Investigation into the circumstances surrounding the death of a man at HMP Leeds, who died in Leeds General Infirmary in August 2009

Report by the Prisons and Probation Ombudsman for England and Wales

July 2010

The man was just 21 years old when he died on 1 August 2009 in Leeds General Infirmary. He had been transferred to hospital the previous day after being found hanging in his cell at HMP Leeds. I offer my sincere condolences to his family and friends for their sad loss.

I wish to thank the Governor of HMP Leeds for making the necessary facilities and information available to my investigator. I am also grateful to the prison's liaison officer for his assistance.

In the course of the investigation, I asked for a clinical review to be carried out into the medical care and treatment of the man received in custody. The clinical reviewer appointed by West Yorkshire Primary Care Trust to undertake a clinical review on my behalf. I am grateful for their assistance and for the clinical reviewer's report.

Since taking over responsibility in April 2004 for the investigation of all deaths in prison custody, there have been 36 deaths at HMP Leeds, including that of the man. Although I have made 137 recommendations in previous reports relating to those deaths, I have not identified any matters that I have written about before that also arise here. I concluded that the man's actions in apparently taking his own life could not reasonably have been anticipated by prison staff.

I make two recommendations in this report.

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

Jane Webb
Acting Prisons and Probation Ombudsman **July 2010**

CONTENTS

Summary

The Investigation Process

HMP Leeds

Findings

Issues

Conclusion

Recommendations

SUMMARY

The man was arrested by officers from West Yorkshire Police on 24 June 2009 and taken to a police station for questioning. Whilst at the police station, he was seen and assessed by a police doctor. After completing his examination, the doctor told police officers that the man had attempted suicide in 2007. He assessed the risk of suicide as high and recommended that the man be placed into a police cell containing a video recording capability.

Following an appearance at a Magistrates' Court on 26 June, the man was remanded into prison custody. This was his first experience of imprisonment.

During the normal prison reception procedure, he was identified as being at risk of suicide or self harm. A nurse decided to begin monitoring him under the Prison Service suicide and self harm procedures known as Assessment, Care in Custody and Treatment (ACCT). An ACCT document was opened, and he was seen and assessed by prison staff and given advice on what support was available to him. On 4 July, ACCT monitoring was deemed unnecessary and the document was closed.

In the meantime, and due to the nature of the allegations made against him, he asked to be regarded as a vulnerable prisoner. This was agreed and he was treated as a vulnerable prisoner from then on. However, due to the main vulnerable prisoner wing (A wing) being full, he was allocated to an overspill cell in C wing, which he shared with another vulnerable prisoner.

The man appeared to have settled in reasonably well to prison life and gave no cause for concern. The only time he did appear to show any visible signs of being upset was following a visit from his family on 30 July. After returning to his cell, he began writing a letter to his family as he wanted to express his feelings for them.

On 31 July, the man declined an offer to join other vulnerable prisoners from C wing who had gone to A wing for a period of association, preferring instead to remain in his cell. However, his cellmate did go, and it was whilst he was alone that the man took his own life. He was later discovered hanging by another prisoner, who then raised the alarm. Despite extensive efforts to resuscitate him both at the prison and in hospital, he was pronounced dead the following day.

I make two recommendations which relate to ACCT procedures at HMP Leeds. One refers to the use of untrained staff to carry out case management tasks. The second refers to post closure interview procedures.

THE INVESTIGATION PROCESS

1. After receiving notification from the National Offender Management Service (NOMS) Prison Service in August that the man had died, I appointed one of my senior investigators to carry out the investigation on my behalf. My senior investigator contacted the prison's governor and arranged to travel to the prison to meet him and his team for the purpose of opening the investigation.

2. On 5 August, my senior investigator arrived at the prison where he attended the opening meeting along with the prison's governor. Also at that meeting were prison liaison officer for my senior investigator, the prison's family liaison officer, a member of the local Independent Monitoring Board (IMB), the senior manager, the Healthcare Manager and the Primary Care Co-ordinator.

3. Following any death in prison, I publish a notice to staff and prisoners inviting anyone with information and who wishes to contact me to make themselves known to the investigator. There was no response to the notices regarding the man.

4. On 24 August, my senior investigator returned to the prison to begin the investigation. He interviewed a number of staff, some formally and others informally. He also spoke to two prisoners whom he believed might have been able to assist my investigation.

5. Four days later, my senior investigator met the deputy governor and outlined his findings to that point. He explained the case was still under investigation and the findings subject to change. Before leaving the prison, my senior investigator arranged to return the following month to continue his work.

6. In the meantime, one of my family liaison officers had been in contact with the man's family. She explained my role and offered the man's family the opportunity to meet her and the investigator. The purpose of the meeting was for the man's family to contribute towards this report and ask any questions they would like examined.

7. On 22 September 2009, my senior investigator and my family liaison officer met the man's parents at their home address, where they were made very welcome. The man's parents were able to provide background information about their son, which I have included within the report. They asked a number of questions relating to the man's time in prison that I believe this report has been able to answer for them.

8. The man's family asked the following questions:

    - What sort of Health and Safety Assessments are done in the prison?

- He had been termed a “vulnerable prisoner” (VP) and they wanted to know what this meant. Additionally, they asked how often he was being checked by prison staff.

- Would he have been able to use the same method of suicide if he had been on the VP Wing?

- Did staff shortages prevent the man moving in with a more supportive cell mate?

- Were there staff shortages at the time of his death due to swine flu? Did this contribute to the length of time he was left before he was found?

- What has been done at the prison following previous deaths?

9. After meeting the man’s family, my senior investigator returned to the prison. The purpose of going back was to meet the clinical reviewer who had been commissioned by the West Yorkshire Primary Care Trust to examine the man’s medical care while he was at Leeds. They interviewed two members of staff who had not been previously available.

10. The clinical reviewer is a general practitioner in Leeds. He qualified in 1986, gaining an MB ChB from Sheffield University. Prior to this he also gained a Bachelor of Medical Science degree at the same university. The clinical reviewer passed the membership of the Royal College of General Practitioners exam in 1990. The following year, he was fully accredited for work in general practice. Between 1997 and 2005, he was chairman of the North East Leeds Primary Care Group and subsequently chairman of the Professional Executive Committee of the North East Leeds Primary Care Trust.

11. In October, the clinical reviewer submitted his clinical review. His report does not include the findings of the post mortem, as it was not available from the Coroner.

12. On 16 March, I received a response to the draft report from the National Offender Management Service (NOMS). They did not identify any factual inaccuracies and enclosed a copy of the prison action plan. The action plan noted that the recommendations made had been accepted and action taken to address them.

13. Two months later, after agreeing to a request from the man’s family to an extension for them to comment on the draft report, my senior investigator received the family feedback. In their feedback, the man’s family asked my senior investigator to include further information about their son. Specifically, they asked:

- Whether the vulnerable prisoner overspill on C wing had been addressed by the prison

- That they receive a copy of the prison response to this report

- Whether there were any plans to reduce ligature points at the prison.

14. I can confirm that the additional family comments about the man have been included and that the prison response to the draft report is included at the recommendations section. I understand that vulnerable prisoners are no longer held on C wing and that they are located on A wing. However, I am not aware of any plans to reduce ligature points.

HMP LEEDS

15. HMP Leeds is situated in Armley, close to Leeds city centre. Built in 1847, the prison has undergone a great deal of refurbishment and extended from four to six wings. It has accommodation for up to 1,008 prisoners.

16. Leeds is a local prison. The majority of prisoners are unconvicted and on remand or awaiting sentence. However, there are a number of convicted prisoners.

17. The prison serves the courts of West Yorkshire and receives and discharges a large number of prisoners each day. The prison has the facility to provide video links directly into court. This helps reduce the number of movements through the prison gate each day. Even so, there were in excess of 20,000 movements in and out of the prison in 2009.

Her Majesty's Chief Inspector of Prisons' report

18. Her Majesty's Chief Inspector of Prisons reports on all Prison Service establishments. The majority of inspections are pre-announced and allow the prison being reported on to prepare for inspection. However, a small number are unannounced, meaning the prison concerned has no prior knowledge that the Chief Inspector's team is visiting until they arrive.

19. In December 2007, the Chief Inspector carried out an unannounced inspection of HMP Leeds. In the introduction to her report, the Chief Inspector referred to her previous inspection carried out in August 2005 in which she focused on negative cultures amongst some staff. She said the latest inspection found there were still considerable problems in the prison, but that vigorous management attempts were being made to deal with them. The Chief Inspector added that the prison was failing to perform well in any of the key areas, with the exception of resettlement. However, she acknowledged there had been progress in all areas.

20. The Chief Inspector said that, between August 2005 and December 2007, there had been 12 self inflicted deaths. She added that the safety of prisoners had been given considerable management attention. She went on to say that a large proportion of prisoners (44 per cent) had felt unsafe, with anti bullying procedures being underdeveloped, high incidence of drug use and vulnerable prisoners not always held safely or decently. That said, she also reported that her inspectors had found evidence of there being "extremely committed individuals" at the prison.

21. In closing her introduction, the Chief Inspector said the inspection showed that there were still fundamental problems which needed to be addressed at Leeds. She added that the management team were working methodically and vigorously to tackle underlying causes as well as the symptoms. She said it was not an easy task in a prison that was "creaking at the seams…" Her final comment was to say that the "… many good and committed staff in the prison … will need considerable support."

22. Under the report heading of "self harm and suicide", the Chief Inspector said:

> "A senior level group had been established to examine how to reduce the numbers of deaths in custody and, as well as implementing practical changes, had identified cultural issues which needed to be addressed. However, not enough was done to ensure that lessons from death investigation reports were learned quickly. Assessment, care in custody and teamwork (ACCT) procedures were inadequate and the safer custody unit was not sufficiently involved. The active group of Listeners largely felt supported. Not enough attention was paid to basic emergency procedures."

    The Chief Inspector made eight recommendations relating to suicide and self harm.

23. In relation to safety, the Chief Inspector said:

> "Vulnerable prisoners were held separately on A wing. Although there was some concern about the mix of sex offenders and others, such as those in debt, most said they felt relatively safe. Arrangements for holding an overspill of vulnerable prisoners on other wings were extremely poor. Some had spent some months in conditions where they felt unsafe and had few, or even no, opportunities for association or exercise."

Independent Monitoring Board (IMB) report

24. Each prison has an Independent Monitoring Board (IMB). Their role is to monitor the prison and to report any concerns that they have regarding the prison or how prisoners are treated. Board members are able to visit any area of the prison at any time, and have direct access to any prisoner who they wish to see or who asks to see them. The Board holds regular meetings in the prison, with the Governor attending for part of the meeting. The Chair of the Board produces an annual report to the Secretary of State for Justice.

25. In the latest report covering the period 2008/9, the IMB Chair, said in the executive summary:

> "The Board judge that, within the constraints of budgets and staff selection and recruitment, HMP Leeds is providing a generally safe environment for prisoners and slowly improving the respect shown to them by staff."

26. The member of the IMB who attended the investigation opening meeting on 5 August, said she had noticed an improvement in how the prison communicated with the IMB. She told my senior investigator that, unlike previous occasions following a death in custody, communication had been good and she and the Board had been kept well informed.

Prison officer grades

27. There are three levels of uniformed prison officer grades. Prison officers are the front-line supervisory staff and, in the majority of cases, prisoners have first and most contact with them.

28. Senior Officers (SOs) are the first grade of managers and act as a reference point for prison officers. SOs are responsible for the day-to-day management of their area, supervising staff and dealing with issues raised by prisoners.

29. Principal Officers (POs) are the highest rank of the uniformed staff. They supervise other uniformed staff and have operational responsibility for the prison.

30. In addition to prison officer grades, there is a group of staff known as Officer Support Grades (OSGs). OSGs wear prison uniform and carry keys but do not carry out the same function as prison officers. Their role is to support the areas of the prison that have little or no prisoner contact: for example, the gate.

First Night Centre

31. First night centres are intended to ensure the safety and well-being of prisoners, particularly during their first night in prison. At Leeds, newly received prisoners are allocated to the First Night Centre once they have gone through the routine reception procedure.

Prison Service Orders (PSO)

32. Prison Service Orders are long term instructions that are intended to last for an indefinite period. Any mandatory instructions to Governors or Directors of contracted prisons are written in italics. Each PSO is given a title and unique reference number.

PSO 2700 "Suicide and Self Harm Management" (Safer Cells)

33. PSO 2700 "Suicide and Self Harm Management" states:

> “The design of safer cells has several features which can assist staff in the task of managing those at risk from suicide, such as specially designed furniture and fixtures which are manufactured and installed to make the attachment of ligatures very difficult, and access to window bars prevented via specialist approved window design. Safer cells are designed not only to minimise ligature points, but also to create a more normalising environment. They have been found to be more durable, easier to maintain and easier to search.
>
> Safer cells cannot deal with the problems underlying a prisoner’s self-harming/suicidal behaviours, and so safer cells can only complement (i.e. not replace) a regime providing individualised and multi-disciplinary care for at-risk prisoners. That said, it is thought that removing or reducing access to means of harm can be an effective way of preventing suicide in some people, especially where suicidal behaviour is an impulsive act in response to particular events or circumstances.”

Vulnerable prisoners

34. Under normal circumstances, vulnerable prisoners at Leeds are held in A wing, holding about 190 similar prisoners. However, at the time of the man’s death, A wing was full and a number of vulnerable prisoners were routinely being allocated to a section of C wing on C4 landing. C wing is part of what is commonly referred to as a “normal location wing”. This means it holds those prisoners who do not need to be kept separated from other prisoners. At the time, there was a mixture of vulnerable and “normal location” prisoners on C4 landing. There were approximately 30 vulnerable prisoners on C4 landing.

Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT requires staff to identify any concerns, take action, and document those actions for prisoners identified as at risk of suicide or self-harm. The ACCT document should be available to all staff where the prisoner is located. Within 24 hours of the document being opened, the at-risk prisoner will be seen by a trained ACCT assessor and have a case review meeting, which is a multi disciplinary meeting. The meeting draws up a care and management plan, known as a CAREMAP, and a member of staff is nominated as the case manager. Wing managers are specifically trained to take on the role of case manager, oversee the management of the ACCT document, and attend case reviews.

Listeners

36. The prison has a “Listener Scheme”, under which the Samaritans train selected prisoners to be the first contact for any prisoner who is feeling

vulnerable and at risk. The scheme is confidential and any prisoner can ask to speak to a Listener at any time of the day or night. Prisoners can access the scheme easily by speaking to a member of staff who will then make the arrangements for a Listener to speak to the prisoner concerned. During the hours that prisoners are locked in their cells, anyone wishing to speak to a Listener can make the request from the night staff on duty. The Night Orderly Officer has the authority to unlock a Listener and to escort him to the cell of the prisoner who is requesting assistance.

Anti-Ligature Knives

37. Staff in contact with prisoners are issued with specially designed anti-ligature knives, commonly referred to as "fish knives" because of their shape, which are used in an emergency to remove a ligature. The knives have a concealed blade which is placed against a ligature and which can be pushed forward to cut it without harming the prisoner.

Care Team

38. Each prison has its own care team. Care team staff are drawn from all areas of the prison and trained specifically to help and support other staff following a serious incident or in other circumstances.

Emergency response codes

39. In the event of urgent medical assistance being required, a number of prisons have chosen to adopt codes to alert medical staff to particular incidents. The most common codes are code red and code blue, although some prisons have opted for code one and code two.

40. At Leeds, codes red and blue are in use. Code red tells medical staff that the patient is bleeding and code blue alerts them that the patient is in breathing difficulty. In prisons where codes are used, healthcare departments have created emergency response bags that contain the necessary equipment to deal with the particular incident. This ensures that medical staff take the correct emergency equipment with them and helps provide the necessary medical care as quickly as possible.

Police investigations of deaths in custody

41. With all deaths in prison custody, the police are notified by the prison as soon as the death has been discovered. In the first instance, the police treat the area where the person is found as a potential crime scene and, as part of their investigation, note the names of everyone involved and those who have been in contact with the body. Additionally, they note the identity of all those entering and leaving the cordoned area. It is only when the police are satisfied that the death is not suspicious that the Ombudsman's investigator can sensibly begin their work.

FINDINGS

24 June 2009

42. On 24 June, the man was in the custody of West Yorkshire Police, being interviewed in relation to a serious offence. As part of the normal procedure for those remaining in police custody, he was interviewed by police surgeon who then completed a risk assessment report. In his report, the doctor warned police that the man had attempted suicide in 2007 by jumping from a bridge. (The man had told the police surgeon this when asked if he had ever tried to harm himself.) The doctor gave his medical opinion in the section of the report headed “Medical advice for the attention of custody officer”, and wrote: “Fit and well. Depression, self harm and overdose two weeks ago, now does not feel suicidal.” Completing his report, the police surgeon assessed the man’s risk of self harm to be high and recommended that he should be located into a police cell with closed circuit television capability. This meant the man would be kept under observation whilst in police custody.

43. Two days later, on 26 June, the man appeared before Bradford Magistrates’ Court having been charged with a number of serious offences. During the hearing he was remanded into prison custody and, following the court appearance, taken to HMP Leeds. This was his first experience of prison.

44. When he arrived at Leeds, the man’s first contact with staff was when he entered the reception department, where his personal details were recorded. During that process, and as part of the normal procedure, he was interviewed by a member of the healthcare staff.

45. The nurse in reception who carried out a medical health screen assessment and recorded the man’s details in his medical record. During that assessment, the nurse completed the suicide risk factor section of the medical record. The section is designed to help identify the level of suicide or self harm risk that a prisoner poses. There are 19 questions, each of which attracts a score of either one or two. Any total score of ten or over means the prisoner is regarded as high risk.

46. After completing the form, the nurse recorded a score of ten for the man. This prompted her to open an ACCT document. At interview, the nurse said she explained the ACCT procedure and her reason for opening it to the man, adding that he appeared to understand what was happening. After completing her assessment, the nurse passed the ACCT form to a member of prison staff for further action. The nurse returned to her normal reception duties and had no further dealings with the man.

47. Having completed the reception procedure, the man was taken by a prison officer to the First Night Centre where he would be expected to

remain overnight. Because an ACCT document had been opened, and in order to keep the man safe, the First Night Centre manager on duty that afternoon, Acting Senior Officer (ASO), allocated him to what is recorded in the ACCT document as a "safer cell". The ASO wrote instructions in the ACCT document for the man to be observed at least two times per hour, and to be given access to a telephone and the Samaritans. Additionally, he noted that the man had been given advice on the Listener scheme and had been told how he could access a Listener.

48. At about 9.10am the following day (27 June), and because of the open ACCT document, the man was interviewed by one of the prison ACCT assessors. In her summary, the officer said there were no outstanding problems or issues affecting the man. She went on to say that he appeared a little blasé about the alleged offence and that he had told her he should not be in prison. He also told the ACCT assessor that he was due to return to court in July and expected to be granted bail. However, it would not be a problem if bail was not granted.

49. At interview, the ACCT assessor said the man appeared confident and had denied the allegations made against him. She said he spoke in depth about his parents and told her that he had spent a lot of time with his father. He told her that he had briefly used cocaine, but had not used unprescribed drugs for at least six months. The ACCT assessor added that she had no concerns about him and repeated that he had said he had not committed the offence.

50. My senior investigator asked the ACCT assessor if she thought the offence was playing on the man's mind. She said that she did not. My senior investigator also asked whether there had been any discussion about previous suicide or self harm attempts. She said he had told her he had taken an overdose in 2007 after falling out with a girlfriend, but there had been no similar event since.

51. Following the assessment, a case review meeting was held with both the ACCT assessor and the man attending. That meeting was chaired by the ASO. At interview, he said he had been temporarily promoted to SO since March 2009. He told my investigator that he had not received any specific training to be an SO, nor to undertake the role of ACCT case manager. The ASO added that he was a trained ACCT assessor and had sat in on a number of case reviews. He noted in the ACCT document that the man had made good eye contact and that his body language was open. The ASO also made a note that the man had denied the offence for which he had been charged, and had told them that he had no thoughts of harming himself. After discussing the reason for opening the ACCT document, they all agreed that it could be closed that day. This was the only occasion that the man was monitored under ACCT. Before closing the document, and as part of the normal ACCT procedure, a post closure interview was arranged for

seven days later, on 4 July. (In fact, the post closure interview did not take place as scheduled and was not held until 7 July.)

52. In the meantime, and due to the nature of the allegations against him, the man asked to be treated as a vulnerable prisoner and submitted a written application. The application was assessed by an officer and she approved the request. As the vulnerable prisoner wing was full, the man was allocated to the overspill facility of C wing and allocated to cell C4/15. Also allocated to the cell with another prisoner. They had asked to share a cell as they had arrived in the prison at the same time and were getting on well.

53. During an informal meeting with my senior investigator, the man's cellmate said he had been in prison a number of times and had previously been a Listener. He said that although the man was often quiet, he never talked about wanting to end his life, or gave him any cause for concern. The cellmate added that he was aware of the man being monitored under ACCT, but said the man told him it was because it was his first time in prison.

54. On 7 July, the man's application for bail was refused and once again he was remanded into custody. There is nothing recorded to show how the man reacted to the news.

55. Also on that day, some three days later than scheduled, the ACCT post closure interview took place. A SO completed the review after which the file was closed.

56. My senior investigator examined why the review was not carried out on the correct date. He spoke to the prison ACCT clerk and asked whether she could explain why the review had been delayed. She could not. She said the ACCT document for the man was sent to C wing on 3 July, but could not say why the review had not taken place on the due date. She said it was unusual for ACCT reviews not to be completed on the correct day. My senior investigator also asked the Head of Performance if he could explain why there had been a delay. In an email to my senior investigator, the Head of Performance said there had been a problem at the prison regarding the timing of ACCT reviews. He said the situation had since been resolved with the responsibility for case management being restricted to fewer managers.

57. Just over three weeks later, on 30 July, the man received a visit from his family. Following the visit he returned to his cell and told his cellmate that his father had cancer and that it had returned after a period of remission. (When my senior investigator and my family liaison officer visited the man's family, they were told that the man's father was not aware at this time that the cancer had returned. His parents left the prison unaware that the man was struggling to cope. Unfortunately, I have been unable to resolve the discrepancy between

the accounts of the man's family and the man's cellmate although I have no reason to doubt that both are an accurate reflection of events at the time.) The cellmate said the man was quiet for a while and then began crying. He told the man that he had previously been a Listener and invited him to speak freely. The man asked him for help writing a letter to his family, saying he wanted to express his feelings and tell them that he loved them, but did not know how to. The prisoner said they spoke about what type of things to write, but that he did not see what was written.

31 July

58. The cellmate told my senior investigator that the following morning was normal. He said the man collected his lunchtime meal and that he was still writing his letter.

59. At about 2.00pm, prisoners on C4 landing were unlocked for association and exercise and escorted to A wing. (Association allows prisoners to mix freely with each other.) Because association and exercise is voluntary, it is not unusual for some prisoners to choose to remain in their cells on their own, or with the other occupant. For those vulnerable prisoners being held on C4 landing, and for their own protection, any prisoner choosing to remain in cell during this period does so in the knowledge that the cell door will be closed and locked. This means they are unable to leave the cell and other prisoners are unable to enter it.

60. The officer who was unlocking prisoners on C4 landing that afternoon. At interview, he said that when he unlocked cell C4/15, the man said he wanted to remain in the cell, whilst the other occupant, decided to leave. The officer said that, although the man had chosen not to go to A wing, he was not concerned about his safety. He added that, as the man was not being monitored for any special reason, there was no expectation that he would be seen until the end of the association period about one hour later.

61. The man's cellmate told my senior investigator that the man said the reason he wanted to remain in his cell was because he wanted to finish writing the letter to his family, and to get it in the post box that afternoon. He told my senior investigator that although it was unusual for the man not to go to A wing, he had no concerns about him. Had he been concerned about him, he felt confident that he would have been able to speak to officers and that they would have taken action.

62. In the meantime, another prisoner had been unlocked to make a telephone call. After completing his telephone call, he went to see a friend on a section of C4 where prisoners who were not regarded as vulnerable were held. He said the purpose of doing so was to ask for tobacco. The other prisoner said he looked into a number of cells in the hope that he would find someone who would share tobacco with

him. When he looked into cell C4/15 he saw the man hanging from the window frame. During an informal interview with my senior investigator, he said the man's feet were off the ground and he was suspended by a piece of bed sheet. He banged on the cell door, but did not obtain a response so ran to tell an officer.

63. One of three officers supervising prisoners on C3 landing that afternoon at interview, said that at about 2.30pm the other prisoner approached them and said there was a prisoner hanging in one of the cells on C4 landing. The officer said that both he and a second officer ran to the cell.

64. The first officer said he looked into the cell through the door observation panel and saw the man hanging. He unlocked the door and both he and the second officer went in. In the meantime, a third officer had used his prison radio to ask for urgent medical assistance using the code blue procedure.

65. The first officer said that, because the man was suspended above the ground, he had to stand on the water pipes to reach the ligature before being able to cut it. At the same time as he cut the ligature, the second officer took hold of the man's legs and lifted him up to take the pressure from around his neck. Once the pressure was released, the first officer used his anti-ligature knife to cut the ligature. The second officer was still holding onto the man when the ligature was cut, but due to the weight he was unable to support the man and unfortunately he hit his head on a radiator as he went to the ground. The second said he saw the man's face twist slightly when he hit the radiator and wondered if he was still alive.

66. As soon as the man was on the floor, the officers placed him into the recovery position and began checking for signs of life, but did not detect anything. The first officer said the man was warm. The second officer said they were just about to turn him onto his back with the intention of performing cardio pulmonary resuscitation (CPR) when healthcare staff arrived and took over.

67. The first nurse on the scene who was on duty that afternoon said that one of her duties that afternoon was to carry a prison radio, and to be first response to any medical emergency. Her radio call sign was 'hotel three'. She told my senior investigator that in the event of a medical emergency, the person carrying the radio is required to go direct to the scene, whilst other medical staff collect emergency equipment and follow on. She said there are specific types of equipment taken depending on the emergency.

68. At interview, the first nurse on the scene said that she and one other nurse were preparing medication prescriptions when she heard the code blue radio message. When she heard the message at 2.31pm, she went straightaway to the man's cell. She said the second nurse on

the scene, arrived at about the same time. The first nurse on the scene told my investigator that when she looked into the cell she saw the man on the floor on his left side. His skin colour was dark, describing it as being almost purple (cyanosed, which is a blue tinge of the skin and caused by a lack of oxygen). The nurse said the ligature had been removed, but she could clearly see where it had marked the man's neck. The first nurse on the scene checked for signs of life but could not detect any. The nurse said the man's skin temperature was warm, his eyes glazed and there was no evidence of rigor mortis. During the brief time that the nurse was waiting for the emergency equipment to arrive, she began CPR at the rate of two breaths to 30 compressions.

69. In the meantime, the emergency medical equipment arrived and the first nurse on the scene attached the automated defibrillator pads to the man's body. (A defibrillator can restart the heart in some cases of cardiac arrest by giving an electric shock. It detects the electrical activity in the heart and gives automated instructions to the rescuer.) The nurse said the automated system did not instruct her to shock, but to continue CPR. (In his clinical review, the clinical reviewer said this was due to a lack of heart rhythm, referred to as "asystole".) She inserted a plastic airway and began to administer oxygen, and also inserted a tube into a vein to allow intravenous access. The two nurses continued CPR until a paramedic first responder arrived at 2.40pm. He was followed a few minutes later by two more paramedics and they took over CPR.

70. The first officer on the scene told my investigator that, when healthcare pulled the man's top up to allow the defibrillator pads to be attached, there was a letter tucked into the top of the man's trousers. The officer, said he did not read the letter, and it was later taken away by police officers carrying out their investigation. (My senior investigator has obtained a copy of the letter. It is a personal note from the man to his parents and explains his reason for ending his life. It is clear that the man did not feel able to deal with prison.)

71. The clinical reviewer notes in his clinical review that paramedics administered four doses of intravenous adrenaline to the man. Additionally, a tube had been inserted to allow full ventilation of his lungs. The first nurse on the scene said she had noticed an improvement in the man's colour and was under the impression that paramedics had detected some sign of life.

72. At the same time as the man was being cared for, prison staff began locking up those prisoners who hade been unlocked on C wing. The other prisoner told my senior investigator that officers had been concerned about him and had asked a Listener to join him in his cell to provide support.

73. At 3.06pm, paramedics transferred the man to Leeds General Infirmary (LGI) by ambulance. The clinical reviewer records that CPR continued throughout the resuscitation attempts and transfer to hospital.

74. The first nurse on the scene said that, under normal circumstances, whenever a prisoner dies in custody, paramedics leave the body at the prison until police have completed their enquiries. However, on this occasion because they transferred the man to hospital, it led her to believe he might still be alive.

75. The man arrived at hospital at 3.25pm and was taken to the resuscitation area where his condition was assessed by doctors. The assessment showed no cardiac output or spontaneous breathing. However, after about 20 minutes the medical team managed to restart the man's heart. He was transferred to the intensive care unit, and still required full airway and ventilatory support using a life support machine.

76. Due to the seriousness of the man's condition, the Governor was asked by a member of hospital staff to contact his family to ask them to go to the hospital as quickly as possible.

77. Under normal circumstances whenever there is such bad news to pass onto a family, the Governor or a representative of the prison would be expected to go to the next of kin and inform them in person. However, because of the urgency of the hospital request, the Governor decided to telephone the man's family. At about the same time as the Governor telephoned the man's family, the Deputy Governor went to the hospital to meet them as they arrived. She also spoke to and supported those prison staff who had accompanied the man to LGI.

1 August

78. Sadly, the man did not regain consciousness. The clinical reviewer says in his clinical review that, having been starved of oxygen for so long, the damage to the man's brain was deemed to be so severe that he was pronounced dead. The time of death was recorded at 4.25pm.

Following the man's death

79. Following the man's death there was a review of all those prisoners being monitored under ACCT to ensure there was no adverse reaction. This was in line with normal procedure.

80. Additionally, there was a 'hot debrief' chaired by a senior manager who met the staff involved. As well as the debrief, the prison staff care team was made available to any member of staff wanting to see them. The Governor arranged for a critical incident debrief to take place. (This offers a more in depth level of support.)

81. The other prisoner said the Governor came to see him personally to thank him for raising the alarm. The Governor had given him a small reward of tobacco, which he appreciated very much. He said a number of officers had spoken to him after the death, wanting to make sure he was okay. Similarly, the cellmate said a number of prison officers and nurses had spoken to him, which he had found supportive.

ISSUES

Assessment Care in Custody and Treatment (Case management)

82. One of the mandatory instructions of the ACCT procedure is that all case managers are appropriately trained. PSO 2700, section 1.3.1, states:

    > "All Senior Officers, Principal Officers and Operational Managers (F and above), including Governors and Directors, must be trained to at least ACCT Case Management level."

83. On 27 June, although not trained, the ASO chaired a case review meeting. This was contrary to the instructions. Whilst I have no reason to believe that the ASO's management of the case review was in any way deficient, it is important that proper systems are in place and are followed. I understand that, since the investigator pointed out this finding, the Governor has taken steps to remedy the system. Nevertheless, I think it sensible to make the following formal recommendation.

    The Governor should ensure that ACCT case managers have received the necessary case management training and are competent to act as case managers. This should include any uniformed member of staff who is temporarily promoted or those carrying out short term "acting up" duties.

Post closure review

84. After closing the ACCT document, a post closure interview was scheduled for 4 July in line with requirements under PSO 2700. However, as a result of what appears to have been an administrative problem and a lack of available managers, the review did not take place for a further three days until 7 July. After raising the finding with the Governor, I understand the Governor has corrected the problem and that there is a new system in place to ensure post closure interviews take place on time.

    The Governor should ensure that the mandatory instructions contained within PSO 2700 are followed.

Vulnerable prisoners

85. As this report has shown, a number of cells on C4 landing are being used as an overspill for vulnerable prisoners unable to be located into A wing. This is clearly not ideal. It means that vulnerable prisoners, although locked into their cells, are potentially liable to intimidation from normal location prisoners able to access the C4 landing. Whilst I have no evidence that the man was in any way subject to intimidation, it

concerns me that the separation between vulnerable and normal location prisoners is not sufficiently robust.

86. It is clear, for example, that the other prisoner was allowed to walk freely to C4 landing and to come into direct contact with any vulnerable prisoners who had decided to remain in their cells. Whilst I make no formal recommendation, the Governor will wish to satisfy himself that his systems for protecting vulnerable prisoners are robustly managed.

Care for prisoners

87. At a time when prison staff were dealing with an extremely difficult situation in C wing, there was clear evidence of care and support being shown towards the other prisoner. To ensure he was supported, a Listener was asked to join him. This was a kind, thoughtful and professional gesture, demonstrating good practice.

Clinical review

88. In his clinical review, the clinical reviewer comments as follows:

> “The commonest method of attempted suicide in prison is one of asphyxiation, as in this case. Unconsciousness occurs fairly quickly and usually within several seconds. Brain death occurs due to oxygen starvation within a few minutes, though the heart can remain beating for several minutes longer (10-15 minutes in total). It was likely that the man was discovered hanging from his cell window just after this period since he was showing minimal, if any, signs of life. Though his body was warm, he had no discernible cardiac output or spontaneous breathing. The cyanosis confirmed the lack of normal oxygenation of his body.
>
> “The response to this situation appears to have been quick and appropriate with medical support arriving promptly. Cardiopulmonary resuscitation (CPR) was begun in a timely manner and was continued throughout until his heart was eventually fully restarted in the emergency department of the hospital.
>
> “From my assessment I would like to note that the man received good quality resuscitation prior to the arrival of the paramedic crews and then subsequently prior to hospital and that he was given the best possible chance of survival from the emergency care he received at this time. However in my opinion the damage had already been done by the time the man was found and so the outcome, despite the best efforts of the prison staff, paramedics and hospital staff, was unfortunately inevitable.”

89. Concluding his clinical review, the clinical reviewer commends the man’s family. He reports that, despite the tragedy that had befallen

them, they had the fortitude and courage to contemplate and then proceed to donate the man's organs. Others will live as a consequence of their kindness, and I add my own thanks to them here.

90. The clinical reviewer makes no recommendations.

Family concerns

91. As well as the matters raised above, the man's family have asked me to consider several other issues that I have set out in paragraph 8 above. My senior investigator has spoken to the prison and has received the following answers.

92. Leeds have confirmed that swine flu was not affecting staff levels on C wing on the day of the man's death. In terms of risk assessments, Health and Safety risk assessments are carried out whenever there are changes made. The prison also conducts a daily fabric check to ensure that the integrity of the cell is sound and secure and that the cell is habitable. Finally, Leeds confirmed that the windows in C wing are a different design to those on the vulnerable prisoner wing. However, the design of the vulnerable prisoner wing windows does not make them anti-ligature, and it is unlikely that this in itself would have been a factor in the man's death.

CONCLUSION

93. I have considered carefully whether the matters I have discussed relating to the ACCT process had any bearing on the man's actions. Although it is clear that the prison was not complying with the instructions of PSO 2700, I do not feel that this meant the man was not supported. In fact, there was every indication that he had settled in reasonably well and was displaying a positive outlook. I am therefore satisfied that the decision taken to close the ACCT document was reasonable and would probably have been made whoever was the case manager..

94. In relation to the man being a vulnerable prisoner, again I am satisfied that he was given the appropriate support and that there were systems in place to ensure he could feel safe. That said, I question the sense of allowing normal location prisoners to gain access to vulnerable prisoners. The issue of the use of overspill accommodation has also been identified by the Chief Inspector of Prisons in her latest report.

95. Overall, I am satisfied that the man's prison and medical care was appropriate. He gave no indication of what it was he was planning to do, but does appear to have given it some thought. He wrote to his parents, setting out his final wishes in some detail, and then ensured he would not be disturbed for a while. I conclude that the man took his own life, but his actions could not reasonably have been anticipated by prison staff.

RECOMMENDATIONS

1. The Governor should ensure that ACCT case managers have received the necessary case management training and are competent to act as case managers. This should include any uniformed member of staff who is temporarily promoted or those carrying out short term “acting up” duties.

   The recommendation has been accepted. The Governor said: “HMP Leeds have moved to core group model* with three Safer Prison’s Senior Officers completing the role of case managers”.

   (*I understand the prison has developed a safer prison group and it is they who are now responsible for ACCT case management.)

2. The Governor should ensure that the mandatory instructions contained within PSO 2700 are followed.

   The recommendation has been accepted. The Governor said: ”HMP Leeds have just received a full PSO 2700 audit with the only area of non compliance being put right during the audit.”