Investigation into the circumstances surrounding the death of a man at HMP Leicester in November 2009

Report by the Prisons and Probation Ombudsman for England and Wales

March 2011

The man was 39 years old when he died at HMP Leicester in November 2009. He had apparently taken his own life. He had been recalled to prison in September 2009, only days after being released on Home Detention Curfew. Although he had problems with his relationship, and was worried about future contact with his children, he gave no explicit warning to staff or other prisoners at Leicester that he was considering taking his own life.

I would like to convey my condolences to the man's family and others affected by his death. I hope that my investigation provides them with some understanding of the events surrounding his death. I also apologise for the delay in issuing this report, and any additional distress this may have caused.

An investigator was appointed from my office and he has been assisted by one of the Family Liaison Officers. I would like to thank the Governor at HMP Leicester and her staff for their assistance during the investigation. In particular, I am grateful to a governor at Leicester who acted as liaison officer throughout the investigation.

A clinical review into the medical care the man received at Leicester was commissioned from the local PCT. They asked a clinical reviewer to conduct the review, and I am grateful to him for his report.

I make three recommendations arising from this investigation. Two concern cardio pulmonary resuscitation training for prison staff, and the third the use of OASys documents.

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

Jane Webb
Acting Prisons and Probation Ombudsman **March 2011**

CONTENTS

Summary

The investigation process

HMP Leicester

Key findings

Issues

Conclusions

Recommendations

SUMMARY

The man was found dead in his cell at HMP Leicester on a morning in November 2009. He was last seen alive at about 8.00pm the previous evening, and he went onto hang himself with a ligature attached to the window frame

He had been in prison before and was well used to the prison regime. He had also served the first part of his most recent sentence at Leicester before transferring to HMP Nottingham in May 2009.

He was released on licence on 25 September, subject to a Home Detention Curfew (HDC), to live with his partner and their two children. Problems in the relationship surfaced almost immediately on the day of his release and his response was to drink heavily. He was arrested the next morning and charged with assault and damage to property. His licence was revoked and he was remanded back into custody at Leicester on 29 September.

Well known to both the local probation service and staff at the prison, the man was never identified as someone at risk of self harm or suicide. On the contrary, he had been a Listener (a prisoner trained to give support to other vulnerable prisoners) during his previous sentence and successfully applied for the same position on his return to Leicester. His outward demeanour gave no clue to staff that he was struggling emotionally or psychologically. He appeared to settle back well into prison life by successfully applying for the highest level of privileges and working in the prison clothing store.

The man's partner ended the relationship after the events of the night of his release. He seems to have been more badly affected by this than he initially showed to others. He appeared to accept that it had been frightening for his children to see him in an aggressive, drunken state and he feared that his ex-partner would prevent him from seeing them in future. Although he shared some of his anxieties about contact with his children with certain friends in prison, none of them felt sufficiently concerned that this was unusual or out of the ordinary.

Two unrelated matters coincided on 12 November. The man's cellmate, with whom he got on very well, was moved to another landing because the two men were on different levels of privileges. Shortly afterwards, he spoke to his ex-partner on the telephone when he repeated his worries about contact with his children. She confirmed that she was in a new relationship and reminded him how badly affected his son in particular had been by his behaviour. She did not say that he could not see the children. He went on to speak with his daughter in a telephone call later that day.

It seems that the conversation preyed on his mind and he spoke to several fellow prisoners about it. Although they acknowledged later that he had been upset and depressed about the implications of the call, nobody thought he was suicidal. They, therefore, did not think to alert staff. He, himself a Listener, made no attempt to find extra support.

The clinical reviewer concluded that there were no opportunities for healthcare staff to have intervened to prevent the man from harming himself. The clinical reviewer found that his death was not avoidable. He had probably been dead for some time before he was found and emergency procedures could not revive him. The clinical review contains two recommendations to improve cardio pulmonary resuscitation training and practice in future. I endorse these, and make a further recommendation about the use of OASys documents at Leicester.

Prison staff had no reason to think the man would take his own life. There had been no history to warn them of this possibility and he chose not to share his intentions with anyone else.

THE INVESTIGATION PROCESS

1. The investigation was opened when the investigator visited the prison on 18 November 2009. He was accompanied by an Assistant Ombudsman. Various documents relating to his time at Leicester were collected and the investigators interviewed some key individuals who might have known about the events leading to his death. One was a prisoner who shared a cell with him in the six weeks before his death.

2. The investigator returned to the prison on a further three occasions to continue interviews with prison, other staff and prisoners. Interviews with medical staff were conducted jointly with the clinical reviewer, who had been appointed by the local PCT to conduct a clinical review.

3. One of my family liaison officers first contacted the man's family by telephone when she spoke to his mother on 4 December. The purpose of the call was to explain the investigation and give the family the opportunity to raise questions and concerns they wished the investigation to address. She went on to write to the man's ex-partner about the investigation and had telephone contact with his adult son.

4. The man's mother said that she had been worried about her son in the weeks before his death. She had noticed that he had lost weight and looked "skeletal". He had also telephoned her during the night of 25 September to say that "she had seen him for the last time".

5. Members of the family had heard rumours in their local community that the man's cellmate had been moved after there had been "a riot" on the wing. They were concerned that this left him alone and vulnerable and wanted to know if this had been allowed.

6. After the publication of the draft version of this report, comments were received on factual accuracy from both members of the man's family and NOMS.

HMP LEICESTER

7. HMP Leicester is situated close to the city centre. Originally built in the Victorian era, it has undergone extensive refurbishment. It is a local prison, which generally means it is used to accommodate remand prisoners, although there are a number who are sentenced. The prison has 24 hour healthcare cover, with inpatient facilities, which are run by Serco Health.

Her Majesty's Chief Inspector of Prisons (HMCIP) inspection

8. The last HMCIP inspection was conducted between 2 and 6 June 2008. In her introduction, the Chief Inspector said:

> "After a tragic recent period with a number of deaths in custody, Leicester had placed greater emphasis on safety … prisoners received good quality care and reported positively on their early experiences. Efforts had been made to improve violence reduction and safer custody procedures and, although these areas still required a good deal of development, prisoners generally reported feeling safe."

9. Inspectors reported that over 10 per cent of the population in Leicester were licence recalls, and that information provided to them had improved since the last inspection.

Independent Monitoring Board (IMB) report

10. The last report for the Leicester IMB covers the period between 1 February 2009 and 31 January 2010. With regard to safer custody provision, they said:

> "Since the staff restructuring, the Safer Custody department has been allocated two Senior Officers covering Safer Custody and Violence Reduction. There has been a considerable increase in the workload and the Board has been concerned that, on occasions, these officers have been deployed to other duties within the prison. However, the Board is pleased to note that 86 per cent was achieved in the Self Harm Audit against a target of 80 per cent."

11. In relation to deaths in custody they also said:

> "Recommendations made by the Prisons and Probation Ombudsman have been integrated into the prison's Consolidated Action Plan which is monitored by the Board. A joint working group of HMP Leicester staff together with representatives from the PCT and Serco meet to discuss all recommendations made after a Death in Custody. Whilst any Death in Custody is always very regrettable, the Board has the highest regard for all the staff at HM Prison Leicester for the professionalism and compassion with which they deal with these difficult incidents."

Previous PPO investigations

12. There have been 18 deaths in custody at Leicester since the Ombudsman took responsibility for such investigations in 2004. Of the reports into these deaths, in several instances I have made recommendations about the emergency response and administering cardio pulmonary respiration.

Assessment, Care in Custody and Teamwork (ACCT)

13. Assessment, Care in Custody and Teamwork (ACCT) is a care planning tool used by the Prison Service to help monitor and support prisoners identified as being at risk of self harm or suicide. Any member of staff can “open” an ACCT by filling in certain documents detailing their concerns and the process encourages staff to work together to tailor individual care to prisoners in distress. Regular checks and reviews of the prisoner’s situation are built in to the process with the ultimate aim of diffusing circumstances where suicide or self harm can take place.

Incentives and earned privileges scheme (IEP)

14. The Prison Service uses the incentives and earned privileges scheme (IEP) as one way of managing prisoners by rewarding good behaviour and withdrawing privileges when a prisoner does not comply with the regime. There are three levels (basic, standard and enhanced) and prisoners can move up or down the levels depending on their behaviour. The higher levels give more privileges which can include extra visits, more association time or access to better facilities in the cell. They can then be removed if the prisoner’s behaviour deteriorates, when they move down a level.

Offender Assessment System (OASys)

15. OASys is an abbreviation of the Offender Assessment System used by the Prison and Probation services to measure the risks and needs of offenders under their supervision. It is a set of documents used to assess the risk of re-offending by an individual and also the risk of harm they present to themselves and others.

KEY FINDINGS

16. The man was released from HMP Nottingham on Home Detention Curfew (HDC) on 25 September 2009. He was being released early from a two year sentence for possession of amphetamine with intent to supply. He was required to wear an electronic tag at all times and to live at the address specified on his licence between the hours of 7.15pm and 7.15am. Further requirements included keeping appointments with his supervising offender manager and to be of good behaviour without re-offending during the course of the licence. He was subject to HDC until 14 January 2010, although supervision on licence would continue until 14 January 2011.

17. It is clear from the prison records that the man had impressed staff at Nottingham with his positive attitude which contributed to the decision to release him early. He had been a Listener at Nottingham, a prisoner trained by the Samaritans to offer confidential support to other prisoners who identified themselves as being distressed or vulnerable to self harm.

18. The man returned to live with his partner, with whom he had two children. This address had previously been checked as suitable by the home probation service and his partner confirmed that he could live with her.

19. Unfortunately, the arrangement seems to have broken down very rapidly. The man started to drink heavily on the day of his release and, after a night of argument and violence, police were called and he was arrested. During the course of the night's events, he told his partner that he had tried to kill himself but had not been able to do so and he had punched the television instead. There is no information about the method he used to try to harm himself.

20. On 26 September, the man was charged with two offences of criminal damage to furniture and property at the house and three offences of assault against his partner. He told police officers that he had drunk a bottle of brandy the previous day. It was noted that he was "incapable" of signing for his own property when he arrived at the police station.

21. There is no record that the man caused any concerns about the possible risk of self harm or suicide. There was no repetition of his declaration the previous night to his partner that he had attempted to harm himself. His mother, however, told my family liaison officer that she had been very worried about her son's state of mind ever since he telephoned her at some point on 25 September. He said that this was the last time she would see him. She said that she had telephoned the police station on 26 September to alert them to her fears. (This contact was not recorded on any of the documents received by my investigators.)

22. The man appeared at Magistrates' Court on 28 September when his licence was revoked, and he was remanded into custody until 6 October.

23. When the man arrived at HMP Leicester from court he was subject to the standard reception procedures. All prisoners are given a first night health

screening on arrival at prison. This means that a member of the healthcare staff works through a questionnaire, addressing a range of health issues. Prisoners are weighed, a medical history taken and information about current medication and medical treatment noted. In his case, this screening was done by Nurse A. When she was interviewed by my investigator and the clinical reviewer, she did not have any specific memory of him but she confirmed that she had completed the relevant document. She had not noted that he had any physical or mental illness and said that he did not show signs of vulnerability to self harm or suicide. His weight was recorded as just over 73 kg (11st 7 lb) and he was not prescribed any medication.

24. Reception procedures also include being assessed for suitability to share a cell. Officer A recorded on the Cell Sharing Risk Assessment form that the man was a smoker and was “polite to staff”. The officer remembered him from previous sentences although he did not know him particularly well. On this occasion, he gave no concerns that he had thought of suicide or self harm. He told staff that he did not abuse alcohol and had never previously been subject to ACCT procedures in prison. He then spent the night in the First Night Centre in cell L1-13.

25. Also on 28 September, the man’s supervising home probation officer completed a Risk of Serious Harm Full Analysis as part of the Offender Assessment System (OASys). He gave a written account of the events of 25 and 26 September and included the information that the man had told his partner that he had tried to kill himself during their protracted argument. However, he also noted that the man had no history of previous mental health conditions or depression and was not considered to be at risk of suicide or self harm.

26. The home probation officer highlighted that the man’s children were at risk of emotional distress because they had been present throughout the altercation between their parents. Overall, however, the risk he presented to others and the public was judged to be low, apart from to his now ex-partner, who was deemed to be at medium level of risk from him in the community.

27. This assessment was sent electronically to the prison and printed off on 29 September. Once received, the OASys form would usually be reviewed in the prison within the next eight weeks. This had not happened by the time of the man’s death (approximately six weeks later) and there is no sign that it had been considered by any prison staff as no reference to it appears in other documents.

28. On 29 September, the man moved to cell L3-16 to share with his cellmate. Other parts of the sentence planning process, which is central to the induction of new prisoners, were completed that day. He was seen by, among others, the chaplain and by Senior Officer (SO) A. He chose not to meet with an officer from the Probation Department to discuss the possibility of bail.

29. The chaplain was later interviewed by my investigator about his impressions of the man during his induction. The chaplain’s memory was quite vague as

an induction appointment would not usually last more than five minutes. However, he did not recall him causing any specific concerns. The chaplain had recorded that the man mentioned that there may be problems with visits from his family but the chaplain did not believe that this made him more vulnerable than many other prisoners.

30. Although the man and his cellmate had not met before, it seems they got on well from the beginning of their time sharing a cell together. The cellmate spoke eloquently to the police in a statement immediately after the man died about how much he liked his new cellmate and that he was “a brilliant bloke”. According to him, the man got on well with everyone and was quite open about how he came to be back in prison and his worries about contact with his children.

31. On 30 September, Officer B introduced himself to the man as his personal officer. (The personal officer scheme is widespread in all prisons and means that designated officers are expected to take extra interest in the welfare of a certain number of prisoners, to meet at least fortnightly and review progress on a regular basis.) The officer noted at the first meeting that the man had been at Leicester before but recorded nothing else of particular note.

32. The Court proceedings had been adjourned to 6 October and the man’s case was heard that day at Magistrates’ Court. He did not travel from Leicester to the court but appeared via video link. He was further remanded in custody until 3 November.

33. Soon after arriving at Leicester, the man mentioned to staff that he had been a Listener at HMP Nottingham. This information was relayed to SO B, the Safer Custody Co-ordinator, who is responsible for co-ordinating the ACCT process in the prison. Later in interview with my investigator, the SO remembered going to see the man sometime in early October to check this with him. He confirmed his interest and the SO told him that he would begin the process for him to be reinstated as a Listener at Leicester. He was very enthusiastic about this prospect and the SO warned him that it could take up to six weeks to happen.

34. On 3 November, SO B went to see the man to tell him that confirmation had come through that he could be reinstated as a Listener. He was told that he needed to stay at Leicester for at least six months and could start to attend the regular weekly meetings between the Samaritans and Listeners. The SO believes that the man attended a couple of these meetings before he died.

35. On the same day, 3 November, the man appeared via video link once more at Magistrates’ Court. Matters were adjourned for trial on 18 November.

36. The man made a written application for enhanced status under the IEP scheme on 4 November. Up to this point, he had been on standard status as are most prisoners when they first arrive. In support of his application, he explained that he had previously been on enhanced status, that he had been

reinstated as a Listener and was working in the Clothing Exchange Stores (CES).

37. Also on 4 November, Officer B, the man's personal officer, recorded that he was "no kind of problem for the landing staff". He described him as polite and conforming to prison rules. He also noted that he had just become a Listener again.

38. The application for enhanced status was supported by SO A, who confirmed on 6 November that there were no security concerns regarding the man. OSG A, who supervised the CES, signed the employer's section of the form on 9 November, recommending that the man's status should be changed to enhanced.

39. The IEP Review Board sitting on 11 November agreed to the man's request and he was notified in writing the same day. This meant, among other improvements in his conditions, that he was now entitled to a DVD player in the cell. One consequence of the change however, was that his cellmate could no longer share a cell with him, who could not be allowed to benefit from increased privileges. The cellmate moved out of the cell on 12 November at about 3.00pm and was placed on the landing above.

40. The man telephoned his ex-partner at 3.45pm and they spoke for about ten minutes. My investigators have listened to recordings of three telephone calls he made on 12 November. His partner was annoyed that she had been summoned to appear at court in connection with his criminal charges. He initially tried to mollify her but they started to argue about his drug use and her new relationship. She confirmed that she had met someone else and that she considered their relationship to be over.

41. From listening to the call, the man seemed to take this news well. He said that he already knew and accepted that she was moving on, but his main concern was his children. However, he was upset that someone else would have access to his home and property. His ex-partner reminded him that his actions had scared both children. She said their son had been especially frightened and did not want to speak to him at the moment. He tried to get a commitment that she would let him speak to his daughter at Christmas but the call ended before she commented either way.

42. Later that afternoon, the man visited his ex cellmate in his new cell. He spoke about the telephone conversation with his partner. His ex cellmate gathered that it had been a difficult conversation and described it as a "Dear John" type of call. (This is a term often used in prisons when a relationship is ended by a partner either by letter or telephone.) He said his friend told him that his partner had started to see someone else and their relationship was over for good.

43. They were only able to speak for about five minutes as the ex cellmate was about to be locked up in his cell. He said that the man had been left "sad and depressed" by the call. However, he did not think this was unusual in the

circumstances and he did not suspect that he was likely to harm himself as a result.

44. The man made two further telephone calls to his ex-partner's number at 6.24pm and 6.37pm. On the first occasion, he spoke briefly to the partner of a close friend, who he knew well. She told him she was looking after the children while their mother had gone out. He told her that his belongings should be handed to a friend and she confirmed that she would pass this on. He also said that his ex-partner would not have to attend court as he would not bother her about it again. The call was amicable in tone and he did not sound distressed.

45. When the man rang a few minutes later, he spoke to his young daughter who had picked up the receiver. She went on to make a game of pretending to be her brother. The call was mostly taken up with the little girl's teasing. He went along with his daughter's playfulness but he did not speak to his son.

46. Officer C came on duty at about 8.00pm on 12 November and he made the roll check shortly afterwards. (This entailed looking through the cell door flap and counting the numbers of prisoners in each cell. There is no requirement for staff to speak to prisoners or get a verbal response from the prisoners.) Although he cannot remember the man specifically, he confirmed both to the police and to my investigator that he would have counted him as present in his cell as part of the roll check.

47. There was no further contact with the man or need to visit his cell that night.

Events of 13 November

48. In the morning, Officer C was responsible for the roll check on landing L3 which he started at about 6.30am. At about 6.42am, he looked through the door flap of cell L3-16 and saw the man's body hanging from the window frame. He raised the alarm by shouting to two officers who were on the landing below. He took his key out of the pouch attached to his belt and opened the door. Officer D was, by this time, just behind him.

49. On his way to assist his colleague, Officer D had used his radio to summon urgent help. Once in the cell, the officer supported the man's body to enable Officer C to cut the ligature with his anti-ligature knife. (Anti-ligature knives are required to be carried by all prison staff.)

50. Officer E, who also responded to Officer C's first shout of alarm, was told by the Night Orderly Officer to go to healthcare to collect the duty nurse (the Night Orderly Officer is in charge of the prison at night). She had heard the alarm call and arrived on the wing just after the officers had gone into the cell. She gave Officer E keys to allow him to go to the healthcare centre and bring the nurse back with him.

51. The officers then lowered the man to the ground. Officer C described his body as being "very, very stiff" and that it was clear to him that "rigor mortis

had set in". The officer has had previous experience of such circumstances when unlike this occasion, the person had been warm to the touch and less stiff. The contrast was very stark for him and neither officer attempted cardio pulmonary resuscitation (CPR). Both officers clearly believed that he was already dead.

52. As this was happening, the Night Orderly Officer instructed the Communications Operator to call an ambulance. She also instructed Officer F, who was standing outside the cell, to start a log of events.

53. Officer E accompanied Nurse B back from the healthcare centre onto the wing and then left her to make her own way to the cell whilst he collected the resuscitation equipment from the centre office. He estimated that he took the bags containing the defibrillator, oxygen and other essential items to the cell within 30 seconds. (A defibrillator is a machine which detects whether there is any electrical activity in the heart and, if there is, can apply a small shock to restart the heart. If there is no electrical activity, the defibrillator will instruct the user not to proceed as there is no point in applying the electric shock.)

54. Nurse B arrived at the cell at about 6.49am and looked for vital signs but could not find a pulse. The man's lips were cyanosed (which means they were blue in colour) and she could not hear him breathing. She also remembered that his skin was greyish and that he had froth at his mouth. She noticed that he was "very, very, very cold" to the touch and that his eyes were "glazed" over, with the pupils dilated.

55. Despite the fact that she could not detect any vital signs, such as breathing or a pulse, the nurse decided to begin CPR using chest compressions only. She explained later in interview with the investigator and clinical reviewer that the rigid position of his neck and the fact that his teeth were clenched made it impossible to attempt mouth to mouth resuscitation.

56. Principal Officer (PO) A, had arrived by this time and he instructed Officer D to leave the area to collect bags and seals to secure evidence in the cell. The PO noticed a letter in the cell and knew that he needed to hand it to the police. Officer C was asked to leave the cell by the PO and was asked to record what had happened. Officer D returned four minutes later with the equipment. The ligature, which had been put to one side, and the letter were bagged and sealed.

57. Nurse B gave the man oxygen at 6.57am and she carried on giving chest compressions until the paramedics arrived at the cell at 7.00am. The ambulance arrived very quickly because it was already at the Infirmary which is opposite the prison. The defibrillator was applied by the paramedics at 7.04 am but could not detect any electrical activity in the heart. He was pronounced dead at 7.05am.

Events after the man's death

58. The chaplain had come in to work on 13 November at about 7.15am, to be told of the news of the man's death. He accompanied the Governor at about 9.00am to drive to break the news in person to the man's family.

59. The prison had two addresses provided by the man, one of which was for his mother. The Governor and chaplain went to her home and told her of her son's death. They explained what would happen next and made sure that she had support from her own partner and niece before driving to the address of the man's ex-partner. They had been warned that she might not be at home but at work which proved to be the case. His mother had already offered to tell other family members if they got no reply and when they rang to say that they had not found anyone in, she confirmed that she would break the news herself.

60. Prisoner A, a friend of the man, approached an officer after news of his death had circulated on the wing. He said that during association the previous evening when prisoners are allowed free time outside their cells, the man had gone round shaking hands with a number of other prisoners and told them his partner had ended their relationship. He apparently could not bear the thought that she would now be with someone else. Another prisoner told staff later that the man had given away items of prison clothing during association the previous evening. Although uncharacteristic behaviour, it had not caused other prisoners to be alarmed about his risk of suicide and no-one spoke to staff about it at the time.

61. Prisoner A shared a nearby cell with Prisoner B, another close friend of the man. Prisoner B said later that he had heard a "loud bang" between two and three o'clock that morning but had not raised the alarm at the time. Prisoner A told my investigator that he did not hear anything himself although he described himself as a light sleeper.

62. The prison appointed a family liaison officer to provide information and support to the family in the aftermath of the man's death. The prison also offered to pay reasonable funeral expenses

63. Staff involved when the man was discovered and in the emergency response were invited to attend a "hot debrief" meeting held as soon as possible after the event. The purpose of such a meeting is to clarify what happened and also to offer support to those closely involved. Various members of staff who attended said that it had been helpful in terms of support and all those interviewed said they knew where to seek support if it became necessary later.

64. The man's cellmate told my investigator that he had been devastated when he heard the news of the man's death. He was offered support in the form of counselling, access to the Listener scheme and also the opportunity to see the chaplain.

ISSUES

Clinical care

65. The clinical reviewer assessed the quality of the clinical care given to the man from his arrival at Leicester on 29 September to his death six weeks later. Contact with healthcare staff was limited to the standard reception health screen and the emergency response to the discovery of him hanging in his cell on 13 November. He makes three recommendations, two of which are repeated from his reviews of previous deaths in custody. The recommendations concern:

The man's apparent weight loss

66. One issue that might possibly have been explored further at the health screening was what appears to be a significant loss of weight by the man. Nurse A recorded his weight as 73kg which, if accurate, meant that he had lost 10kg (approximately a stone and half) since he had been last weighed at HMP Nottingham in May 2009. She, however, did not have that information at the time. He did not volunteer that he had lost weight and she did not remember him looking like someone who had done so.

67. Although this echoes a comment made by the man's mother to my family liaison officer that she had been worried about him because he had lost so much weight, Nurse A would not have been aware of this. Furthermore, he did not complain to medical staff subsequently about his weight. The clinical reviewer was not able to comment further on the apparent loss of weight but thought that, even if it was confirmed, it was unlikely to have contributed to his death.

Administering cardio pulmonary resuscitation

68. Nurse B guessed that she carried out chest compressions for about 20 minutes. In fact, the timings of various arrivals and departures at the cell make it more likely that the actual time was about ten minutes. However, this early over estimation might indicate how strenuous she found the physical effort of giving compressions on her own. She acknowledged in interview that it was tiring and she would have welcomed assistance from prison staff but did not ask for help at the time.

69. Officers C and D had both been CPR trained but a long time before. Their decision not to begin CPR was clearly influenced by their belief that the man was already dead. When Nurse B arrived at the cell she saw the officers standing at the door and thought they looked scared. Neither officer expressed doubt in interview about their willingness to start CPR if they had felt there was any realistic chance of success.

70. Both officers were sent away from the immediate area by Principal Officer (PO) A. He remembered asking Nurse B if she needed assistance, but he thought she said she felt able to carry on until the paramedics were able to

determine whether the man was alive. (Only a paramedic or doctor is authorised to pronounce death.)

71. Following a previous death at the prison, the clinical reviewer recommended that CPR training for prison staff should emphasise the physical effort required to undertake chest compressions. Ideally, two or more trained people should carry it out to increase the chances of resuscitation. It is clear that the man's circulation and respiration had stopped for far longer than the period in which CPR is likely to be successful. However, it could be crucial on another occasion for chest compressions to be attempted as effectively as possible. He repeats his recommendation, which I endorse:

The Head of Healthcare should ensure that training in resuscitation procedures for both prison and healthcare staff should emphasise the tiring nature of undertaking chest compressions. Successful resuscitation is more likely if undertaken by two or more trained staff.

72. The clinical reviewer also recommends that both healthcare and prison staff take equal responsibility to ensure that resuscitation is attempted by sufficient numbers of trained staff. He advises that:

The Governor and Head of Healthcare should ensure that prison staff with appropriate training should volunteer to assist their medical colleagues if they are alone in a resuscitation attempt and, similarly, healthcare staff should actively elicit help from trained prison officers.

73. Whilst the clinical reviewer's comments are relevant, I consider that the real issue was whether delivering CPR was actually appropriate. PSO 2700, annexe 13a, advises prison staff that CPR need not be attempted if it is clear that rigor mortis has already set in. The officers clearly thought that it had, and so did not begin CPR. The nurse took a different view. It is unfortunate that none of her colleagues assisted. I do not believe that this detracted from her efforts or the outcome for the man.

Prison keys

74. The clinical reviewer raised questions in his report about which members of staff carry keys at night. Currently, there is one full set of keys which allows access to all parts of the prison. They are held by the night orderly officer, the most senior member of staff on duty.

75. On 13 November, an SO was the night orderly officer and she handed the keys to Officer E to collect the duty nurse from healthcare to enable her to get to the man's cell. Leicester is a small prison and it took four minutes from 6.45am, when Nurse B heard the alarm call on the radio, for her to meet Officer E on the way and arrive at the cell. The importance of attempting resuscitation as quickly as possible has been highlighted in the clinical review and no time was lost on this occasion.

76. The prison liaison officer told my investigator that there was no practical benefit to move staff holding other types of keys as they would be unable to unlock the double locked doors which surround the residential wings. These doors are automatically locked at night when the prison goes into “State A” (patrol state) when everything is locked down.

77. The allocation of one full set of keys to the night orderly officer in the prison is a national Prison Service requirement made for security reasons. The current practice of sending a prison officer to collect the duty nurse affords the opportunity for the officer to collect emergency equipment at the same time. Nurse B was unable to carry the heavy equipment on her own and Officer E’s assistance was necessary in this matter.

78. The clinical reviewer recommends that the Governor should discuss with the healthcare provider ways that medical staff can carry keys to enable them to reach prisoners at night more quickly. While sympathetic to the spirit of his recommendation, I do not endorse it as I recognise the importance of security. It seems to me that prison and healthcare staff work effectively to minimise possible delays.

Assessment of risk of suicide

79. There was almost no sign that the man was at risk of taking his own life throughout the events addressed in this report. The only possible indications were when he told his partner that he had tried to kill himself during the night of 25 September and when he called his mother the same night to say that it was the last time she would see him. He did not repeat these threats to harm himself to anyone else at the time or subsequently. Indeed, when asked by police, probation and prison staff whether he had any suicidal intentions he always said that he had not.

80. The information about the man’s attempt to kill himself on the night of his release was recorded on the OASys form completed by his home probation officer. This was done promptly and was passed to the prison the same day that he arrived on 29 September. If the full OASys document had been reviewed at this point, it is likely that a member of prison staff would have asked him directly about its significance. This did not happen as the procedure for OASys reviews only requires it to be done within eight weeks.

81. The information on OASys regarding the risk of self harm for the man was limited and, even had it been seen earlier, it might not have made a difference to how he was regarded by staff. However, in other circumstances the information might be of crucial importance. I believe that eight weeks is too long to wait for an important document like OASys to be reviewed, especially if it contains information that might prove vital to protect a prisoner from harm.

The Governor should ensure that OASys documents are reviewed at the earliest opportunity, and staff are reminded that they might contain valuable information about the risk of self harm or suicide.

82. It must be emphasised, however, that the man's risk of suicide in the same OASys document was assessed as low. He had no history of self harm or depression and no concerns were expressed about his vulnerability. There was no reason for the probation officer to follow up the OASys form with an email or letter outlining concerns for his safety.

CONCLUSION

83. The man was returned to prison having breached the terms and conditions of his Home Detention Curfew. He had been in prison on a number of different occasions. During his admission to HMP Leicester he gave no indication that he was struggling with being returned to prison or that it was affecting his state of mind. He settled back at Leicester, resumed his role as a Listener and successfully applied for enhanced prisoner status.

84. The man spoke to a number of fellow prisoners about his telephone call to his ex partner and the fact that their relationship had come to an end. Although they could see that he was upset, none of them thought that he was at risk of self harm or worse and as such no concerns were passed on to the prison staff on duty. He gave away his belongings and bade farewell to fellow prisoners on the night before he took his life. No one recognised that this might be significant and staff were not told about it. I conclude that staff at Leicester could not have foreseen his death. I make two recommendations concerning the emergency response, and one about the use of OASys documents.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that training in resuscitation procedures for both prison and healthcare staff should emphasise the tiring nature of undertaking chest compressions. Successful resuscitation is more likely if undertaken by two or more trained staff.

NOMS response – Accepted – "This will be highlighted in both First Aid and Intermediate Life Support training and on Staff information notice."

2. The Governor and Head of Healthcare should ensure that prison staff with appropriate training should volunteer to assist their medical colleagues if they are alone in a resuscitation attempt and, similarly, healthcare staff should actively elicit help from trained prison officers.

NOMS response – Accepted – "This will be highlighted in both First Aid and Intermediate Life Support training and on Staff information notice."

3. The Governor should ensure that OASys documents are reviewed at the earliest opportunity, and staff are reminded that they might contain valuable information about the risk of self harm or suicide.

NOMS response – Partially accepted:

1) **"Oasys documents will be reviewed at the earliest opportunity in line with National Guidelines.**

2) **The present system of communication between outside Probation and Safer Custody department will be reviewed. The review will see if in addition to prisoners with an alert flag being identified by Probation, any information identifying that someone may be vulnerable can be highlighted.**

3) **System will be put in place to ensure Senior Officers check Oasys documents when carrying out a CSRA review."**