

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

**Report by the Prisons and Probation Ombudsman
for England and Wales**

August 2009

This is the report of an investigation into the death of a man at HMP Leicester in August 2007. He was found hanging in his cell. He had been in prison for less than two months.

My colleagues and I offer sincere condolences to the man's family and friends for their sad loss. I must also apologise for the delay in issuing this report. This was caused in part by a delay in receiving the clinical review.

The investigation has been undertaken by my colleague. I would like to thank the Governor of HMP Leicester at the time of the investigation and his staff for their participation. Particular thanks go to prison family liaison officer.

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

The man had been identified by his personal officer as someone who was at risk of committing suicide or self harm and had appropriately been placed on monitoring and support procedures. Indeed, he illustrated a number of risk factors. He suffered from paranoid schizophrenia and psychopathic personality disorder. He had a history of depression, particularly following the death of his mother, and had previously attempted to take his own life. He had been admitted to a psychiatric hospital four years earlier. He drank to excess and took illegal drugs.

The investigation has highlighted a number of concerns about the man's care and my report includes eight recommendations, six of them derived from the clinical review, and a number of other points for the Governor's attention. I have also cited two examples of good practice.

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SUMMARY

In June 2007, the man was detained at a Police Station, and charged with robbery. He was assessed by a Forensic Medical Examiner, who noted that he suffered from paranoid schizophrenia and psychopathic personality disorder and used unprescribed methadone from time to time. The Forensic Medical Examiner concluded that the man was mentally stable. He said he was taking medication to treat his schizophrenia. He did not have any medication with him. The Forensic Medical Examiner prescribed the relevant medication which was obtained the next day. He told Forensic Medical Examiner that he had not deliberately self-harmed for three years. He was judged fit to be detained. Nevertheless, half hourly observations were arranged.

When the man arrived at HMP Leicester three days later on 25 June 2007, the initial reception health screen noted that he had been in prison a year previously. He did not have any concerns about his physical health. He said that he drank excessively and that he had last taken alcohol three days previously. He also said that he had used illegal drugs in the last month. He said that he suffered from schizophrenia and that he had been in a psychiatric hospital in 2001. He told the nurse that he had previously harmed himself both in prison and outside, but he did not wish to talk about it. The man did not think he would harm himself as a result of being in prison. The nurse offered to put him in contact with the chaplaincy, Listeners and Samaritans for counselling as he was having trouble coming to terms with his mother's death in February 2007. (Listeners are prisoners who are trained by the Samaritans to give confidential emotional support to fellow prisoners.) The nurse referred him to the Mental Health In reach Team (MHIRT).

The man saw a doctor whose opinion was that he was fit for normal location and to share a cell. He also recommended alcohol detoxification.

On the next day (26 June), the man had a secondary health screen by a doctor. The record of that assessment contains information about his height, weight, blood pressure and smoking.

On the same day, the man saw a detoxification nurse. He was showing signs of alcohol withdrawal, and he was put on an alcohol detoxification programme. He did not fully co-operate with the programme.

Two members of the MHIRT saw the man on 4 July 2007. They concluded that he did not show any sign of mental illness and there was no role for them. They were to see him again at the end of August to review his situation.

On 13 July, the man was placed on an Assessment, Care in Custody and Teamwork (ACCT) form by his personal officer as she was concerned about his wellbeing. (ACCT is the system used by HM Prison Service to monitor and support a person at risk of suicide or self-harm.) He had his first ACCT review the next day and the next review was scheduled for 30 July. (That review eventually took place on 5 August.)

On 31 July, the man's personal officer was concerned about him and she noted in his ACCT record that she had contacted the healthcare centre to ask for him to have

another mental health assessment. His mental health was not reviewed and there is no evidence that this message was ever received. On 5 August, the man said that he wanted a different cellmate. He claimed that his cellmate was untidy and dirty and he did not want to share the cell with him.

On 7 August, the man had a disagreement with his cellmate and asked to move cells. His cellmate was moved out which left him in the cell on his own. Again, a member of staff noted in his ACCT that he needed to be seen by a member of the MHIRT. This never happened.

Sadly, the man was found hanging in his cell on the morning of 13 August 2007. Attempts to resuscitate him were unsuccessful and he was taken to the local hospital at 6.40am where he was pronounced dead.

THE INVESTIGATION PROCESS

1. My investigator studied all relevant prison records relating to the man. These included his main prison record, medical record and statements made by prison staff.
2. A doctor was asked to carry out a review of the man's clinical care and I am grateful to him. My investigator also contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist in his enquiries into the man's death.
3. One of my family liaison officers contacted the man's partner who was his nominated next-of-kin, and his father and step-mother. My family liaison officer informed both parties about my investigation and offered them the opportunity to ask any questions. They were also invited to raise any concerns about the care he received whilst at Leicester for consideration as part of my investigation. His partner told the family liaison officer that on her last visit to him on 4 August 2007 he had told her that he had cut himself and was not coping well in prison. He further revealed during a telephone call on Sunday 12 August that he had cut his leg and was struggling in prison. His partner asked if the investigation could identify what he had used to cut himself and why he did not receive a further mental health assessment at this time. She also asked why he had been allowed to have bed sheets when he was being monitored as a risk of self harm or suicide. These points are addressed under paragraphs 33 - 44 of my report.
4. My family liaison officer and my investigator also visited the man's father and step-mother at their daughter's home. They were concerned as to why his medication for schizophrenia had been discontinued whilst he was in prison. They asked why the prison had not found an alternative method of administering the medication, such as dispensing it in liquid form or under supervision. They asked whether his personal officer had been on duty during the night when he died. They questioned whether the man's difficulty with sleeping had been related to the cessation of his medication. They asked whether his solicitor had been in contact with him during the weeks prior to his death. They were also unhappy with the contact from the prison following his death. They were upset that the prison appeared to be treating his partner preferentially as the man's nominated next-of-kin. They were also distressed to receive a letter of condolence from the Governor which was incorrectly addressed to the man's partner. Again, these issues are addressed in paragraphs 33 - 44. I hope this report will help the man's family and partner better understand what happened in the time leading up to his death.
5. My investigator discussed aspects of the man's treatment with staff at Leicester and with the clinical reviewer. (Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to contribute). During the course of the investigation 16 members of staff were interviewed by my investigator and the clinical reviewer. My investigator also

spoke with the police in relation to their investigation and obtained all their statements.

HMP LEICESTER

6. HMP Leicester is a category B local prison situated in the centre of the city. It is a Victorian establishment with an operational capacity of 385 prisoners. The main residential unit is a large, four-storey building. Level 1 holds the First Night Centre, Segregation Unit and Behaviour Improvement landing. Level 2 contains a self-contained Detoxification landing and Vulnerable Prisoner Unit. Levels 3 and 4 hold prisoners on basic, standard and enhanced status under the Incentives and Earned Privileges Scheme.

7. The most recent report at the time of the man's death, by HM Chief Inspector of Prisons, was published in August 2006. It says:

"Of particular concern was the approach to suicide and self-harm, given that the prison had experienced nine deaths in custody over the previous 28 months, seven of them apparently self-inflicted. The timescale for implementing recommendations from the inquiries into these deaths was unacceptably long, and the operation of the new assessment, care in custody and teamwork (ACCT) process for supporting those at risk of self-harm was not effectively managed.

"A re-inspection by the Adult Learning Inspectorate in 2005 had found that standards in education and training had slipped - most areas of training were weak or unsatisfactory. Challenges had been implemented by a new head of learning and skills, but there was as yet no education manager. Opportunities for purposeful activity were limited, there was no vocational training at all and only 80 of the prison's 330 men could access education."

Leicester received a further inspection in June 2008 which shows some improvement:

"A safer custody policy and monthly meeting provided strategic oversight to suicide and self harm work, and relevant management information was collected and analysed. There were delays in receiving Prisons and Probation Ombudsman (PPO) draft reports from previous deaths in custody but local action plans were in place. A full-time safer custody coordinator was in post and the quality of assessment, care in custody and teamwork ACCT) documents was good, although reviews were insufficiently multidisciplinary. ACCT assessors met monthly, and family liaison work was very good. Listeners were generally well supported but access was limited during the patrol states."

8. Since April 2004, when I started investigating all deaths in prison custody, there have been 15 other deaths at Leicester. There has been one homicide, 11 apparently self-inflicted deaths and three from natural causes. Not all reports have been issued. There are no common issues between the death of the man who is the subject of this report and my previous investigations.
9. Every prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life and ensure that proper

standards of care and decency are maintained. The IMB report for Leicester for 2007-2008 says:

“In-Reach Team. The Leicester Partnership Trust provides the two members of the In-Reach team permanently based at HMP Leicester. Though located within the healthcare facility the team provides secondary mental health help to prisoners within the prison. However, the IMB is concerned that this is insufficient personnel for the high numbers of prisoners requiring mental health support.

“Safer custody - 2007 was the first full year of the Safer Custody Group and this will expand further in the next year with the appointment of a Violence Reduction Co-ordinator. The Safer Custody Committee meets monthly. The IMB occasionally attends, and receives the minutes of each meeting.

“ACCT - During the year (2007-2008) 263 ACCT documents were opened compared with 268 in 2006-2007. ACCT documents are checked both weekly and monthly and the majority are rated as ‘acceptable’ and some as ‘excellent’. Systems are in place to improve the overall rating. The Board is now satisfied with the ACCT reviews which take place. Prisoners to be reviewed are highlighted in the Daily Report. Other agencies and the IMB are now better informed and attendance has consequently improved. ACCT assessors - during the calendar year 2007, the number of trained assessors fell from 18 to 12, though staff have continued to manage the workload. More assessors are due to be trained.”

KEY EVENTS

10. On 22 June 2007, the man was detained at a Police Station and charged with robbery. He was seen by a Forensic Medical Examiner, at 9.45pm. The Forensic Medical Examiner noted that the man suffered from paranoid schizophrenia and psychopathic personality disorder and that he used unprescribed methadone from time to time. The doctor concluded that the man was not withdrawing from opiates and that he was mentally stable. The man said he was taking Chlorpromazine 50mg three times a day and Olanzapine 10mg at night (both medications are used to treat schizophrenia). He did not have any medication with him. The Forensic Medical Examiner prescribed Diazepam 5mg that night to help the man sleep. Chlorpromazine and Olanzapine were prescribed and obtained the next day. He told the Forensic Medical Examiner that he had not deliberately self-harmed for three years. Half hourly observations were arranged for him. The Forensic Medical Examiner assessed that the man represented a medium risk of harming himself but was fit to be detained.
11. On 25 June, the man was transferred from police custody to HMP Leicester. An officer completed a cell sharing risk assessment which was agreed by a nurse. He was considered a medium risk of sharing a cell with others. (That is, there was no immediate risk if he shared a cell, but the situation would have to be reviewed regularly.) The officer noted by way of the tick boxes on the form that the man had abused alcohol/drugs and was currently dependent on drugs or alcohol. The man said he had previously been monitored on a F2052SH in prison. (This was the system used by the Prison Service to monitor and support a person at risk of suicide or self-harm before the introduction of ACCT.) The nurse noted that the man had mental health problems and said he would like to share a cell with another prisoner.
12. The nurse completed a first reception health screen. She recorded that the man had been in HMP Wellingborough one year previously. He told her that he had not seen a doctor within the last few months but that he was taking Olanzapine 10mg daily and Largactil (another name for Chlorpromazine) at a dose of 150mg three times a day. This was not what he had told the police doctor. The nurse recorded that he did not mention any concerns about his physical health but said he was a heavy drinker, drinking 15 bottles of whisky a week. He had last taken alcohol three days previously. She noted that he had used LSD, cocaine and 'speed' (amphetamines) in the last month.
13. The man told the nurse that he suffered from schizophrenia and that he had been in hospital in 2001. At this point in the record of the interview, he told the nurse that he was taking Olanzapine 10mg daily and Largactil 100mg a day. The nurse recorded information from the man that he had previously harmed himself both in and outside prison. His most recent episode of self-harm had been two months previously but he did not wish to discuss the issue. He told her that he did not feel he was likely to harm himself as a result of being in prison.

14. According to the nurse, the man had told the police that he had not self-harmed for three years. He indicated that his mother had died in February 2007. The nurse offered to put him in contact with the chaplaincy, Listeners and Samaritans who would support him. He said that he did not believe in them. The nurse referred him to the Mental Health Inreach Team.
15. In interview, the nurse said she thought that a doctor had been present with her during the reception health screen. She explained that in the majority of cases a doctor would be with her when she conducted a first reception health screen.
16. The doctor completed a medical fitness assessment for the man. He told my investigator and the clinical reviewer during interview that he was unable to remember whether he had been present at the man's reception health screen interview. He did not recall anything significant having emerged from it. He noted in that assessment that the man suffered from paranoid schizophrenia and took Olanzapine and Largactil. He considered that the man was fit for normal location and to share a cell. He also recommended an alcohol detoxification programme. The doctor passed him as fit for light duties and non-contact sport only, but in interview could not recall why. He surmised that it was probably because of the man's general appearance and alcohol problems. He was prescribed a once only dose of Olanzapine 10mg and Chlorpromazine 50mg.
17. The next day (26 June 2007), the man had a resettlement interview with a member of the Probation Department. He was also seen by a Counselling, Assessment, Referral, Advice, and Throughcare (CARATs) worker, to be assessed for their programme. (The CARATs programme provides non-clinical treatment for prisoners who have substance misuse problems. CARATs teams assess prisoners and provide on-going support and referral to outside agencies.) The man told the CARAT's worker that he would engage with the CARATs team and she was to arrange an assessment. A secondary health screen was undertaken (the signature is not legible). The record of that assessment only contains routine information about his height, weight, blood pressure and smoking. His medical record says that a telephone call was made to his doctor that morning to confirm his medication. The doctor said that the man had last been prescribed Olanzapine 10mg on 6 June, but this was not a repeat prescription. He was prescribed two doses of Chlorpromazine 50mg.
18. On the same day, the man saw a detoxification nurse. The detoxification nurse noted in the medical record that he had been admitted to hospital in 2000/2001 with a self-reported diagnosis of paranoid schizophrenia. He said he was taking 150mg Chlorpromazine and 10mg of Olanzapine, which was presumably to be daily. The detoxification nurse recorded that he had a history of self harm and had cut his arms when he was very young. The man told the detoxification nurse that he was not sleeping well and had aches in his stomach, legs and arms. He said that he had blurred vision and poor focus, felt slightly nauseous and was a little low in mood. The detoxification nurse also recorded that the man was showing signs of alcohol withdrawal as

his hands had a tremor when they were outstretched. He said that he was suffering from extreme night sweats and was hearing voices. He told the detoxification nurse that he had been inhaling £80 worth of cocaine and taking £100 - £120 worth of amphetamine tablets daily. He reported that he was drinking one to two bottles of whisky every day and that he had taken between eight and 12 LSD tablets over the previous weekend. He had taken cocaine, amphetamines and alcohol most recently on 21 June. A reducing course of Chlordiazepoxide was prescribed from 26 June to 4 July, but he did not attend to collect the majority of his doses. (Chlordiazepoxide is used for the short-term relief of symptoms of anxiety and management of anxiety disorders and for treating symptoms of withdrawal from acute alcoholism.) As part of the detoxification programme he should have had two reviews, on the fourth and ninth days of the programme. Neither of these reviews was completed.

19. The continuous clinical record contains a note written on 26 June by the mental health inreach nurse that she received a referral from the initial reception nurse. The mental health inreach nurse made a telephone call to the prison service mental health liaison nurse in Northamptonshire. He said that he knew the man and that he would telephone the team on Thursday (presumably 28 June) "to inform of collateral history".
20. On 28 June, the man had a chaplaincy induction interview and was introduced to his personal officer.
21. On 4 July, the man saw three members of the MHIRT. The mental health inreach nurse told the clinical reviewer that the team had a report from a consultant psychiatrist, which said that the man had a personality disorder and not a psychotic illness. The team concluded that there was no evidence of mental illness and no role for the MHIRT. The man was to see the prison service mental health liaison nurse again at the end of August. Following the assessment the mental health inreach nurse wrote in the man's medical record that she would ask the doctor to prescribe Olanzapine and Chlorpromazine to help him with his short temper and anger issues. There is no evidence that the nurse discussed this with the doctor, nor that the doctor read this entry.
22. The man's prescription chart shows that he was prescribed Chlorpromazine 100mg to be taken three times a day. Olanzapine was not prescribed as it was ascertained from his GP that it had been prescribed only for three weeks not as a repeat prescription. Healthcare staff did not make further enquiries whether the doctor had intended to review this medication.
23. The man's medical record shows that he did not attend to collect his medication (Chlorpromazine) on many occasions between 4 July and 13 July. He was warned on 9 and 11 July for hiding his medication under his tongue. His medication was cancelled but it is not clear when that happened. The prescription entries stop on 13 July.

24. The man's education and APEX induction was completed on 10 July. (APEX is a personalised study plan relevant to the individual's strengths.)
25. On 13 July, an ACCT form was opened for the man by his personal officer at 3.15pm. The man had told her that he felt he could not cope any more and that he had lost his mother from alcohol poisoning in February 2007. He added that he had turned to alcohol himself after his mother's death. He said his girlfriend was his main support, but he was concerned that he had not heard from her since he was taken into custody. An ACCT assessment interview was completed by another officer at 4.35pm. Following the interview, the officer who completed the ACCT assessment and a senior officer (SO) completed an immediate action plan. The plan was for the man to stay in a shared cell and be observed hourly. He was also to be given telephone calls as requested and as practicable. The chaplain also agreed to try and get in touch with his partner.
26. The next day the first ACCT case review was carried out by another senior officer (SO). The man was considered to be a high risk of self harm. He continued to be concerned about his partner not contacting him, and the chaplain was still trying to contact his partner for him. His personal officer spoke to the Alcoholics Anonymous co-ordinators. She also contacted the chaplaincy about bereavement counselling and spoke to a chaplain. The chaplain told the personal officer that she would put the man on her list to be seen, but she would not be able to meet him that week and was on leave the following week. The chaplain managed to speak to his partner at 8.45am. His partner said she was fine, did not have any concerns about the man and was in contact with him by letter. The personal officer passed this information to the man at 2.10pm that day. His next ACCT case review was scheduled for Monday 30 July.
27. Another officer noted on 27 July that the man seemed very down and recommended that staff should monitor him regularly. On 30 July there is a note in the ACCT form by the SO who conducted the first case review, "I spoke to [the man] and agreed to leave the review until Wed pm [1 August 2007]." There are no reasons given for the review being delayed. The SO told my investigator:

"I can't remember why the review was delayed, it is quite a long time ago, but if there is something that crops up I am not going to be able to sit down and do the interview then we don't just leave them, we actually go and speak to them and say, 'Look, is everything okay, you know, we do need to speak but unfortunately something has cropped up, I haven't got time to do this, can we do it another time' and if an individual says, 'No I really need to sit down and talk with you,' then if they are in agreement and you have actually told them, you will keep the ACCT document open so they are still going to be observed by the staff. The only difference you would have got if I had done a review at the time would be either increased observations or reduced observations. Every time I spoke to [the man] he was pretty much the same. He wouldn't open up very much even though I kept trying to get behind things, he would give little snippets but he

wouldn't open up very much. I suppose it is difficult to explain. When the prison is very busy it is hard to take an individual out with everything around them. We did have a chat to say that the interview wouldn't be taking place and I asked if he had any problems, would he like to sit down, or was it okay if we saw him in a couple of days. He was in agreement with that."

28. The next day the personal officer left a message with the MHIRT to contact the wing regarding completing an assessment. However, the man was not seen again by the MHIRT. There is no note in the medical record that the message from the personal officer was ever received by the MHIRT, and the MHIRT notes could not be located for my investigator to examine.
29. On 1 August, a governor completed management checks on open ACCT forms. On the man's ACCT he wrote, 'ACCT review due today.' The review was not completed.
30. The next day the governor again completed management checks on open ACCT forms. He wrote on the man's ACCT, 'Review needs to be completed today.' Again, the review was not completed.
31. On 5 August, the man's ACCT record shows that he asked for a different cellmate. He complained that his cellmate was untidy and dirty. An officer then completed the ACCT review originally scheduled for 30 July. This officer noted that the man was to remain on the ACCT for a further two weeks and the next review was scheduled for 15 August. The ACCT Caremap was updated, 'Art classes stopped so to look at other classes or work. Observation, Classification and Allocation Unit [OCA] to look at transferring him to Wellingborough when sentenced.'
32. It appears that the man had a dispute with his cellmate on 7 August. At 5.30pm he spoke to another officer. He told her that his cellmate had threatened him with a plastic knife following a disagreement about the cellmate's poor standard of hygiene. A cell sharing risk minimisation plan form was completed for him and the cellmate was moved out, leaving the man in a cell on his own. The assessment said that he would be kept in a single cell pending a full case review with healthcare staff. The specific need for a mental healthcare assessment was identified by a wing manager whose name is illegible. This plan was agreed by a principal officer (PO), who noted that the man needed to be assessed by mental health staff at the earliest opportunity. Despite this, no review took place and in fact there is no evidence that the need for a review by healthcare staff, and particularly the need for a mental health review, was ever passed on to healthcare staff.
33. The continuing ACCT record shows that the man was feeling much better after his cellmate was removed and that this lasted until 12 August.

EVENTS ON 13 AUGUST 2007

34. The personal officer was on night duty on 12 August 2007 and started her shift at 8.45pm. According to the ACCT observation record, she checked the man every half an hour between 9.30pm and 2.00am on 13 August (the entries are signed and dated). The personal officer noted that the man was awake. In interview, she told my investigator that she spoke to him but he appeared reluctant to talk to her. The personal officer said he appeared very withdrawn but that was not unusual as sometimes he would be open and talk but other times he would not open up. Another officer checked the man at 2.30am, 3.30am and 4.00am and noted in the observation record that he was still awake. (There are several timed entries in the observation record, at regular half hourly intervals from 9.30pm to 6.30am. The entries between 4.30am and 6.30am are signed by the second officer. The entries between 4.30am and 6.30am were clearly completed and signed before they were actually undertaken.) At 4.00am, the second officer noted in the man's ACCT record that he was pacing up and down in his cell. He told the second officer that he was fine but that he had not slept well.
35. At 4.30am, the man was seen hanging in his cell by the second officer. She shouted for assistance and her colleague arrived, followed by the personal officer. Her colleague unlocked the cell and went inside followed by the second officer and the personal officer.
36. The officer's colleague supported the man and cut the ligature to release him. The ligature was made from a torn sheet and tied to the window bars. The night orderly officer arrived at 4.34am. The night orderly officer and the officer's colleague laid the man flat on the ground. The officer's colleague noticed blood on the ground but could not find any obvious wounds on the man. (He later found that the man had cut his leg). The officer's colleague checked the man for a pulse. He was not breathing and there was no obvious pulse. He checked that the man's airway was cleared and told the night orderly officer to start chest compressions. The personal officer left the cell to get a First Aid kit (mask) from the office on the fourth floor. He returned immediately with the equipment and the officer's colleague was then handed a mask and began mouth to mouth resuscitation.
37. At around the same time, the second officer left the cell to go to the healthcare centre to escort the nurse to the wing. The personal officer then went back to the office on the fourth floor to raise the alarm for healthcare assistance and to ask the control room to call for an ambulance using the telephone in the office. (This is the personal officer's account given to my investigator and when interviewed by the police. However, the incident scene log completed by her contradicts this and records that the second officer went to get the first aid kit from the office at 4.33am and the personal officer went to alert healthcare and the control room at 4.34am.) The gatekeeper's log records that they received a request to call the ambulance at 4.38am. The ambulance was called at 4.39 and arrived at the prison at approximately 4.47am. The crew were in the prison by 4.50am and at the cell around 4.52am.

38. A nurse arrived at around 4.38am and brought an oxygen cylinder. She did not bring a defibrillator with her. The officer's colleague connected the ambu bag to the oxygen and then connected it to the mask and turned the oxygen on. (An ambu bag is a hand-held device used to provide ventilation to somebody who is not breathing or who is breathing inadequately.)
39. The officer's colleague continued resuscitation using the ambu bag and oxygen for 20 minutes while the night orderly officer maintained chest compressions. The nurse offered to assist with the resuscitation but the officer's colleague said he was content to continue. The night orderly officer then left to collect ambulance staff from the gate. The officer's colleague took over with chest compressions assisted by a PO, who administered the oxygen. The paramedics then took over and the man was taken to hospital where he was pronounced dead at 6.40am.

ISSUES

Family concerns

40. As noted earlier, one of my family liaison officers spoke with the man's partner and his father and step-mother. His partner said that he had told her that he had cut himself while in prison. She asked if the investigation could identify what he had been using to cut himself. In fact, I have found no evidence that the prison was aware that he was cutting himself. When he was found hanging he had a cut on his leg. However, there is no evidence that any member of staff was previously aware of that. My investigation has been unable to identify when or how the man sustained the cut.
41. The man's partner also asked why he did not receive a further mental health assessment at this time. As I have shown, the members of the MHIRT who saw him on 4 July considered that he did not have any mental health illness.
42. The man's partner also asked why he had been allowed to have bed sheets when he was being monitored as a risk of self harm or suicide. The relevant Prison Service Order (PSO) is PSO 2700 which deals with suicide and self-harm prevention. A revised PSO 2700 was issued on 26 October 2007 but the version of PSO 2700 in force at the time of his death was issued on 4 November 2002. Chapter 4 of the November 2002 document is devoted to 'Managing Prisoners Identified At-Risk to Self' and section 4.4 of the chapter which deals with 'Removal of items in possession,' says:

"Personal items including shoelaces and belts must not be removed from at-risk prisoners as a matter of course. The reasons for the decision to remove or return items must be recorded in the prisoner's F2052SH." (F2052SH was the set of procedures previously used by the Prison Service to monitor and support prisoners thought to be at risk of suicide or self-harm. By the time of the man's death, F2052SH had been replaced by ACCT).
43. Section 4.1.3 of the same chapter of the PSO deals with special accommodation and refers expressly to the removal of bedding or clothing from the cell of a prisoner who is at risk of suicide. Section 4.1.3 says:

"Prisoners identified as being at risk of suicide or self-harm must not be placed in an unfurnished cell ... unfurnished cells do not contain furniture, fittings, bedding and clothing."
44. Staff at Leicester would have been acting in defiance of the PSO if they had removed the man's bed sheets from his cell. Nor do I think it would have constituted humane treatment. I am satisfied that permitting him to retain his bedding was an appropriate decision and one which complied with the relevant Prison Service instruction.
45. The man's father and step-mother were concerned that his medication for schizophrenia had been discontinued while he was in prison. They asked

why the prison had not found an alternative method of administering the medication to ensure it was taken, such as dispensing in liquid form or under supervision.

46. The man's family also asked whether his personal officer had been on duty during the night he died. I have reported that the personal officer was indeed on duty when he died and this is detailed in paragraph 30 above.
47. The family questioned whether the man's difficulty with sleeping had been related to his medication being discontinued. However, it appears that he had trouble sleeping generally and this cannot be directly related to his medication being discontinued.
48. The man's family asked whether his solicitor had been in contact with him during the weeks prior to his death. I have found no evidence that his solicitor had been in contact with him during the weeks prior to his death. The only recorded visits were from his partner on 7 July and 4 August.
49. Finally, the family were also concerned about the contact from the prison following the man's death. The prison correctly notified the man's partner of his death as she had been named by him as next of kin. On her own insistence she then notified his brother, who told his father and step-mother.
50. The man's father and step-mother explained that the prison told them that all arrangements had to be made through the man's partner who was his nominated next of kin. They said the prison refused to have any dealings with them directly, and insisted that all contact was through his partner. They were very upset that they were informed of the man's death by his brother, who had been contacted by the man's partner. They were aware that his partner had been insistent that she break the news to his brother herself. However, the family felt strongly that the prison's Family Liaison Officer should have supported her better, perhaps advising her to arrange to meet his brother and then accompanying her to help break the news to him.
51. The man's father and step-mother confirmed that they were invited to visit their son's cell, but chose not to do so. They were also upset that they were not given any choice with regard to collecting his belongings. They had not wanted to return to the prison but were told that they had to collect his belongings in person. They had a meeting with the Governor following the man's death. However, they felt that the meeting was primarily for his partner and said they were told they could attend the meeting if they wanted.
52. Section 3.4 of the Prison Service guidance on Family Liaison (PSO 2710 - Follow up to deaths in custody) is entitled 'Who is the family?' This is clear that prisons should be prepared to deal with more than one section of a family. It says:

"The family may be large, split geographically, at odds amongst themselves. Many modern families are split by divorce or separation and there may be several branches all with equal rights to information. The

Family Liaison Officer may be able to get the family to nominate a single point of contact who undertakes to keep other family members up to date. This may not always be possible, or may not work in practice, so the Family Liaison Officer should be prepared to deal with different sections of one family if necessary. The police sometimes deploy more than one Family Liaison Officer to a family. This may be an answer in extreme circumstances of family division.”

53. The man’s father and step-mother said they were very hurt by the condolence letter they received from the prison which referred to the man as their partner, not son. This is deeply regrettable. I understand that a letter of apology was sent by the Prison Service Area Office.
54. I simply report the account given by the man’s family. Clearly his family found contact with the prison frustrating, and felt the prison gave preferential treatment to his partner. I agree the prison could have been more proactive in their contact with the man’s father and step-mother as well as his partner. Although I make no formal recommendation I would draw to the attention of the Governor the guidance in PSO 2710 regarding contact with more than one section of the family. The Governor will wish to consider whether local contingency plans should be revised.

ACCT

55. The Prison Service has various strategies to assist prisoners at risk of suicide or self harm. Prisoners can be monitored by an Assessment, Care in Custody and Teamwork (ACCT) form. They can speak to a Listener or access Samaritan support over the telephone.
56. The man was known to be depressed about the death of his mother earlier in 2007. He said that he had previously attempted suicide. He also suffered from paranoid schizophrenia and a psychopathic personality. He was assessed as being at high risk of harming himself and was placed on an ACCT on 13 July 2007 following concerns from his personal officer.
57. There was a delay in the second ACCT review being held despite reminders by managers that a review was required. Prison Service Order 2700 ‘Suicide and self-harm prevention’ says:

“The second and subsequent case reviews usually take place under less pressure of time than the first one. Therefore it is possible that a wider range of staff and specialists may be able to attend. One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner’s location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff. The case review must also be attended by the prisoner. The Assessor is not required to attend subsequent reviews. Where referrals have been made to specialist staff or those staff are already involved in the care of the prisoner, they must be invited to attend the next case review. Where attendance is not possible, they must

provide input in writing or by telephone to that case review (and subsequent reviews if requested). Wherever possible the Case Manager should arrange subsequent reviews at a time that he or she can be present, in order to provide some continuity of care for the prisoner. Where the named Case Manager cannot attend, they must explain to the prisoner who is to take their place at the review, and record that they have done this. A case review must be held following a change to a more lethal method of self-harm, for example from cutting to using ligatures. The case review will consider if another assessment is required.”

58. The two ACCT reviews held for the man were not multi-disciplinary as recommended in the PSO and did not result in continuity in his care. The second review was conducted by a manager who had not met him previously.

The Governor should remind staff of the requirements of PSO 2700 in relation to the management of prisoners being monitored on ACCT forms and ensure that reviews are carried out in a timely manner by the appropriate people.

59. Between 9.30pm on 12 August 2007 and 6.30am on 13 August there are several signed entries in the observation record for the man as he was on an ACCT. These entries are at regular half hour intervals and record that checks have been made on the prisoner depending on the level of observation required in each case. However, I am extremely concerned that the entries between 4.30am and 6.30am must have been completed in advance. I am pleased that the prison issued a memo in October 2007 reminding staff about required observation for prisoners who are on an ACCT document. That memo states:

“The observations should be tailored to the individuals’ needs. All observations should be irregular and not predictable, for example:

Once hourly - one observation should be made during an hourly period. This should be random and irregular.

Twice hourly - two observations per hour, again should not be on the hour and every half hour eg 13.30, 14.00, 14.30. They should be irregular.”

In light of my findings in respect of the entries made in the man’s ACCT form after 4.30am, the Governor should consider what other actions are required to ensure the integrity of the ACCT process.

Clinical care

60. I thank the clinical reviewer for a very comprehensive report and highlight below the recommendations which I accept.
61. The clinical reviewer finds that communication between discipline staff and healthcare staff was lacking. On 4 July 2007, the man saw members of the MHIRT. They concluded that there was no evidence of mental illness and no role for the MHIRT in his care. He was scheduled to see a member of the team again at the end of August. There were concerns raised by staff in the man's ACCT on 31 July and 7 August indicating that he should be seen again by the MHIRT team. However, there is no evidence that this was followed up or that the MHIRT team were even aware of these concerns.

The Governor and PCT should investigate whether the lack of communication between healthcare and discipline staff is an ongoing failure and if so how urgent action can be taken to improve communication between them.

62. I am also most concerned that the MHIRT notes for the man could not be located for my investigator to consider.
63. The clinical reviewer identifies some training needs for medical staff. Not all clinical staff interviewed were aware of current first aid (resuscitation) procedures. The nurse that completed the first reception health screen said that her cardiopulmonary resuscitation training had taught her to undertake 15 compressions to two breaths. However, the clinical reviewer points out that the current standard, established some 18 months before the nurse was interviewed, is 30 compressions to two breaths. In addition, the nurse that attended the scene said she had not been trained to use a defibrillator and would not be confident using one. That was why she did not bring a defibrillator with her to the man's cell. I believe that all healthcare staff should be up to date with current first aid (resuscitation) procedures. All staff should also be trained and confident to use a defibrillator.

The PCT should ensure that all healthcare staff are up to date with current first aid (resuscitation) procedures. The PCT should also ensure that all staff are trained and confident to use a defibrillator.

64. The clinical reviewer also finds that communication between MHIRT staff and primary care staff was poor. There are no clear written notes to explain why the man's medication was not prescribed at the earliest opportunity. His prescription chart shows once only prescriptions for Olanzapine 10mg for the afternoon of 25 June and Chlorpromazine 50mg for the afternoon of 25 June, morning of 26 June and afternoon of 26 June. There was a recommendation after the MHIRT assessment on 4 July that Chlorpromazine and Olanzapine should be prescribed for him. There is then a prescription only for Chlorpromazine 100mg three times a day starting on 4 July. There is no indication why Olanzapine was not prescribed.

65. The record shows that the man did not collect his medication on most occasions and that he was caught concealing medication under his tongue on 9 and 11 July. The prescription was cancelled but the date of cancellation is not given. Entries on the prescription chart stop on 13 July. It appears from the clinical reviewer's review that the medication was not dispensed in an alternative form due to cost.
66. The doctor confirmed in interview that the man's prescription for Olanzapine had not been continued after the first night because information had been received from his doctor that this was not a repeat prescription. The doctor also confirmed that the man's prescription for Chlorpromazine had been stopped on 13 July. He was unable to say who had authorised the medication to be stopped. It appears that a locum doctor gave permission for his anti-psychotic medication to be stopped because he was not taking it regularly and, when he did collect it, was hiding it under his tongue. There is no record of who authorised the cessation of medication and no effort was made to find out why he was not taking it. An instruction dated 4 June 2007 was issued to healthcare staff to ensure that if prisoners refuse to take their medication they are aware of their duty to investigate the reason why and record any action taken. This instruction predates his admission to Leicester.

The PCT should undertake an audit to establish whether this instruction relating to the recording of reasons when prisoners do not take medication is being followed by healthcare staff.

The PCT should review the mechanisms for communication between healthcare staff to ensure that there is a sound system in place.

The PCT should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard to the expected standards of records and record keeping.

67. The clinical reviewer has considered whether the medication could have been given in an alternative form. The clinical reviewer asked the doctor whether he might have considered prescribing Chlorpromazine to the man in liquid form to make it harder for him to hide, but the doctor said that liquid Chlorpromazine was not available at HMP Leicester because it was too expensive.
68. The clinical reviewer also finds that there are overlaps in the first reception health screen process. In the majority of cases a nurse completes the first reception health screen in the presence of a doctor. This procedure is sometimes followed by a secondary health screen undertaken by a doctor. Much of the information is therefore duplicated.

The PCT should ensure that there is a robust reception health screen process avoiding duplication of effort between the initial reception health screen and the secondary health screen.

69. It appears that it took approximately eight minutes to call an ambulance after the man was found hanging at 4.30am. The gatekeeper's log records that they received a request to call the ambulance at 4.38am. They called the ambulance at 4.39am. Leicester's contingency plans for a death in custody do not point out sufficiently clearly that an ambulance should be called as necessary and as quickly as possible. The Governor will wish to address this as a matter of urgency.
70. The personal officer should be commended for her interaction with and care for the man. The officer's colleague should also be commended for his action in terms of performing and directing CPR procedures for the man.

RECOMMENDATIONS

1. The Governor should remind staff of the requirements of PSO 2700 in relation to the management of prisoners being monitored on ACCT forms and ensure that reviews are carried out in a timely manner by the appropriate people.
2. In light of my findings in respect of the entries made in the man's ACCT form after 4.30am, the Governor should consider what other actions are required to ensure the integrity of the ACCT process.
3. The Governor and PCT should investigate whether the lack of communication between healthcare staff and discipline staff is an ongoing failure and if so how urgent action can be taken to improve communication between them.
4. The PCT should ensure that all healthcare staff are up to date with current first aid (resuscitation) procedures. The PCT should also ensure that all staff are trained and confident to use a defibrillator.
5. The PCT should undertake an audit to establish whether this instruction relating to the recording of reasons when prisoners do not take medication is being followed by healthcare staff.
6. The PCT should review the mechanisms for communication between healthcare staff to ensure that there is a sound system in place.
7. The PCT should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard to the expected standards of records and record keeping.
8. The PCT should ensure that there is a robust reception health screen process avoiding duplication of effort between the initial reception health screen and the secondary health screen.

Good Practice

The personal officer should be commended for her interaction with and care for the man. The officer's colleague should also be commended for his action in terms of performing and directing CPR procedures for the man

Comments on draft report:

Family comments:

The man's partner told my investigator and family liaison officer that due to his illness the man had two distinct personalities and had even named his other personality, using his middle name. She was never sure which personality she was going to see but over time she learnt to differentiate between them.

She also pointed out that the summary of the report says that he had drunk alcohol within the last three days but he had been in police custody during that time.

This was the information the man gave to prison staff during his reception healthcare screening.

In response to the information in the summary that the man used methadone, his partner said that she had never known him to use methadone.

This was information the man gave to healthcare staff.

The man's partner also said that it was not true that he had not self-harmed within the past three years (paragraph 12 refers). She described two incidents when he had self-harmed in her presence.

The information in paragraph 12 reflected the information the man had given to the Forensic Medical Examiner when he was detained at the Police Station.

The man's partner also said that she has since been told by a friend who was in Leicester at the same time as the man that he may have been bullied by other prisoners. She was also told that possibly he told the officer who found him in his cell (the officer described as 'the officer's colleague' in this report) about the bullying.

The violence reduction coordinators have checked the relevant prison records and there was no record of bullying being an issue for the man. The personal officer said that the man definitely did not raise any concerns about being bullied with her and she felt that if he had any such concerns he would have spoken to her about it. The officer's colleague also said that the man had never raised any concerns about being bullied with him.

The man's father and step-mother questioned why MHIRT decided that he showed no signs of mental illness and there was no role for them in his care after examining him on 4 July.

This was a decision taken by MHIRT based on their assessment of the man at the time.

They were also concerned to read about the differing accounts of events given by the personal officer to my investigator and the police and as detailed in the incident scene log, as highlighted in paragraph 39.

They were also concerned that a radio was not used by staff to summon help when the man was found in his cell.

I raised my concern over the length of time it took to call an ambulance in paragraph 71 and made a recommendation about this.

Further, the man's family have voiced their concerns that the nurse in charge did not know how to use a defibrillator.

The doctor shared those concerns and this issue is addressed in paragraph 65 and I have made a recommendation about this.

Finally the man's family said that they felt that generally Leicester does not seem to have a system of management checks on ACCT forms to assess their quality.

I have noted my concerns about the management of the ACCT form completed for the man in paragraphs 57-61 and made 2 recommendations about this.

Prison Service comments:

The Prison Service has accepted all the recommendations apart from recommendation 6 which has been partially accepted. Action plan is attached.

Also the report by HM Chief Inspector of Prisons mentioned on page 9 is not the most recent report. The establishment received a further inspection from HMCIP in June 2008 therefore this quote is not from the most recent report by HM Chief Inspector of Prisons. An additional paragraph has been added on page 9 to reflect the more recent inspection and reads:

"A safer custody policy and monthly meeting provided strategic oversight to suicide and self harm work, and relevant management information was collected and analysed. There were delays in receiving Prisons and Probation Ombudsman (PPO) draft reports from previous deaths in custody but local action plans were in place. A full-time safer custody coordinator was in post, and the quality of assessment, care in custody and teamwork (ACCT) documents was good, although reviews were insufficiently multidisciplinary. ACCT assessors met monthly, and family liaison work was very good. Listeners were generally well supported but access was limited during patrol states. No separate record was kept of the use of gated cells, and prisoners in crisis were, on occasions, placed in strip conditions in these cells. A weekly cell sharing risk assessment (CSRA) meeting facilitated detailed discussions about those prisoners who were deemed medium or high risk."

Please see attached action plan.

No	Recommendation	Accepted/ Partially accepted/ Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should remind staff of the requirements of PSO2700 in relation to the management of prisoners being monitored on ACCT forms & ensure that reviews are carried out in a timely manner by the appropriate people.	Accepted	Information related to current ACCT reviews and Post Closure reviews is now on the daily briefing sheet which is emailed to all staff, this is also discussed at the Daily Operational meeting, chaired by the Governor. The ACCT quality management checklist has also been amended to include a more detailed assessment of reviews.	Actioned	
2	In light of findings of the entries made in Mr B's ACCT form after 4.30am, the Governor should consider what other actions are required to ensure the integrity of the ACCT process.	Accepted	A robust system whereby the Orderly Officer, Safer Custody Co-ordinator and the Duty Governor carry out a programme of quality checks of all ACCT documents. The Safer Custody Committee examines all recently closed ACCT documents as a further quality control measure.	Actioned	
3	The Governor/PCT should investigate whether the lack of communication between healthcare staff and discipline staff is an ongoing failure and if so how urgent action can be taken to improve communication between them.	Accepted	PCT/SERCO feel this was an isolated issue and is not an ongoing failure. Clinical Governance Committee will continue to ensure that the referral process for prisoners to the mental health teams is both effective and timely.	May 09	
4	The PCT should ensure that all healthcare staff are up to date with current first aid (resuscitation) procedures. The PCT should also ensure that all staff are trained and	Accepted	Basic Life Support is part of healthcare staff's mandatory training, and is up to date for this financial year. SERCO (Prison Healthcare Provider) need to ensure that either specific defibrillator training or Advanced Life Support is made mandatory for all		

	confident to use a defibrillator.		healthcare staff and that yearly updates are made part of an individual's personal development plan. The Primary Care Trust will ensure compliance by encompassing this requirement into the Healthcare Clinical Governance Action Plan, and if required/appropriate, any contractual agreements.	August 2009	
5	The PCT should undertake an audit to establish whether this instruction relating to the recording of reasons when prisoners do not take medication is being followed by healthcare staff.	Accepted	(Joint action) Primary Care Trust and Healthcare Provider to create an audit tool and ensure audit of DNA's is carried out on all patients who DNA over an agreed period of time. This will highlight the numbers of DNA's and ascertain if instructions are being followed. Subsequent action plans will be put in place if any areas of concern become apparent	August 2009	
6	The PCT should review the mechanisms for communication between healthcare staff to ensure that there is a sound system in place.	Partially accepted	Whilst the Primary Care Trust are the Commissioner for healthcare at HMP Leicester, SERCO are the current healthcare provider and any work regarding SERCO staff communication needs to be led by SERCO and overseen and monitored by the Primary Care Trust. PCT to facilitate a meeting with the healthcare manager to ascertain how systems can be put in place and what support is needed to ensure these systems are effective.	August 2009	
7	The PCT should remind staff of the need to complete medical notes appropriately and in accordance with the guidelines of the professional bodies for doctors and nurses with regard to the expected standards of records and record keeping	Accepted	Clinical record keeping audit has now commenced and is carried out monthly by the Healthcare Manager. Results are reviewed and action taken where necessary.	Actioned	

8	The PCT should ensure that there is a robust reception health screen process avoiding duplication of effort between the initial reception health screen and the secondary health screen.	Accepted	The PCT will oversee this, and will ensure that a protocol is in place re: health care screening process and that SERCO ensure all staff are made aware of this process.	August 2009	