Board suggesting that this was the correct date, and told the man that he would hopefully be released in one month’s time.

46. On 27 June, the recall file notes that the man’s ‘reps pack’ was sent to Leeds. The pack was received at Leeds on 29 June.

47. On 30 June, the Senior Psychiatric Nurse met with the man again. They spent a good deal of time talking about his situation. The Senior Psychiatric Nurse told my investigators that during the meeting the man described himself as up and down, believing this to be more about the environment than himself. The man talked about working with Alcoholics Anonymous and about his positive approach to life during his time in the community. He spoke about his ex-girlfriend and the fact that he had been issued with a “non molestation order”. The man also talked about the incident involving his motorcycle for which he was subsequently arrested. He concluded the meeting by indicating that he would be receiving information about his arrest from his Solicitor in the next few days. The Senior Psychiatric Nurse told the man that he would see him again the following week.

48. During the meeting, the Senior Psychiatric Nurse completed a mental health risk profile, indicating that at that time the man was not at risk of self harm or suicide. The Senior Psychiatric Nurse told my investigators: "… having known [the man] previous and the relationship that the man and I shared, because he's been honest with me, I had no reason to think otherwise."

49. Following the meeting, the Senior Psychiatric Nurse completed an initial care plan. He identified the man's problems as being his fluctuating anxiety levels, due to his recall from the community, and issues with regard to alcohol use. Intervention was identified as "exploring the issues further at the next meeting". This was scheduled for 6 July.

50. My investigators asked the Senior Psychiatric Nurse whether the man mentioned anything about his recall paperwork. The Senior Psychiatric Nurse said that the man did not know why he had been recalled, and that he had not seen the recall papers.

51. On the same day (30 June), an officer introduced himself to the man as his Personal Officer. He wrote in the man's history sheets that the man had concerns about being recalled and was expecting to be advised of the reasons any time. In his statement to the police, the Personal Officer said that the man was optimistic about his recall being revoked, and expected to be released from prison within days. The Personal Officer allowed the man to phone his solicitor, but said that the man did not appear to have been encouraged by the solicitor, feeling that he had been "fobbed off". The Personal Officer sought advice before informing the man that the recall paperwork could take up to six weeks to come through. The Personal Officer told the police that he saw the man briefly on a number of occasions over the next few days. The man seemed quite normal and gave the Personal Officer no cause for concern.

52. At 11.10am on 3 July, the man rang his Solicitor. He asked his Solicitor if he had heard from the Parole Board about his release date. The Solicitor advised the man that he had not. The lady dealing with his case was currently on sick leave and no one could review the file. However, the solictor told the man that there was a good chance of him being released on 26 July. When the man enquired as to why it was only a good chance, the solictor said that he did not want to build his hopes up unduly. The solictor said that as far as he was concerned the release date would be 26 July 2006, the licence expiry date.

53. Also on 3 July, the Personal Officer recorded that the man had received his 'reps pack' but that parts of it were missing. The part that the man received contained the various reports, but not the annex A which notifies the prisoner of the reasons for his recall and provides him with the necessary forms to appeal. The Personal Officer told my investigators that the man was frustrated and angry about not receiving

all the papers. The Personal Officer said that he delivered the man's 'reps pack' to him on the same day that it arrived on the wing, although he was unable to remember at what time. He remembered that the man was very upset as he only had five days in which to appeal and he was already out of time. The Personal Officer said that the man threw his papers all over the floor and, on returning to his cell, paced up and down in an aggressive manner. The Personal Officer could not get any sense out of the man, so left him to calm down before trying to talk with him again later. During interview, the Personal Officer described the man as being "absolutely furious" on learning that some of the recall papers were missing. The Personal Officer and another prisoner tried to calm him down. They made a wing application on his behalf asking that the man be allowed to speak with someone about an appeal against his recall.

54. The Personal Officer said that the application was to look into why the man had not received the correct paperwork. The Personal Officer said that, even if all the papers had been there, it would have been out of time anyway. The Personal Officer explained how, after this incident, the man made no eye contact with him but just paced up and down. He said that he did not want the man:

> "… to do any sort of violence at all. I didn't want that, I didn't want him being dragged down to the segregation block and I felt confident, given a few days, I could turn him around."

The Personal Officer said that he continued to keep an eye on the man.

55. In his police statement, the Personal Officer said that on 5 July, during the wing's morning briefing, he warned officers to be careful with the man because of his outburst. He said that the officer to whom the application had been made entered the meeting, with the application that had been marked urgent, saying there was nothing he could do with it. All he could do was pass it to legal services.

56. On 5 July, there were 17 'reps packs' to be distributed amongst prisoners at Leeds prison: An officer who works on the legal services desk in OCA (the unit within the prison which organises the transfer of prisoners between establishments), told my investigators that on Wednesday 5 July he had a number of licence recall papers to distribute. He explained that he would have collected them from the administration block at around 11.00am that morning. The Legal Services Desk Officer said:

> "… rather than go around the jail and try and find all the prisoners in their work or in their classroom, or whatever, I decided to wait to lunchtime when all the prisoners were in their cells. Then it would be easier and quicker to go round and see them."

The Legal Services Desk Officer said he saw the man at about midday, seeing him for five minutes at the most. He said that he opened the man's cell door and advised him that he was about to serve him with his recall papers. The Legal Services Desk Officer that:

> "I opened his door, told him who I was, where I was from, and that I was going to serve him his licence recall papers. He seemed quite happy. I explained to him what they were about. I asked him if he wanted to make representations to the Parole Board against his recall and he replied 'yes I do'. I filled in Annex A, which we have here, got him to sign it. I counter-signed it and explained to him that I would send that off to the early release and recall section in London for him that day, which I did, or I took it over to the clerk that does that, and he said he was quite happy, and that's fine, and I put him back in his cell and shut the door."

57. The man did not tell the Legal Services Desk Officer that he had already received other parts of his recall paperwork. The Legal Services Desk Officer was not aware that the man's paperwork was out of date when he received it. The Officer said that there was some contention as to whether it was five days from the date of the letter, or from when the paperwork was issued, that a prisoner had to lodge an appeal.

58. The Legal Services Desk Officer said that, prior to 5 July, the previous time that he had been on legal services duty was on Wednesday 28 June. My investigators asked the Legal Services Desk Officer whether the man had discussed any release dates with him on 5 July. The Legal Services Desk Officer said that, if he had, he would have given the man the sentence expiry date as it appeared on the prison's Local Inmate Database System (LIDS – a computer system used by prisons to record the personal and sentence details of prisoners). However, the Legal Services Desk Officer said that he did not tell the man of his release date because, if he had, he would have noted it.

59. The man was sentenced under the Criminal Justice Act 1991. As such, he would have been released on his licence expiry date, (LED) which was 26 July 2006 as he had been advised by his solicitor on 3 July. However, a representative from the Release and Recall Section explained to my investigators that, under the Criminal Justice Act 2003, prisoners recalled to prison can, at worst, be detained until their sentence expiry date. Had the man been sentenced under the 2003 Act, his release date would have been 10 March 2007. The representative explained that the Prison Service's database only allows the recording of one release date. As a consistent date needs to be entered for all offenders, whether they have been sentenced under the 1991 Act or 2003 Act, it was the sentence expiry date that was recorded, reflecting the requirements of the latest legislation.

60. This was confirmed by the Discipline Office Manager at Leeds, who said that there had been an instruction from the National Offender Management Service that the release date that had to be logged, pending receipt of the notification from the Parole Board, was the SED. As a consequence, it was the SED that would have appeared on the local database as the man's date of release. He said that, if an officer were to enquire on the system, it is the SED that would be seen. The Discipline Office Manager said that an officer would not necessarily be aware that the prisoner would actually be eligible for release on LED, if sentenced before the 2003 Criminal Justice Act. It is clear that the man was told by someone that his release date would be 10 March 2007. However, my investigators have been unable to establish who this was.

61. I make no recommendation in respect of the limitations of the Prison Service database revealed in the paragraph above. However, the Governor may wish to share them with relevant colleagues in Prison Service Headquarters.

62. At 3.16pm on 5 July, the man telephoned his solicitor's office and spoke to someone there for two and a half minutes. It has not been possible to establish what was said during this call, and to whom the man spoke. Telephone calls to legal advisors are not recorded by the Prison Service, and no note of the call appears to have been made by the man's solicitor or his office.

63. At 3.44pm, the man made a phone call to his mother. He said he had just been told by a prison officer that he would be in prison until his SED, which was March 2007. The man explained to his mother that his flat would only be kept for 13 weeks and that she should let everything go into a skip. He asked his mother to sell his motorbike, and told her that there was nothing for him to live for any more. The man said: "I can't stand this waiting for an appeal, I can't stand being in here another day." He went on to say that he would take his own life and that there was only one way out. The man told his mother that they would not be able to do anything more to him now. The man's mother told him "not to be so daft", and not to do anything stupid. The man ended the conversation by saying: "I mean it mum, they are not doing anything more to me now. I will have to go. I will see you later, but I tell you they have drove me to this."

64. The Personal Officer said that he continued to keep an eye on the man during the rest of the day, adding that "on that particular day he [the man] was very polite". During 'lock up', he deliberately left the man out on the landing until last. The Personal Officer said:

> "I left him there while I went round and did all the others. I came round to the centre and I said to him, "will you bang your door for me". He put his thumbs up and I felt we had turned a corner at that point, and I thought well he's obviously ready for some interaction so I'll try and engage him in the next few days. I was

> really pleased at that because I expected him, I visualised him, going in and banging his door and not saying anything, but he actually gave the thumbs up when he went in."

6 July 2006

65. At approximately 4.45am on 6 July, a Checking Officer completed his early morning check of prisoners on E Wing. On reaching the man's cell, the Checking Officer opened the cell door observation flap, using the natural light coming from the cell window to check the cell. The Checking Officer closed the flap then, doing a double-take, reopened it straightaway. On the second time of looking into the cell he put the light on and saw the man facing forwards, hanging from the window bars. The Checking Officer told my investigators that the man's arms were stiff and that it appeared as if rigor mortis had set in. The Checking Officer said that his response was to take several steps away from the door. He called for assistance on the radio, asking for the Night Orderly Officer and healthcare to attend immediately.

66. My investigator asked the Checking Officer whether he was aware of any policies with regard to officers entering cells at night. The Checking Officer said that he was not aware of any policy. He said:

> "I have always been told, and I have always been taught, you do not enter a cell unless you have got a member of staff with you. [You] do not enter a cell under any circumstances unless you have got somebody there with you."

When asked if he was aware of the policy, with regard to attending a cell where a prisoner had been found hanging, that officers should enter the cell immediately and cut the body down, the Checking Officer said that he was. When asked if it crossed his mind that the man should have been cut down, the Checking Officer said "no".

67. My investigators spoke with the Officer who was working on F Wing that night. The F Wing Officer was asked to explain what happened that morning and whether he heard the call by the Checking Officer on his radio. The F Wing Officer said that he had just come out of the centre office when he saw the Checking Officer. He was walking down the wing whilst on the radio saying that he required staff assistance. The F Wing Officer said the Checking Officer was trying to contact the control room on the radio. He said that the Checking Officer told him that he thought he had a suicide. He and the Checking Officer returned to the cell, "looked through the hatch, closed it down and waited for the staff to arrive."

68. The F Wing Officer said that, when he first looked into the cell, he saw the man at the far end by the window. He was apparently standing up with his head hanging down, as if resting, and there was a ligature around his neck. The F Wing Officer said that other staff arrived and

the cell door was opened. He said that the Nurse who entered the cell confirmed that the man was dead. The F Wing Officer said that he only stepped in and out of the cell briefly.

69. My Investigator asked the F Wing Officer if he and the Checking Officer had discussed whether or not to enter the cell, by breaking into their key pouches, before the SO and Nurse had arrived. The F Wing Officer said that they had not. When asked if there was any reason why he did not enter the cell before the other staff had arrived, the F Wing Officer said: "More or less by the time we got back to the cell, the staff were there anyway, you know, so it didn't enter my mind I have got to be honest." When asked about the prison's policy on entering cells, the F Wing Officer said that it was a bit of a grey area, and he was not aware of any written policy on the matter. When asked if he was surprised that the man was not cut down, or if it occurred to him that the man should have been cut down, the F Wing Officer said that it had never crossed his mind.

70. The Checking Officer said that, about one minute after he made the call for assistance, a Nurse arrived at the man's cell with a Senior Officer (SO) the Night Orderly Officer. The Checking Officer did not break into his sealed key pouch as the SO, who was approaching the cell, carried a full set of keys. The SO unlocked the cell door. The Nurse entered first, followed by the SO. The Checking Officer remained in the cell's doorway and did not enter the cell or attempt to cut the ligature. The Checking Officer said that another officer arrived at the cell approximately five or six seconds after the Nurse.

71. The SO was in the Regime Monitoring Unit office. At about 4.45am, she was alerted on the radio to a "blue call" by the Checking Officer. (A blue call is a code used by staff to warn healthcare staff that the incident they are attending involves a prisoner with breathing difficulties.) Whilst making her way to the man's cell, the SO was joined by the Nurse who had also been alerted by the Checking Officer's call.

72. The SO said that, when she arrived at the man's cell, the Checking Officer and the F Wing Officer were standing outside. She said that, on looking into the cell and seeing the man hanging, she immediately opened the cell door. The SO said that the Nurse entered the cell and proceeded to check for signs of life. The Nurse told her that rigor mortis had set in and that the man was dead. Whilst the Nurse was attending to the man, the SO spoke to the police who advised her not to cut the man down. The SO said she was surprised that the officers had not entered the cell before she got there.

73. The Nurse told my investigators that her night shift was coming to an end when she heard the call for assistance, at about 4.46am, asking the Night Orderly Officer to attend E Wing immediately. She said by the sound of the Checking Officer's voice she knew something was not right. The Nurse said she arrived on E wing at the same time as the

rest of the staff. They were directed to the man's cell by the Checking Officer and another member of staff, although she could not remember who this was. The Nurse recalled looking through the cell flap, and within a few seconds the door was opened by the SO. During her interview with my investigators, the Nurse expressed surprise that the officers already present had not entered the cell before her arrival.

74. The Nurse entered the cell and checked the man for any signs of life. She checked his pupils, which were dilated, and searched for a pulse. The man was cold to the touch. The Nurse said it was obvious that the man had been dead for some time.

75. My investigators asked the Nurse if any attempt was made to cut the man down. The Nurse said she had considered cutting the ligature, but that there had been conflicting views as to whether this should be done. She explained that she had been told that, "police prefer them to be left, you know, obviously where they are but there is the dignity side of it." The Nurse said she asked the SO if the man should be cut down, but was told no. The Nurse said that the paramedics were also content for the man to be left where he was.

76. A member of staff was deployed to start a movement log at the cell, and the Checking Officer ensured privacy by placing a piece of cardboard across the cell door's observation flap. The man's cell was sealed at 4.50am and the prison post incident log records that an ambulance was also called at 4.50am. In her post incident statement, the SO wrote that the paramedics attended at 5.05am and pronounced the man dead at 5.10am.

77. A hot debrief was held at approximately 6.40am. It was attended by staff who had been involved in the discovery of the man. A full review of all prisoners on open ACCTs was completed, and staff were offered the facilities of the welfare team at the prison.

78. Amongst the personal property that was left in the man's cell was the Notification for Reasons for the Revocation of his Licence Form, which had formed part of his recall paperwork. On the notification form, the man had, in what is assumed to be his own hand, recorded his thoughts. These included several sentences expressing his anger at 'the system', the 'mental turmoil and abuse' he had suffered, and his belief that he had 'died for freedom'.

79. The prison's Family Liaison Officer, along with the Deputy Governor,, and a colleague from the IMB visited the man's parents at about 9.15am to break the news of their son's death. The man's family subsequently visited HMP Leeds on 14 July and were met by the Deputy Governor and the prison FLO. During this visit, the man's family spent some time alone in the cell he had occupied. The man's personal property was returned to his parents on 25 July.

ISSUES

Clinical Review and Post Mortem Report

80. The clinical review looked at the level of health care the man received during his time in prison. In particular, the review considered the man's time at Leeds after his recall to prison.

81. The clinical reviewer noted the man's history of depression, alcohol misuse and self harm. He observed that the man's medical notes were not available to healthcare staff at the prison. The man was seen by mental health professionals on a number of occasions. The clinical reviewer concluded that the man was promptly referred to and seen by the mental health in reach team. In his opinion, it was "difficult to see what further steps could have been taken to prevent the final incident."

82. A post mortem was conducted on 6 July. The post mortem report gave the man's cause of death as "hanging".

Healthcare

83. The man was assessed correctly by a nurse during the reception process at Leeds. The First Reception Nurse noted the man's history of depression, alcohol abuse and self harm. As part of the healthcare reception process, a suicide self harm assessment was completed. As noted above, the man scored four out of a possible 22. A score of ten would have triggered the opening of an ACCT document.

84. As with other recalled prisoners, I believe the man was in fact at greater risk of self harm than the self-harm assessment indicated. The first reception healthscreen document used at Leeds is a good example of how a medical snapshot of a prisoner's past and current health status can be obtained. However, I judge that the self-harm assessment does not take adequately into account the particular problems of recalled prisoners, and their increased risk of self harm

    The Prison Health Partnership should review the first night reception healthscreen to take into account the particular circumstances and issues presented by recalled prisoners.

85. At Leeds, the man was seen by a locum doctor. However, no note of the Locum Doctors assessment was recorded on the man's electronic medical record (EMIS). The First Reception Nurse explained that locum doctors sometimes had a problem in accessing the EMIS system. I am unable to ascertain whether or not a full medical assessment of the man took place due to the lack of documentation. However, it is clear that the man was seen by the Locum Doctor as he prescribed the medication the man had been receiving in the community.

The Prison Health Partnership must ensure that all locum doctors and healthcare professionals have access to security codes/passwords, allowing them full access to electronically held medical records.

Psychiatric Care by Mental Health In-Reach Team

86. Although it is not clear what input the locum doctor had with regard to an assessment of the man's mental health, it is evident that the man did have immediate access to psychiatric services at the prison. The man was reviewed by an RMN the day after his recall to prison. He was seen by the Senior CPN with whom he had previous contact, the following day. There was no suggestion to any of these mental health care professionals that the man was at risk of self harm.

87. I concur with the clinical reviewer's finding that the man's mental healthcare needs were identified promptly.

Reason for the man's Recall to Prison

88. During their meeting with my Family Liaison Officer, the man's parents asked why the man was recalled to prison, and whether or not his ex-girlfriend had been involved in the decision to recall him. Although the reasons for the man's recall are beyond my remit, I trust that some of the family's questions have been addressed in this report.

89. My investigator was able to establish that after release from Wealstun on 9 December 2005, the man made good progress in the community whilst on licence. He moved into a new flat, he bought himself a motorbike and attended various courses to assist him with his rehabilitation. In her reports, his Probation Officer noted the excellent contact she had with the man and the good progress he made.

90. However, the man's relationship with his ex-girlfriend appears to have placed a strain on his efforts to rehabilitate. The man turned again to alcohol on several occasions. On 20 May 2006, he was arrested for driving whilst over the prescribed alcohol limit. A complaint was also made by the man's ex-girlfriend that he attended her home that evening, although the police said that there were no witnesses and that it was not recorded as a crime.

91. The man was advised by his Probation Officer that he would be recalled to prison. She told him on 26 May 2006 that the recall would only be until his licence expiry at the end of July.

92. On 31 May, the man's Probation Officer made a recommendation that he should be recalled. It was recorded that:

> "Despite his good progress on licence to date, [the man's] recent alleged actions demonstrate a continuing risk to the general

public, particularly the motoring public, and to known adults – i.e. his ex-fiancée in the verbal domestic violence incident."

93. The probation service is required to notify the Home Secretary of any breach of licence, and to provide information in order that a decision can be made whether to recall an offender to prison. It is evident that the decision to recommend the man's recall to prison was not taken lightly, bearing in mind the progress he had been making and that his licence was about to expire. However, given the circumstances of his initial offence and recent behaviour, I do not think the decision to recall the man to prison was wrong procedurally or on its merits.

Recall Paperwork

94. During her interview with my investigators the administrator from the discipline office at Leeds, explained how prisoners received their 'reps packs'. She explained that each day she would contact the Release and Recall Section with the names of prisoners who had been returned to custody as licence revokees, noting in her own logs when the licence was revoked, and when the request for the recall pack was faxed. As already established, the administrator made the request for the man's pack on 8 June.

95. The Discipline Office Manager explained that a prisoner is not formally aware of the official reasons for their recall until the 'reps pack' is forwarded. During interview the CRSA Completion Officer confirmed what the Discipline Office Manager had said. She said that many prisoners, who had been recalled to prison were unaware of the reasons. She added that prisoners were advised to contact their landing or Personal Officer if they had not received their reps packs within a week.

96. The Discipline Office Manager told my investigators that prisoner reps packs should be sent out within five days of an offender's recall to prison. However, he explained that the Release and Recall Section was experiencing a backlog. The Discipline Office Manager said that, if a prisoner was approaching his SED, then staff would chase for the recall pack. Prison Service Order 6000 on Parole Release and Recall (PSO 6000) states at chapter 7 that:

> "When ERRS [Release and Recall Section] is notified that a prisoner has been received into custody, it will issue the representations against recall dossier' to the establishment within 1 day. The parole clerk must ensure that it is disclosed to the offender immediately upon receipt."

97. The discipline office administrator went on to tell my Investigators: "… they had a backlog in the Release and Recall Section. We were waiting for revocation packs from December 2005 as far back as that." The Discipline Office Manager said that, the issuing of the man's reps pack

by the RRS was “quick”, considering that he was returned to prison on 6 June.

98. On 29 June, the man’s recall pack arrived at Leeds and the discipline office administrator logged its arrival at the prison. The Discipline Office Manager and administrator have told my investigators that, at around this time, annex A of the reps pack (the part the prisoner completes in respect of his representations) was faxed to the establishment together with the reasons for recall. The main dossier, which included the previously faxed annex A, would follow by post. When asked by my investigators whether reps packs had ever been split before being sent to prisons the Head of Casework in the RRS, and a Senior Manager in the RRS, said that the pack would not have been split and that there would be no point in doing so.

99. In the man’s case, annex A and the reasons for recall were not faxed in advance of the main dossier. However, the discipline office administrator explained to my investigators that, in order to maintain the system then in operation at Leeds, it was at this point that the reps pack was split into two sections. She explained that section one, including annex A “reasons for revocation”, was picked up by the Legal Services Desk Officer in the observation, classification and allocation unit (OCA) at the prison, and that the remainder of the recall pack was placed separately in a pigeon hole to be sent directly to the man’s wing. The discipline office administrator said that annex A was usually collected every morning and afternoon. However, since the beginning of July 2006, due to staff shortages, they had not been collected at all and staff from OCA had not organised any other system for collecting the packs.

100. The discipline office administrator told my investigators that the problem with OCA not collecting the packs had happened before. She said she had advised them previously of the importance of the document. In her police statement, the administrator said that she had made contact with the OCA department with regard to the annex As not being collected between Friday 30 June and Wednesday 5 July. She was told that the department had no staff to collect them.

101. The discipline office administrator explained that the annex A should be returned to her from the prisoner within 24 hours. It is unfortunate that no note was made when the man’s annex A was eventually returned to the parole clerk. During interview, the Legal Services Desk Officer said that on 5 July he explained to the man that he would either return the appeal paperwork directly to the Release and Recall Section or to the parole clerk.

102. Chapter 7 of PSO 6000 clearly states at page 2 that on receipt of the pack:

> “The prisoner must consider whether they wish to make representations against the decision to recall. The parole clerk

must confirm to ERRS [Release and Recall Section] that the reps dossier has been disclosed and whether the prisoner wishes to exercise their right to make representations within 5 days."

103. My investigation has established that there was a failure in providing the man with this documentation. Records indicate that on 6 June notice was given to the police that the man should be arrested and returned to prison. However, nothing further is recorded until 23 June where an entry simply notes "proceed". The man was arrested and returned to prison on 7 June. A log kept by the licence revokee clerk at Leeds clearly indicates that a request for the man's recall pack was made on 8 June.

104. On 23 June, the man's Probation Officer completed the recall risk management plan. Although there is no definitive note on the man's file, I suspect that it was the covering Probation Officer's phone call, several days earlier, which prompted action from the Release and Recall Section in the form of a request for the risk management plan. Given the evidence available, I conclude that on receipt of the plan on 23 June the Release and Recall Section proceeded with the issue of the man's pack.

105. The pack was subsequently sent to Leeds on 27 June. At around the time of the man's recall, the team covering the region concerned were issuing only 22.3% of recall requests within 24 hours. The representative from the Release and Recall Section acknowledged to my investigators that at the time there were staffing issues within this particular team. The representative said that substantial improvements had recently been made with 70.7% of requests now being met within 24 hours.

106. the man's pack was received at Leeds, as one complete document, on 29 June. Staff at Leeds say that, because of the backlog at the National Offender Management Service 'reps packs' had previously arrived at the prison in two parts. Annex A was sent by fax, with the remainder being sent by post.

107. However, as previously noted, to maintain the system operated by Leeds, the man's pack was split into two when it was received by the prison. My investigation has established that between Friday 30 June and Wednesday 5 July the annex A's were not collected, and consequently not received promptly by prisoners. The man eventually received the second part of his recall pack on 3 July, with annex A being issued on 5 July, six days after it had arrived at the prison.

108. It is quite clear that the Release and Recall Section failed to provide Leeds with the man's paperwork within the required 24 hours, appearing only to issue it when alerted by the probation service. This was further compounded by staffing shortages in OCA in late June and

early July. The man's pack was further delayed by six days once it had reached the prison.

109. The man was evidently troubled by not knowing the full reasons and circumstances of his recall to prison. He had made a number of calls to his solicitor and to his family and was obviously upset in the days leading up to his death. It is evident, given the man's contact with mental health services and probation, that he was somebody who had fluctuating anxiety levels. It seems he was not good at handling uncertainty.

110. As a consequence of Leeds's failure to provide the man with his recall information, he had missed the five day deadline to confirm his wish to appeal. His Personal Officer noted that the man was "absolutely furious" on learning that some of the papers were missing, and he tried to assist him with this. This anger and frustration with the system is reflected in the comments that he made before his death on the revocation licence form found in his cell.

111. The Legal Services Desk Officer, charged with distributing the reps packs on 5 July, was unable to spend more than a few minutes with each of the 17 prisoners whom he saw over the lunch period that day. However, since the man's death a number of changes have been made at Leeds with regard to the way in which the packs are distributed and how recalled prisoners are advised of their expected release dates. I understand that prisoners at Leeds are now issued with their entire pack by the Legal Services Desk Officer. Recalled prisoners at Leeds are now also issued with a standard letter, devised locally, in advance of their recall information which outlines the recall process and sets out provisional dates of release.

112. PSO 6000 sets out a number of actions to be followed by staff when dealing with recalled prisoners. It is clear from my investigation that both the Release and Recall Section of the National Offender Management Service and HMP Leeds failed to comply with these. I also note that the Parole Board was not told of the man's death, reviewing his case on 7 August, one month after his death.

The Release and Recall Section should issue reps packs to prisoners within 24 hours, the time target set out in PSO 6000.

The Governor of Leeds should review local policy and procedures with regard to the issuing and returning of reps packs, ensuring compliance with PSO 6000.

All legal services staff at Leeds should be adequately trained to deal with the legal problems and concerns of prisoners recalled to the prison.

The Governor must ensure that all relevant agencies and

authorities are notified promptly in the event of a death in custody.

The discovery of the man's body

113. The man was found in his cell by the Checking Officer at approximately 4.45am. The Checking Officer told my investigators that he did not enter the cell, but took several steps away from the cell door to call for assistance. The F Wing Officer said that the Checking Officer had left the cell and was walking towards the centre of the prison when radioing for assistance. The F Wing Officer said that he and the Checking Officer then returned to the man's cell together. There is no other witness to confirm one or other account.

114. In his interview with my investigators, the Checking Officer said that the first staff to arrive at the cell were a Nurse and SO. However, the SO and Nurse said that, on arriving at the man's cell, both the Checking Officer and the F Wing Officer already present. The F Wing Officer himself concurs with this account. I think it most likely that both the Checking Officers and F Wing Officer were present at the cell before assistance arrived, and that the Checking Officer was mistaken in believing that the F Wing Officer arrived after the SO and Nurse.

115. Annex C of Prison Service Order 2700 on Suicide and Self Harm Prevention (PSO 2700) clearly states that, upon discovering an apparent suicide, officers should: "Enter the cell as soon as possible, following the local strategy for safely doing so." Prison Service Order 2710 on Follow up to Deaths in Custody (PSO 2710) section 2.3 reiterates this policy stating that:

> "If the apparent death has taken place in a cell, the first person on scene must enter the cell as soon as possible, following the local strategy for safely doing so. Local protocols must contain clear instructions covering cell entry, especially for Night Patrols."

116. Leeds's local protocol, Leeds Policy Document on Caring for the Suicidal and Those Who Self-Harm, says that after summoning help staff should:

> "Enter the cell as soon as possible. Staff can do so alone, taking into account any risk factors that may exist for their own safety by doing so."

117. My investigators have established that upon discovering the man, the Checking Officer called for assistance promptly. But he did not immediately enter the man's cell and cut him from his ligature. I am further concerned that, upon the arrival of the F Wing Officer, no consideration was made by either of the officers to enter the cell as per national and local Prison Service instructions.

118. Annex C of PSO 2700 says that, when confronted with a hanging, staff should support the body to reduce constriction, cut the prisoner down, release the ligature and immediately place the prisoner on his back or a flat/solid surface, check for signs of life and commence resuscitation, if appropriate. This guidance is also reflected in Leeds's own local policy document.

119. The Nurse made a clinical decision not to resuscitate the man as she believed that he was already dead. Indeed, its seems apparent from the statements of staff that the man had been dead for some time before he was discovered. However, whilst I entirely accept the Nurse's decision not to commence resuscitation, it is difficult to see how a full assessment of the man's condition could have been made without cutting the ligature.

In response to the draft report the Prison Service made the following comment:

> "Notwithstanding the fact that the correct procedures were not followed upon the discovery of the man's body, the criticism that the Nurse could not have made a full assessment without cutting the ligature could be considered unfair when read in conjunction with the information in paragraph 79. It was clear that the man had been dead for some time and the decision not to attempt to resuscitate was appropriate."

120. In an earlier investigation into a self inflicted death at Leeds in August 2004, I reported that the prisoner had not been cut from his ligature on being found by staff. As with the man, a medical assessment was completed whilst he was suspended by a ligature. While I am conscious of the need to preserve potential evidence, it is both disrespectful and a breach of PSO 2700 to leave a prisoner suspended from a ligature.

The Governor should remind all staff of the need to comply fully with PSO 2700, PSO 2710 and Leeds's local policy document on self-harm. In particular, he should draw attention to the mandatory action that must be taken by staff upon discovering a prisoner who has made an attempt on his life.

Quality of Post incident Logs

121. My investigators have noted that a number of the post incident logs kept by Leeds have been poorly completed, thus diminishing their usefulness.

The Governor should remind all staff of the importance of completing accurate, contemporaneous and comprehensive logs after any death in custody.

Previous Medical Notes and Files

122. My investigators also drew my attention to the apparent delay in Leeds obtaining the man's previous prison records and medical records. (I believe this had no bearing upon his subsequent death.)

The Prison Health Partnership should review the systems employed at Leeds to obtain previous prison and healthcare records of prisoners who have been recalled to prison, in order to ensure that in future all records are obtained promptly.

Family Liaison Issues

123. The man's family raised a number of concerns with my investigator and my Family Liaison Officer about the way they were treated by staff when informed of the man's death and during their subsequent visit to Leeds on 25 July. My investigator has raised these issues with Leeds. I remind the Governor of the importance of Family Liaison Officers being given the resources to complete their duties appropriately and sensitively.

124. I note that a member of the Independent Monitoring Board attended with staff when the news of the man's death was passed to his parents. I am sure this was well intentioned, but I do not believe it was appropriate to the role of the IMB. Nor was it in line with the advice of the IMB National Council. I do not judge that a formal recommendation is required, but the Governor will wish to discuss this matter with the IMB at one of their forthcoming meetings.

RECOMMENDATIONS

The Prison Health Partnership should review the first night reception healthscreen to take into account the particular circumstances and issues presented by recalled prisoners.

Partially Accepted – "The screening tool used 'The Grubin Assessment Tool' is primarily a validated risk assessment tool. A Forensic Psychiatrist under-took research with HMP Leeds to develop this tool. Any assessment only assesses the patient at that specific time so by the nature of assesses there are limitations but work has been carried out on the tool to ascertain more information."

"Since the concerns raised over prisoners being recalled to prison the Healthcare Department ensures all prisoners undergo a full assessment rather than a shortened Change of Circumstances assessment."

The Prison Health Partnership must ensure that all locum doctors and healthcare professionals have access to security codes/passwords, allowing them full access to electronically held medical records.

Accepted – "All regular locums and consultants have passwords and access to EMIS. At present consultants that only come in on an ad hoc basis do not have access to the system. There is also and administration limitation in that to put clinicians onto the EMIS system and allocate passwords we have to go through the EMIS company to put them on the system. So whilst we endeavour to log all professionals onto the system at short notice this cannot always be achieved. This does not mean they cannot use the system though as they can make entries using the assisting nurses log in protocols clearly documenting that they are entering under the nurses protocol and free texting their name."

The Release and Recall Section should issue reps packs to prisoners within 24 hours, the time target set out in PSO 6000.

Accepted – "Whilst performance against the target has improved over the past 12 months, the Release and Recall Section acknowledge that there needs to be further improvement. Arrangements have been put in place to manage performance more tightly and they are in the process of recruiting additional caseworkers to increase casework capacity."

The Governor of Leeds should review local policy and procedures with regard to the issuing and returning of reps packs, ensuring compliance with PSO 6000.

Accepted – “Policy and procedures have been completely reviewed. Packs are no longer split and legal services staff now deliver to prisoners and advise as appropriate. Now compliant with PSO6000.”

All legal services staff at Leeds should be adequately trained to deal with the legal problems and concerns of prisoners recalled to the prison.

The Governor must ensure that all relevant agencies and authorities are notified promptly in the event of a death in custody.

Accepted – Verbally – New Recommendation.

The Governor should remind all staff of the need to comply fully with PSO 2700, PSO 2710 and Leeds’s local policy document on self-harm. In particular, he should draw attention to the mandatory action that must be taken by staff upon discovering a prisoner who has made an attempt on his life.

Accepted – “Guidance to be issued to staff via Staff Information Notices (BD).”

The Governor should remind all staff of the importance of completing accurate, contemporaneous and comprehensive logs after any death in custody.

Accepted – “Guidance to be issued to staff via Staff Information Notices (BD).”

The Prison Health Partnership should review the systems employed at Leeds to obtain previous prison and healthcare records of prisoners who have been recalled to prison, in order to ensure that in future all records are obtained promptly.

Partially Accepted – “in view of the fact that there is no central organisation that collates electronically the Healthcare records of any person, the systems that are employed by the H/C department are as robust as possible under the circumstances.

The following morning after a prisoner is placed in HMP Leeds administration staff fax the given GP to request information if that prisoner is indeed registered with a GP.

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The system of choice is if the prisoner was released from HMP Leeds then old notes will be searched for, bearing in mind the prisoner will have been allocated a new prison number each time they enter prison. Due to storage and staffing issues for the last 12 months healthcare records at HMP Leeds have been almost impossible to retrieve we are hopeful this situation will be resolved in the near further. As the H/C

department has been fully utilising the clinical IT system EMIS for 18 months then it is possible electronic records can be accessed immediately.

If prisoners were discharged from another prison then the paper records are again requested within a very short period of time, it is simply a matter of waiting for the records to be found and posted on to the receiving prison.

Until all health records are electronic and the Prison Services H/C departments have access then the systems in-place work in an adequate manner.”