

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

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

May 2009

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Leeds on 28 September 2007. The man was found hanging in his cell shortly before 5.00am. At the time of his death the man was a remand prisoner awaiting trial for the murder of his wife. He was originally from Ethiopia and came to this country in 2003. At his death, the man was 30 years old.

I offer my sincere condolences to the man's relatives and friends for their loss. I am aware that difficulties were experienced in tracing family members, and that this resulted in a significant delay before his funeral could be held.

This investigation has been undertaken by one of my colleagues. I would like to thank the Governor of Leeds, and his staff for their participation. Particular thanks go to the Principal Officer who facilitating interviews and made all the practical arrangements. A clinical review was carried out and I must also thank the reviewer for his contribution.

The man had two young children who one day may read this report. I have to tell them and others that I have been unable to say conclusively why the man apparently took his own life. However, he had expressed a number of anxieties to prison staff particularly about the welfare of his children. Additionally, fellow prisoners have reported that he might have been subject to bullying.

My report also includes allegations that staff may have had a part to play in the bullying of the man by other prisoners. The contents of my draft report into the man's death were brought to the personal attention of the Director General of the National Offender Management Service. I am now content that these complaints have been enquired into by the appropriate authority.

Minor amendments were made to my draft report after comments were received by the Prison Service. I have made no amendments to recommendations.

I make two recommendations to the Prison Service in respect of monitoring prisoners following closure of ACCT documents, and providing information on incidents in single cells. I make a further five recommendations for the Governor regarding the provision of information, recording contact, monitoring procedures and cell sharing risk assessments. I note one example of good practice.

Finally, I must apologise for the delay in issuing this report. This was due, in part, to the time needed by the police to investigate some of the issues uncovered by my investigator.

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Prisons and Probation Ombudsman

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SUMMARY

The man was born in Ethiopia in May 1977. He moved to the United Kingdom with his family in 2003 to seek asylum and settled in Bradford. On 30 June 2007, the man was arrested and charged with the murder of his wife. He was found hanging in his cell at HMP Leeds shortly before 5.00am on 28 September 2007, little more than two months after his arrest.

When he arrived at Leeds, the man had numerous wounds to his hands that required surgery. These injuries were possibly sustained during the attack on his wife. Although he initially refused treatment for his injuries, the man eventually had the necessary surgery. As a result, he was located in the prison's healthcare centre during the early weeks of his time in custody. I believe the period in healthcare, with support from the healthcare team, helped him come to terms with the early stages of his imprisonment. However, he was anxious about the welfare and whereabouts of his children and his legal representation. In addition, the man spoke little English.

The man moved to C wing on 27 July. At about 4.55am on the morning of 28 September, a prison officer discovered the man hanging from the window bars in his cell. The officer raised the alarm and waited for colleagues to arrive before he went into the cell. Several staff responded. The night orderly officer and a second officer removed the ligature and lowered the man to the ground. The night orderly officer, a staff nurse, the second officer and a healthcare officer attempted cardio pulmonary resuscitation (CPR) until paramedics arrived at about 5.10am. The man was assessed by the paramedics and CPR ceased at about 5.15am.

On 29 September, a complaint was submitted by a prisoner who was located in the cell next door to the man at the time of his death. The prisoner claimed that prisoners had been bullying the man because officers had told them that he was a sex offender. The prisoner believed the man had killed himself due to intimidation. The prisoner told my investigator that the man had visited him in his cell on the morning before his death. He added the man had been distressed and crying and insisted that he was not a sex offender.

I have not been able to determine why the man took his life. However, if the prisoner's account is accurate, the man must have believed that other prisoners thought he was a sex offender. Coping with imprisonment for the first time in the man's circumstances must have been extremely difficult. The concern he had for his children may also have added to his distress. To be wrongly accused of being a sex offender, and bullied by other prisoners, might well have been too great a psychological and emotional burden for the man to bear.

I have made five recommendations to the Governor of Leeds and two to the Prison Service. I have also identified an instance of good practice in which officers on night duty make a point of checking prisoners in single cells when they carry out monitoring on other prisoners at risk of self-harm or suicide.

THE INVESTIGATION PROCESS

1. My investigator made initial contact with the Governor at Leeds on 1 October 2007, and formally opened the investigation during a visit on 3 October. All available documents likely to be required for the investigation were collected or requested at this time.
2. Before my investigator's visit, notices were issued to staff and prisoners. They announced the investigation and invited anyone who had information about the man to make themselves known. One prisoner came forward.
3. My investigator carried out 12 interviews with staff and three with prisoners. Interviews with staff were recorded and copies of the transcripts are attached as annexes to this report. Notes were taken of interviews with prisoners. A clinical review of the man's clinical care whilst in custody was conducted on behalf of Leeds Primary Care Trust.
4. My investigator considered the reports of other death in custody investigations I have undertaken at Leeds, and the recent reports by the Independent Monitoring Board (IMB) and HM Chief Inspector of Prisons, Dame Anne Owers, were also considered. My investigator also contacted HM Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, my report will be sent to the Coroner to assist in his enquiries.
5. One of my Family Liaison Officers attempted to contact the man's next-of-kin to offer them the opportunity to participate in the investigation. Unfortunately, she was unable to do so.
6. My investigator was made aware of serious allegations against members of staff when he interviewed prisoners in December 2007. Two of the prisoners said they would be concerned for their own safety if the information provided became known whilst they were still in Leeds. The Governor was informed informally and plans were put in place to move the individuals concerned.
7. In January 2008, I wrote more formally to the Governor outlining the allegations. The matter was referred to the police. The police found insufficient evidence to warrant a full investigation.

HMP LEEDS

8. HMP Leeds is category B local prison built in 1847. It is located approximately two miles from Leeds city centre. The prison serves magistrates' and crown courts in the West Yorkshire area. Up to 1,000 prisoners are held on six wings and in the healthcare centre in accommodation that is certified to hold 824 prisoners. (It is common practice in Victorian local prisons for prisoners to share cells originally designed for one person. This is known colloquially as doubling.)
9. During her inspection of Leeds in August 2005, Dame Anne Owers, HM Chief Inspector of Prisons, found a negative culture among some staff. Relationships between staff and prisoners had deteriorated, and this was particularly evident among black and minority ethnic prisoners. The Chief Inspector carried out a further unannounced inspection of Leeds in December 2007. She found that, although there were still considerable problems in the prison, there had nevertheless been progress in all areas. However, a survey carried out by Dame Anne's researchers at the time of the inspection found that black and minority ethnic prisoners felt significantly less safe than other prisoners at Leeds.
10. The latest Independent Monitoring Board (IMB) annual report does not identify any particular concerns relating to suicide prevention, violence reduction or diversity. The report describes a prison that is making progress in all these areas. In particular, the IMB note a reduction in the number of self-inflicted deaths in 2007 compared to the previous year.
11. The prison's healthcare centre has 20 in-patient beds. There is a wide mix of medical needs and each patient has an individualised care plan during their time in healthcare.
12. There have been 13 previous self-inflicted deaths at Leeds since I took on responsibility for undertaking all death in prison custody investigations in 2004. Numerous recommendations have been made covering a wide range of issues. There are no similarities between my findings in earlier investigations and my recommendations in the man's case.
13. Approximately five per cent of the prisoners at Leeds are foreign nationals. My investigator reports that there are few special arrangements for these prisoners, who are dispersed throughout the prison.

KEY EVENTS

14. On 30 June 2007, the man was arrested and charged with the murder of his wife. Whilst he was in police custody, West Yorkshire police completed a medical record sheet. The doctor who examined the man noted that he had no history of mental illness and showed no signs of acute mental illness. The record sheet also included information relating to injuries to his hands that were likely to have been received when the alleged offence was committed. The man initially refused hospital treatment to his hands. A comment entered by a nurse on page two of the record noted that the man ran and head butted a wall after she had re-dressed his hands. The police medical record and a risk assessment report accompanied the man when he left police custody.
15. The man appeared at Bradford Magistrates' Court on 4 July and was remanded into custody at Leeds. The Prisoner Escort Record (PER) that accompanied the man includes an entry on the front cover that states he was a suicide risk. It goes on to say that he was the subject of constant supervision whilst in police and escort contractor custody. (The PER is a form that accompanies prisoners during journeys to and from prison. It provides a chronological record of events such as meals served and journey times and serves as a communication tool about risks a prisoner poses on escort or transfer.) A suicide/self-harm warning form was completed by a Senior Custody Officer. A recommendation was made that the man should be re-assessed when he arrived in prison custody.
16. When the man arrived at Leeds, routine reception procedures were carried out. The PER was checked and signed by an officer. A Cell Sharing Risk Assessment (CSRA) was completed in which the man was identified as at high risk of harming a cell mate if located in a shared cell. This was based on information received from the police and escort staff. (A CSRA is completed when a prisoner is admitted to prison to assess whether he is suitable to share a cell or poses a risk to other prisoners.) It was therefore recommended that the man should be located in a single cell. An entry was also made on the CSRA that said the man would harm himself at the earliest opportunity. The duty manager completed the section of the CSRA. She noted that he appeared to be agitated and possibly in shock. The duty manager confirmed that the man should be held in a single cell and should be subject to self-harm monitoring.
17. An Assessment, Care in Custody and Teamwork (ACCT) document was opened during the evening of the man's reception into prison. The immediate action plan section was completed by a Principal Officer (PO) at 8.20pm. He instructed that the man should be monitored every 30 minutes until a full review could be carried out the following day. (The ACCT procedure provides additional monitoring and personalised support for prisoners considered to be at risk of self-harm or suicide.)
18. The man was placed in a single cell on D wing, the induction unit. (Induction is the process of introducing new prisoners into custody. It is designed to explain the immediate consequences of being in custody, the routines of the prison, and the rules and regulations prisoners must observe.) The first night induction

procedures were completed and the man signed two compacts agreeing to abide by the rules and regulations of the unit. During his induction interview, the man expressed concern about his children. This information was also noted as part of his caremap in the ACCT document.

19. On 5 July, the ACCT assessment interview took place and a caremap was prepared. Lack of contact with his children and problems finding a solicitor were the two issues identified. An entry in the caremap notes that the man's children were safe but added that he was not to be informed of their whereabouts. An officer made an entry in the ongoing record confirming that she had told the man this information. Another officer interviewed the man and completed a foreign nationals referral form. (This form is used to collect basic information about a foreign national prisoner which is forwarded to the UK Border Agency.) The man answered most of the questions and the majority of the form was completed. Chambers of Bradford were identified on the form as the man's solicitors.
20. The man received a letter from his solicitors on 10 July. An entry in the ACCT ongoing record, at 11.15 am, says that staff tried to explain the contents but found it difficult due to the man's limited ability to speak English. The entry goes on to say the man was very distressed and could not understand why he could not see his children, or be told where they were. At 3.50pm that day, the man became tearful and chanted, "My kids, my kids". When the staff member present tried to talk to the man, he said he was sorry and ended the conversation. On the same day, the man requested treatment to the injuries he had received before he came into custody on his hands. He was admitted to Leeds General Infirmary (LGI) that evening to undergo surgery.
21. An ACCT case review was carried out at LGI during the morning of 11 July. The summary of this review says that the man remained anxious and concerned about the welfare of his children. An entry in the ongoing record made at 1.10pm the same day by the second principal officer says that the man was asking about his children. The second principal officer explained that they were in a place of safety and told the man that investigations could be made on his return to prison. Several other entries were made the same day relating to the man's concern for his children.
22. Later that evening, the man's solicitor visited him in hospital. An entry in the ACCT ongoing record says he became distressed when his children were discussed. There are no further entries relating to this subject during his time at the hospital.
23. During the afternoon of 13 July, the man returned to HMP Leeds. His injured hands had been heavily bandaged, and he therefore required assistance to carry out basic activities. Consequently, he was located in the healthcare centre. An entry in the ACCT ongoing record, made during the afternoon of 15 July, noted that the man had many concerns. Three worries were listed in the record. The man was still concerned about his children; he did not feel he was being represented well by his solicitor; and he was unsure of his legal status in the UK. The person who made the entry explained to the man that they would

try and answer some of his concerns the following day. An entry the following day says that a senior officer would visit the man that day to discuss these issues. However, there is no written evidence that this visit took place and the senior officer told my investigator that he did not recollect meeting the man.

24. At 7.15pm on the evening of 17 July, an officer from the healthcare centre, spoke to the man. An entry in the ACCT ongoing record notes that he was still very upset at not being able to see his children. He did not understand why he could not see them. The member of staff said he would make enquiries the following day. At 9.15am the following day, an entry in the ongoing record shows that the man had used the telephone to try to contact his family, but had been unable to get a reply. The entry also notes that the man was very content and had no serious problems. There was no reference to the entry the previous evening or any indication that enquiries had been made about the man getting access to his children. Following a review later that day, the ACCT was closed. The summary of the review recorded that the man denied any intentions to self-harm. It was agreed that staff would look at his legal issues and childcare concerns. A post closure interview was planned for 25 July. There is no documentary evidence that this review ever took place.
25. On 27 July, a second nurse spoke to the prison's police liaison officer about the possibility of the man having access to his children. The nurse was advised to contact Bradford Social Services and, on doing so, was informed that the man could not see his children under any circumstances. The man was informed and an entry to that effect was made in the man's history sheet. Later that day, he was discharged from the healthcare centre and located on C wing. A careplan was put in place and follow up medical appointments were made. The nurse completed a healthcare advice and information sheet for wing staff. This summary highlighted that an ACCT had been closed on 25 July and that the man was not to have contact with his children. (The ACCT document was actually closed on 18 July. The date of 25 July was in fact when the post closure review was due to take place.)
26. In the period between the man's discharge from the healthcare centre on 27 July and his death two months later, only two entries were made in his wing history sheet. Both related to an incident in an education class (described below). As part of the personal officer scheme within a prison, prisoners are given a named officer who they can approach for advice or to resolve complaints. There is no evidence of any significant contact between the man and his personal officer. The man's personal officer told my investigator that he knew very little about the man.
27. On 5 September, a member of staff from Bradford Social Services visited the man. The staff member told my investigator that she had been accompanied by an interpreter who, unfortunately, had refused to enter the prison. The staff member therefore saw the man alone to discuss possible contact with his children. The staff member said the man had been prevented from seeing his children as they had been clearly traumatised by the events on the night of their mother's death. The staff member said that, in spite of this, she considered that the man would be able to see his children in the future. She told my

investigator that she thought that the man had understood details of the conversation.

28. The man was allocated to an ongoing basic English class. During one of these classes on 17 September, the man became aggressive towards his teacher. The man did not want to participate in the class and was therefore removed. Staff issued a warning under the Incentives and Earned Privileges (IEP) scheme. (IEP is a system to reward and encourage good behaviour in prison. The scheme has three levels - basic, standard and enhanced. Incentives include access to in-cell television, a higher allowance of private cash, wearing own clothes, increased time out of cell and community visits.) An entry confirming the warning was made on the man's history sheet the following day. This was the only entry on the history sheet following his discharge from healthcare and the last before his death 11 days later.
29. At about 4.55am on the morning of 28 September, a prison officer discovered the man hanging from the window bars in his cell, C3-41. The man was the only occupant of the cell. The discovery was approximately 45 minutes before a scheduled roll check. The officer told my investigator he checked the man as he was checking prisoners who were on ACCT documents. The prison officer raised the alarm and waited for fellow staff to arrive before he went into the cell. (Staff on residential units do not routinely carry keys at night. They carry a sealed pouch containing a cell key to be used in an emergency). An ambulance was called immediately by the prison radio operator. Several staff responded. The Night Orderly Officer and the second officer removed the ligature and lowered the man to the ground. The night orderly officer, the staff nurse, the second officer and the healthcare officer attempted cardio pulmonary resuscitation (CPR) as soon as they arrived at the cell. The second officer said in interview that he held the man whilst the night orderly officer removed the ligature. The man was lowered to the floor and chest compressions were started by the night orderly officer whilst the staff nurse undertook breathing. The second officer said he left the cell to collect CPR equipment, returning a few minutes later. The staff nurse said in interview that the man was cold, clammy and failed to respond. Another nurse arrived at the cell and helped with CPR. He told my investigator that they continued to attempt resuscitation until paramedics arrived at about 5.10am. Shortly after this time, at about 5.15pm, it was concluded that the man had died. The other prisoner, in cell C3-42 said he thought he heard someone say "He's gone" about thirty minutes after the alarm was raised.
30. The duty governor arrived at the prison at about 5.15am. He ensured the cell was sealed and that death in custody contingency plans were put in place. The duty governor held a "hot debrief" for staff who had responded to the man's death. (Hot debriefs are primarily carried out to ensure staff have the opportunity to discuss emotive issues relating to incidents. Minutes are not normally taken at these meetings.) Staff completed the appropriate incident report forms before they went off duty. They were offered the services of the staff care and welfare team when they attended the hot debrief. Most staff told my investigator they felt supported after the man's death. Some said that members of the care team spoke to them a few days afterwards and I judge

that the support offered to staff was appropriate. However, none of the prisoners interviewed mentioned any support being offered to them by prison staff.

31. The duty manager was appointed as the prison's Family Liaison Officer (FLO). The man's children were informed of their father's death by the foster parents who had been appointed by Social Services. Numerous attempts to contact other family members were made by the prison and Social Services, but without success.
32. A post-mortem was carried out during the afternoon of 28 September by a doctor at Pinderfields Hospital, Wakefield. The doctor concluded that the man's death was due to hanging. A toxicology screen to determine whether the man had taken any legal or illegal drugs was negative.
33. On 29 September 2007, a complaint was submitted by the other prisoner. The prisoner was located in cell C3-42, next door to the man, at the time of his death. The other prisoner told my investigator that the man had visited him in his cell on the morning before his death. He said the man was crying and had asserted that he was not a sex offender. The other prisoner's complaint claimed that prisoners had been bullying the man because officers had told them that he was a sex offender. The other prisoner believed the man had killed himself due to intimidation.
34. A principal officer and a senior officer interviewed the other prisoner and gave him a written response on 2 October. In the response, the principal officer noted that the complaint could not be pursued as the other prisoner had refused to name any staff who he alleged had behaved in an unprofessional way. My investigator interviewed the other prisoner and two other prisoners who had been in the cells next to the man when he died. They all spoke of inappropriate behaviour by more than one member of staff. I deal with this matter below.

ISSUES

Allegations of bullying

35. The complaint submitted by the other prisoner on 29 September 2007 led to him being called to a meeting with a Principal Officer. The other prisoner told my investigator that a Senior Officer was also present and that the complaint was discussed. The other prisoner alleged to my investigator that the PO had said to him, "I can make people's life hell." He added that he was encouraged to withdraw his complaint. He said he was told that, in return, he would be given a job as a cleaner as well as enhanced status under the Incentives and Earned Privileges (IEP) scheme. At the end of the meeting, the other prisoner said he saw the PO turn to another member of staff and raise his thumb. He interpreted that to mean, "It has been sorted." The other prisoner said he sent a copy of his complaint to the Governor several days after he received the formal response as he felt he should be aware of the contents. He told my investigator that about a week later he received the complaint back in a plain envelope with his name written on the outside of the envelope. There was no written response from the Governor included. My investigator could find no evidence that the complaint had been registered or sent to the Governor. When my investigator showed the complaint to the Governor he said he had never seen it before.
36. The other prisoner told my investigator that he knew the identity of the staff member who had told prisoners that the man was a sex offender. He added he would not name him as he was afraid that he would be assaulted if he did. He believed the officer concerned had allowed two cleaners to enter a cell to assault an Asian prisoner about six months before the man's death. The other prisoner said he was hoping to be released in early January 2008 and he would then be safe.
37. My investigator also interviewed a prisoner who shared a cell with the other prisoner at the time of the man's death. He told my investigator that he was not afraid to talk as he was serving a life sentence and was not afraid of staff. The other prisoners cellmate alleged that an officer had told him that the man was a sex offender. He added that after the man's death the other prisoner was very upset and told him that it was not correct what staff had done. The cellmate added that he encouraged the other prisoner to submit a complaint. The cellmate moved cells shortly afterwards and alleges that the same officer came to his new cell and tried to provoke his new cellmate, a black prisoner. The cellmate also told my investigator that, the day before the interview, this officer approached him and tried to be very friendly and appeared to be worried. The cellmate believed it was because the officer knew he was due to be interviewed by my investigator the following day.
38. Another prisoner was located in cell C3-40 at the time of the man's death. He told my investigator that he did not know the man very well, only that he spoke little English. When asked if he was aware of any issues related to bullying, the prisoner told my investigator that he also had problems with one particular member of staff. He went on to say that a female officer had a problem with

sex offenders. He alleged that she had told prisoners that he was a sex offender and, as a result, he had felt afraid to go out on exercise for several months. He added that he had told an SO and she replied, "She wouldn't do that." The prisoner said he submitted a complaint but the response was that the officer he complained about could not have made the comments as she had been on two weeks annual leave. The prisoner said he felt this was a cover up as clearly she could have made the comments before her leave. The prisoner also told my investigator that, in about June 2007, another officer had told cleaners that a stocky foreign national prisoner was a sex offender, this was the same officer named by the other prisoner's cellmate. This prisoner requested protection and moved to A wing (the vulnerable prisoner unit). The prisoner added that the officer concerned had approached him before his interview with my investigator in what he believed was an attempt to influence what he would say. He said that he feared for his safety if staff became aware of the information he had provided. My investigator discussed the matter with the Governor and agreed to wait until the prisoner had transferred to another prison and the other prisoner had been discharged before formally raising the issues outlined above.

39. In mid-January 2008, my investigator formally informed the Governor of the allegations outlined above and provided the names of staff against whom the allegations had been made. As a result, the Governor reported the matter to the police and informed my investigator that an enquiry would be conducted. The police enquiry resulted in no criminal charges against any member of staff. Be that as it may, I am very concerned about allegations that prisoners who are from a minority ethnic background or have committed offences of a sexual nature might have been targeted by a small number of staff at Leeds. It is of equal concern if, as alleged, wing managers cover up for staff when a prisoner does choose to make a complaint. There are numerous issues that arise from the allegations outlined above.

The Governor should undertake a formal internal investigation into the allegations of staff malpractice outlined in this report.

Support for the man

40. A prison officer interviewed the man on 5 July 2007. He completed a foreign nationals referral form the same day. The role of foreign nationals co-ordinator involves gathering information for the UK Border Agency. It does not include helping to deal with day to day problems faced by foreign prisoners on arrival in prison custody. Nor does it involve maintaining contact with foreign national prisoners after the initial meeting. The man was clearly anxious about the whereabouts of his children and had concerns about his solicitors. He also had difficulty understanding English. I believe the issues faced by the man in respect of his children and legal representation could be experienced by any prisoner, regardless of their nationality. However language barriers are likely to have made resolution of the issues more difficult. These issues should have been brought to the attention of the man's personal officer. This could be achieved by providing the personal officer with a copy of the referral form supported by a note of the interview from the foreign nationals co-ordinator.

The Governor should ensure that the foreign national co-ordinator provides information for personal officers on any prisoner who is likely to have difficulty communicating with staff as a result of language barriers.

41. Whilst the ACCT document was open, and throughout his time in the healthcare centre, staff attempted to help the man. He had daily contact with staff in the healthcare centre and numerous entries were made in either his medical record or on the ACCT document itself. The ACCT document was closed on 18 July 2007. A week later, the man moved to C wing. There is no evidence that he was offered any subsequent support or had any constructive contact with staff. The personal officer should be the first point of contact for a prisoner. There is no evidence that the man approached his personal officer or that the personal officer spoke to him. Indeed, the man's personal officer, told my investigator that he knew very little about the man. He acknowledged in interview that language barriers were an issue. There is no documentary evidence that attempts were made to communicate effectively with the man after he left the healthcare centre. Translation services such as Bigword and Language Line might have helped. Language Line was contacted when the man was in healthcare and interpreters were used when he was in LGI. It is possible that Bigword and Language Line were contacted after his move to the wing but, if that is the case, no records were kept.
42. The man was charged with the murder of his wife. His young children may have been present at the time the offence was committed. This must have been a very traumatic time for all the family members. The correlation between intra-familial homicide and suicide is well known. However, this does not appear to have been considered in respect of the man. Had the man been eventually convicted of murder, he would have received a life sentence. He would then have been seen by the prison's lifer team, and it is likely that support would have been provided at that time. However, this would have been several months away. I have decided not to make a formal recommendation on this matter. However, the Governor may wish to consider ensuring that any prisoner who is likely to receive a life sentence is seen shortly after their initial reception by a member of the lifer team.
43. With the exception of two entries relating to the incident in the education department, no entries were made on the man's wing history sheet after he left healthcare until his death. This was a period of just over two months. While I understand the pressures that exist in busy local prisons like Leeds, in my opinion this level of reporting is wholly unacceptable. Ideally, all prisoners should have regular meaningful contact with staff and detailed entries should then be made on their wing history sheets. It was particularly important in this case as the man had made threats to self-harm and had difficulty speaking English.

The Governor should ensure that contact is made with all prisoners at least monthly, and that details of the contact are recorded in the prisoner's history sheet.

Assessment, Care in Custody and Teamwork

44. All appropriate initial actions were completed when the ACCT document was opened on 4 July 2007. However, there was very little information documented in the assessment interview, possibly due to language difficulties. The caremap identifies lack of contact with the man's children and problems with his solicitor as the two issues that needed to be addressed. Any efforts made to try to resolve these issues do not appear to have been successful at this time. The summary notes of the case review carried out on 11 July stated that the man remained anxious and concerned about his children. They also said he was crying and visibly upset when discussing the death of his wife. At the next case review, held on 18 July, it was acknowledged that the man remained emotional about his circumstances. The review panel agreed to look at his legal issues and childcare concerns. Several entries were made in the ACCT document and medical record to confirm that these concerns were followed up. The man was adamant that he was not at risk of deliberate self-harm. The ACCT document was therefore closed. It appears that the underlying issues were identified and appropriately addressed whilst the man was subject to ACCT procedures. However, a post closure review was scheduled for 25 July and I have found no evidence within the ACCT document that this review took place.

The Governor should ensure that all ACCT post closure reviews take place on the scheduled date and the ACCT document is updated.

45. The ongoing record section of the ACCT document should provide a record of significant events, conversations linked to the caremap, and observations as specified in the introduction to the section. I consider that the number of entries in this section might confuse staff. For prisoners on half hourly checks, there could be over 50 entries per day recording routine observations such as "asleep on left side". It might become difficult for staff to identify key issues amongst so many routine entries. I believe this section should be reserved for significant contributions linked to the issues identified in the caremap. The recording of uneventful observations during regular checks might sensibly be entered elsewhere in the ACCT document. Some establishments choose to put routine observations on a separate document. The Governor may wish to consider a way that key information is not missed when staff view the ACCT form.
46. The man's ACCT document was closed a week before he left healthcare. Having spent around three weeks in the healthcare centre soon after he went into prison, the move to a large residential wing would have represented a considerable change in the man's circumstances. The apparent lack of contact on the wing might have had a significant effect on him. The man had been identified as at risk of attempting suicide and as at risk of self-harm. I believe it is essential for staff to have regular contact with prisoners who have recently been subject to ACCT monitoring. For prisoners in this category, I believe meaningful contact should be made at least weekly. Detailed entries of the contact should be entered on the wing history sheet. The contact and entries should be made for a considerable period after ACCT documents have been

closed. Had a member of staff looked at the man's history sheet, they would not have got any idea of how he was coping with prison life or any other issues. This is clearly unacceptable. There is no current policy on this issue. I believe that such a policy should be developed.

The Prison Service should consider developing a policy that ensures detailed entries of weekly contact with prisoners who have been identified as at risk of suicide are made in the individual's history sheet for a period of three months after the ACCT document has been closed.

Cell Sharing Risk Assessment

47. Following a brief period in police custody, the man was remanded into prison custody on 4 July 2007. All the necessary documentation accompanied him into custody. This included information on the PER relating to threats to self-harm and the police medical record that noted the man had deliberately banged his head on a wall and had been subject to constant supervision. When the man arrived at Leeds, reception and induction procedures were completed and a CSRA was carried out. The CSRA recommended that the man should be located in a single cell. Given the level of risk indicated, I believe the single cell recommendation was appropriate at that time. However, at a later stage it might have been more appropriate and of some benefit to the man to move him to a shared cell. Prison Service Order (PSO) 2750, Violence Reduction, outlines the requirement for regular reviews of prisoners initially identified as high risk. I can find no evidence that any CSRA reviews took place.

The Governor should ensure that Cell Sharing Risk Assessment reviews take place in accordance with the requirements of PSO 2750.

The events of 28 September

48. The prison officer discovered the man hanging in his cell at about 4.55am. The time of discovery is somewhat unusual as there was no formal requirement to check on the man at this time. The prisoner who was in the cell next door to the man, told my investigator that he thought the man had been checked several times during the night. When my investigator asked the prison officer why he had checked the man he replied that he had been carrying out checks on prisoners who were on ACCT documents. He had been told by more experienced staff in the prison that it was good practice to check prisoners in single cells at the same time. He added that he had no specific concerns about the man. Ideally, I believe this procedure should be carried out in all prisons. However, I accept that given resource constraints it might be extremely difficult to adopt this practice in prisons that have large numbers of prisoners who do not share cells. I therefore do not make a formal recommendation on this matter, but I note the prison officer's actions, and the advice on which they were based, as an example of good practice.

At prisons where it is normal for prisoners to share cells, I believe that checking prisoners in single cells during the night to be an example of good practice.

49. When the man was found, the alarm was raised via the prison radio net. The night orderly officer was in charge of the prison at the time. He told my investigator that he was on D wing when the alarm was raised and responded immediately. He said he was at the man's cell within about one minute. He added that as he approached the cell he shouted to the prison officer to break into his sealed pouch and open the cell door. The second officer arrived at about the same time as the night orderly officer. He told my investigator that the prison officer was still outside the cell at that time. He added that when he spoke to the officer he appeared shaken. The prisoner in cell C3-40, said he thought it was about five minutes after the alarm was raised before staff went into the cell, but it is impossible to say exactly how long it took for staff to arrive. I have found no other evidence to suggest that their response was in any way delayed.
50. In interview, the night orderly officer told my investigator that he would not expect any member of staff to enter a cell on their own at night. He added that officers are expected to wait for another member of staff to arrive. The Prison Officers' Association (POA) representative who accompanied the night orderly officer advised at the interview that, "It's down to the individual person's discretion, as long as they don't think it's a set up, I mean if there's only one person in the cell it's a bit clearer." Prison Service policy leaves it to the discretion of the individual member of staff whether to enter a cell on their own. Staff may enter a cell in an emergency if they feel it is safe to do so.
51. It is impossible to say whether an immediate entry into the cell would have helped to save the man's life, but it is unlikely given that other staff arrived at soon after. Nevertheless, it is self-evident that the swifter the response to a prisoner who has seriously harmed the more likely it is that his or her life will be saved. A delay of just a few minutes whilst waiting for support to arrive could mean that all subsequent efforts might fail, no matter how professionally undertaken. It is difficult to say authoritatively when staff should use their discretion to enter a cell because circumstances will differ. However, if prison staff lack confidence to enter a single cell when a prisoner is clearly hanging, it is difficult to imagine any circumstances when they would feel safe to go inside. I acknowledge that some staff may be reluctant to enter a cell alone for fear that the prisoner might attempt to overpower them. But it would be interesting to know just how often such an event has taken place. If the actual level of risk is very low (as I suspect), a more balanced and informed judgement could be made.

The Prison Service should provide further information about the number of prisoners in single cells who have apparently attempted suicide at night and then tried to overpower staff who went into the cell alone. The information should be used to advise staff when to use the sealed pouch.

52. Once staff went into the man's cell, all actions taken seem to have been appropriate and in line with Prison Service policy. I have found no evidence to suggest that staff who attended did not make every effort to resuscitate the man.

53. Support provided to staff following the man's death also seems to have been appropriate. Prisoners interviewed appeared to have concerns about the treatment of the man rather than needing support themselves. Nevertheless, I take this opportunity to remind the Governor that appropriate support should be offered to prisoners as well as staff following any death in custody.

Clinical Care

54. A review of the man's clinical care was undertaken at my request. He concludes that the man's medical problems were dealt with promptly and appropriately. He also finds that all actions taken at the time of the man's death were appropriate. The clinical reviewer has made no recommendations.

CONCLUSION

55. The man arrived in prison custody in a distressed and emotional state. I believe the period he spent in healthcare helped him come to terms with the early stages of his imprisonment. His period of supervision under the ACCT procedures also seems to have been a success and it may have prevented him self-harming or attempting to take his own life.
56. Having spent several weeks in the relatively safe environment in healthcare and under ACCT supervision, the man transferred to C wing. Following this move, there is little evidence of contact with staff or that their support was available. It seems likely that this sudden reduction in supervision and support from staff made it difficult for the man to cope.
57. It is impossible to determine exactly what caused the man apparently to take his own life. It is said that he went into the cell occupied by the other prisoner and his cellmate on the day before his death in a very distressed state and insisted that he was not a sex offender. If so, he clearly believed that other prisoners thought he was. Coping with imprisonment for the first time under the circumstances in this case must have been extremely difficult. Concerns about the safety of and access to his children may have added to his distress. If it is true that he was wrongly accused of being a sex offender and bullied by other prisoners, that may well have proved too great a psychological and emotional burden for the man to bear.
58. I am obviously very concerned by the allegations that staff may have contributed to the bullying of the man. I emphasise that these are allegations only, and that the passage of time will make their investigation all the more difficult. Nevertheless, I have no doubt that the Governor and the Prison Service will wish to ensure that they are examined as thoroughly as possible.

RECOMMENDATIONS

1. The Governor should undertake a formal internal investigation into the allegations of staff malpractice outlined in this report.

Prison Service response

Partially accepted. A review by West Yorkshire Police and the Governor concluded that there was insufficient evidence to initiate a formal investigation.

2. The Governor should ensure that the foreign national co-ordinator provides information for personal officers on any prisoner who is likely to have difficulty communicating with staff as a result of language barriers.

Prison Service response

Accepted. All prisoners identified as foreign nationals will have relevant information attached to their wing history sheet.

3. The Governor should ensure that contact is made with all prisoners at least monthly, and that details of the contact are recorded in the prisoner's history sheet.

Prison Service response

Accepted. In place. The new personal officer scheme requires weekly contact with prisoners.

4. The Governor should ensure that all ACCT post closure reviews take place on the scheduled date and the ACCT document is updated.

Prison Service response

Accepted. In place. A new system to ensure compliance was put in place in April 2008.

5. The Prison Service should consider developing a policy that ensures detailed entries of weekly contact with prisoners who have been identified as at risk of suicide are made in the individual's history sheet for a period of three months after the ACCT document has been closed.

Prison Service response

Accepted. Scope currently exists within PSO 2700

6. The Governor should ensure that Cell Sharing Risk Assessment reviews take place in accordance with the requirements of PSO 2750.

Prison Service response

Accepted. Ongoing. A new system is in place maintained by the Violence Reduction co-ordinator.

7. The Prison Service should provide further information about the number of prisoners in single cells who have apparently attempted suicide at night and then tried to overpower staff who went into the cell alone. The information should be used to advise staff when to use the sealed pouch.

Prison Service response

Accepted. PSO 2710 contains mandatory instructions about immediate actions following an apparent death. SCOP will consider reiterating these in the Safer Custody News.

GOOD PRACTICE

At prisons where it is normal for prisoners to share cells, I believe checking prisoners located in single cells during the night to be an example of good practice.