Investigation into the circumstances surrounding the death of a male prisoner at HMP Leeds at Leeds General Infirmary in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

May 2010

This is the report into the circumstances surrounding the death of a male prisoner from HMP Leeds, at Leeds General Infirmary on 27 March 2008. The man had been found hanging in his cell at around 11.10am on the previous day. Having removed the ligature, prison staff tried to resuscitate him and managed to restore a pulse before he was transferred swiftly to hospital. Sadly, the man did not recover from his injuries and he died in hospital at 5.00am the following morning. He was 27 years old.

This investigation was led by an investigator from my office and written by another investigator. I would like to thank the Governor of Leeds and his staff for their participation in this investigation. I also thank Leeds Primary Care Trust for commissioning a Doctor to undertake a clinical review. The production of this report has been delayed because of staff changes within the Ombudsman's office, and because of a delay commissioning the clinical review. I much regret any additional distress or inconvenience this may have caused.

The loss of a loved one is always hard to bear. It is particularly so in this case due to the family history, and as the man had young children. I offer my sincere condolences to the man's mother, partner, family and friends for their tragic loss.

I make five recommendations to the Governor of Leeds.

Jane Webb
Acting Prisons and Probation Ombudsman
May 2010

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SUMMARY

The man died serving a 30 months sentence at HMP Leeds.

Prior to his arrest and conviction, two of the man's brothers committed suicide by hanging. The man found them both and had to cut them down. During his time in prison, he had received news that two of his friends had also committed suicide.

The man was first received at Leeds on remand on 3 August 2007. Initially, he was assessed as being at low risk of harm to himself or others. However, on 9 August, he attempted to hang himself. Prison staff intervened swiftly and he was successfully resuscitated and transferred to hospital. An Assessment, Care in Custody and Teamwork (ACCT) plan was opened on him, and he was supported and monitored appropriately on his return to prison. He was bailed from prison, pending sentence on 13 August 2007.

Over the next six months, the man received psychiatric care in the community both on an inpatient and outpatient basis under his psychiatrist. He made a number of further attempts at suicide whilst in the community.

The man was sentenced in February 2008, and arrived at Leeds prison later in the day. An ACCT plan was immediately opened by reception staff and he was first placed under constant observation, and then monitored for a longer period than usual on D1 induction wing. The plan was closed on 21 February, by which time the man had been located on a normal wing.

On 2 March, the man disclosed further suicidal ideas, and said he was being bullied. He was relocated briefly to the healthcare unit under constant observation, before being transferred back to D1 wing. He settled on D1 wing and was given a job as a cleaner which he enjoyed.

The man was found to have stolen tobacco from his cell mate on 17 March. He said that he was being bullied, but was unable to identify any individual. Due to this abuse of trust he was moved to C wing, and lost his job, but he was not placed on a disciplinary report as staff considered this would be likely to increase his level of stress. A new ACCT plan was opened the same day as he was relocated.

The man was moved to F wing on 20 March. The same day he learned that another friend had committed suicide. At his mother's request, a member of staff spoke to him and the man gave assurances that he was coping. The following day, the man disclosed to staff he had taken an overdose of his cell mate's medication, and he was taken to Leeds General Infirmary for tests and monitoring. The man was received back at Leeds in the evening of 22 March, blood tests having shown negative. His ACCT plan was reviewed and closed on 24 March, but without a multi-disciplinary review. A post-closure interview date had been set.

In the morning of 26 March, the man made an allegation of bullying and assault against his cell mate. He was assured by an officer that this would be investigated and he would be examined by a nurse later. His request for transfer to another shared cell was going to be considered. The officer liaised with the senior officer in respect of the allegation, and the senior officer checked that the cell mate was on a visit at the time and not present in the cell.

Before the allegation could be investigated, another prisoner went to the man's cell by chance, saw him hanging inside, and immediately alerted staff. Both uniformed and clinical staff responded quickly, cut the man down, and were successful at first in resuscitating him. The man was taken by ambulance to Leeds General Infirmary.

Further treatment and tests were undertaken before the man was admitted to the intensive care unit. Tests showed, however, that he had suffered a severe brain injury. He died at 5.00am on 27 March with his family present.

I make five recommendations as a result of this investigation. The recommendations refer to the ACCT process.

THE INVESTIGATION PROCESS

1. This investigation was originally allocated to a Senior Investigator. After her promotion to Assistant Ombudsman a very short time later, it was reallocated to a fellow investigator. He visited the prison and spoke to staff who had come into contact with the man during his time in custody. The investigator interviewed 12 members of staff. The interviews were tape recorded and transcripts are annexed to this report. Copies of these transcripts were sent to the interviewees to confirm that they were accurate.

2. Following the investigator's retirement, another Investigator was asked to write the report. On reviewing the first draft of the report, another Assistant Ombudsman considered that further investigation was needed to address two particular issues. He arranged to interview a further two officers at Leeds in October 2009. Unfortunately, neither officer was available when the Assistant Ombudsman visited the prison (The Investigator who later retired had also tried to speak to one of the officers before his retirement). This has left several outstanding issues that I mention later in the report.

3. Notices were posted to staff and prisoners about the investigation, inviting contributions. Two prisoners were informally interviewed.

4. A clinical review of the man's care was commissioned from Leeds Primary Care Trust. It appears that they did not identify a medical practitioner to carry out the review for some time, and this has contributed to the delays in this case. However, I am grateful to Leeds PCT and, in particular the Clinical Reviewer, for undertaking this review. The investigators discussed aspects of the man's treatment with healthcare staff at Leeds and with the clinical reviewer.

5. The investigators contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation, and to request a copy of the post-mortem report which was received. Upon completion, the report will be sent to the Coroner to assist with his enquiries into the man's death.

6. One of the Ombudsman's Family Liaison Officers, spoke to the man's mother, his partner, and two of his sisters, as well as to a close friend of his family, and visited them at the start of the investigation with the initial investigator who was later promoted. The Family Liaison Officer has kept in close touch with the family through the investigation, and met the family again in the summer of 2009 with the Investigator that wrote up the report. It was during this visit that one of the additional issues was raised.

HMP LEEDS

7. HMP Leeds is a category B local prison built in 1847. The prison serves magistrates' and Crown Courts in the West Yorkshire area, taking adult male prisoners on remand until trial and for short periods after sentence. Up to 1,004 prisoners are held on six wings including the healthcare facility in accommodation certified to hold 674.

Previous deaths at Leeds

8. Sadly, there have been 40 deaths at Leeds since I was entrusted with responsibility for undertaking death in custody investigations in 2004. Although ACCT procedures have featured in the recommendations made after three of these investigations, there are no direct similarities to this investigation. However, as a result of one of the recommendations, Leeds implemented a new system to measure compliance with ACCT post closure procedures in May 2008.

Healthcare

9. The healthcare department includes a 20 single bed inpatient unit. Healthcare staff at Leeds are commissioned and provided by Leeds Primary Care Trust.

Her Majesty's Chief Inspector of Prisons

10. HM Inspectorate of Prisons carried out an unannounced inspection of Leeds in December 2007. In her subsequent report, the HM Chief Inspector of Prisons found that reviews of ACCT assessments were not sufficiently multidisciplinary and that ACCT caremaps were not well targeted. She also found that there was a lack of primary mental health provision and the in-reach team's criteria were strict. These findings and associated recommendations are pertinent to the circumstances of the man's death.

Independent Monitoring Board (IMB)

11. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained.

12. The latest IMB annual report for 2007-08 describes the prison making progress in the areas of suicide prevention and violence reduction under the co-ordination of the Safer Custody Group. I note that the IMB makes particular mention of a 'significant dates' diary introduced to note particular dates when prisoners could feel upset, distressed or depressed, and that prisoners prone to self-harm could have increased observations around their significant dates. This improved practice is relevant to the recommendations made in my report.

Assessment, Care in Custody and Teamwork

13. Assessment, Care in Custody and Teamwork (ACCT) is a set of procedures designed to reduce self inflicted death and self harm. It provides assessment and care planning, personalised care and support before, during and after a crisis experienced by a prisoner.

14. If observations are required, the ACCT assessor will decide what level of observation is appropriate. This can range from constant observation (where the prisoner will be watched at all times) to defined numbers of meaningful contacts, for example a detailed conversation between the prisoner and member of staff. Observations should be conducted irregularly; for example, an hourly check should not be done at the same time every hour).

Safer Custody Programme

15. The Safer Custody programme at Leeds is available on all wings and has been in place since 2003. It is designed to help prisoners reduce their levels of distress and to reduce the risk of self harm.

KEY FINDINGS

16. The man appeared at a magistrates' court in August 2007, charged with possessing Class A drugs with intent to supply, and property offences. He was remanded in custody to appear a Crown Court at a later date and was taken to HMP Leeds.

17. After going through induction at Leeds, the man appeared to settle well and was placed in a normal wing. A Cell Sharing Risk Assessment (CSRA) identified him as low risk and suitable for normal location.

18. However, on 9 August, the man made his first attempt at suicide. Staff unlocking him for the afternoon workshops found him hanging from a ligature made from a bedsheet tied to the cell window bars. They cut him down, and called for medical assistance. Nursing staff arrived quickly and placed him in the recovery position. The prison doctor arrived shortly afterwards and found that he was breathing spontaneously. He gave the man some medication and ensured that a cervical collar was applied. The man was then taken by ambulance to Leeds General Infirmary (LGI) at 2.50pm. A member of the prison healthcare later contacted the hospital and was told that the man was stable. She then telephoned his mother, advising her to attend the hospital.

19. After treatment at LGI, the man returned to Leeds on 10 August. Records indicate he was admitted to the Acute Assessment Unit there for psychiatric assessment. There is no record that the assessment was actually undertaken.

20. As a consequence of the man's suicide attempt, an ACCT document was opened on 9 August by a Senior Officer (SO). The ACCT action plan included the need for general staff support and allowing him telephone calls as required. A review of the ACCT was undertaken appropriately by another SO on the man's return from hospital the following day.

21. During the ACCT review, the man said that he had not planned his suicide attempt but had waited until his cell mate had gone to education, and that he "still wants to die" to be with his two brothers. The man further explained that he hated being away from his family and felt prison was "tipping him over the edge". The reviewed action plan identified constant supervision and a referral for bereavement counselling as necessary.

22. The ACCT was closed with a revised follow up action plan after the man was granted bail by the Crown Court and discharged from prison on 13 August. In accordance with the ACCT arrangements, the prison made efforts when releasing him to ensure he was picked up by his mother at the gate, and provided him with counselling agency addresses in the community. It is not clearly recorded what discharge information was provided to the man's doctor in the community, although healthcare

records confirm that he was informed of his release. Before he was released, the man was also seen by a counsellor, who provided further information about opportunities for counselling in the community.

23. After his release, the man returned to live with his mother at home. His doctor made a further referral to a Doctor at the Becklin Centre, and he was seen again on 17 September. The Doctor wrote that the man reported a low mood and describing ongoing suicidal thoughts but without any active plans. The man saw his children as protective factors. However, he clearly described that, if he were sent to prison, he would kill himself. The Doctor diagnosed a Moderate Depressive Episode with Prolonged Grief Reaction and prescribed the anti-depressant citalopram and arranged a follow up appointment.

24. However, in early October, the man contacted the mental health duty worker expressing suicidal ideas. He was referred to the South Leeds Acute Community Service (SLACS) and attended the unit for three days. He was then informally admitted to an inpatient ward at the Becklin Centre as his risk was deemed too high. At one point he attempted to strangle himself in his room. He was diagnosed as having an adjustment disorder, but the assessment found no evidence of depressive illness. He was discharged on 15 October.

25. A follow up community mental health assessment reported the man's persistent suicidal ideas and lack of engagement with community services. On 3 November, the man was readmitted to the Becklin Centre having attempted to hang himself from a tree. He was discharged after two days and was not diagnosed with a depressive illness.

26. On 10 November, the man was readmitted to SLACS after he took an overdose of his mother's medication. He was later readmitted to the Becklin Centre after a close friend killed himself on 16 November by hanging. He made a further serious attempt to kill himself on 20 November in the ward bathroom. He explained that he had met someone on the ward who knew his brother which had brought back memories of his suicide.

27. The man was discharged again on 28 November with a diagnosis of adjustment disorder. He attended an outpatients appointment on 18 December and it was noted that he had continuing thoughts of suicide but without any active plans. He was complying with medication, which now included olanzapine (an anti-psychotic drug sometimes prescribed in a mild dose for people experiencing suicidal ideas).

28. The Doctor from the Becklin Centre saw the man for what was to be the last time on 21 January 2008. He found no evidence of anxiety, suicidal ideas, or formal thought disorder. He did find, however, that the man exhibited a low mood due to the death of his brothers and his continuing grief. He also said that he felt suicidal as he did not want to go to prison.

29. The Doctor prepared a psychiatric report for the court at the request of the man's defence team. He diagnosed him as suffering from an adjustment disorder with a prolonged grief reaction as a consequence both of the suicides of his brothers and his impending court case. He identified the man's suicidal ideas as directly related to his fear of being sent to prison and said that they were not due to any treatable mental illness. The Doctor concluded that there was a genuine risk that if the man was sent to prison he would attempt to kill himself.

30. The man was sentenced to two and a half years imprisonment on 5 February 2008 at the Crown Court for the offences of possession of Class A drugs with intent to supply. Due to the length of his sentence, the earliest date for his conditional release would have been 24 April 2009, although he would have been eligible for earlier release on home detention curfew from 11 December 2008. There is evidence that the man was not expecting to be sentenced that day. He had only appeared at court following an urgent telephone call from his solicitor. The family believe the letter advising him of his sentencing date had been sent to a previous address.

31. At the time of the man's sentence, both the report from the Doctor and a report from the local probation officer were available to the court. Both identified the risk of suicide. The probation report highlighted the imminent risk of suicide if he was sentenced to imprisonment.

32. Immediately following sentencing, the probation court duty officer at the local Crown Court faxed HMP Leeds with a notification of concern of suicide risk for the attention of the Governor. This included a copy of an e-mail from the author of the probation report as well as a copy of the probation report. Similarly, the prison court officer (PCO) completed a suicide risk/self harm warning form which highlighted the man's history of suicide attempts. He felt depressed due to his sentence, but would tell staff about his self-harm on arrival. This form was countersigned by the reception officer when the man arrived at Leeds at 3.30 pm.

33. A CSRA was undertaken. It indicated that the man was a low risk to others and suitable for location in a shared cell. However, the man was also seen by a Nurse on reception who recorded that he was in a low mood and said that he wanted to die and would take his life at the next opportunity. She recorded a high score of 11 on the suicide risk assessment. (There are several different scoring systems used clinically to determine the potential risk to a patient.) He declined the support of a 'Listener' (Listeners are prisoners who are trained by the Samaritans to offer a confidential service to other prisoners) and access to the Samaritans telephone line. The Nurse immediately opened an ACCT document with recommendations that he should be monitored all the time until he was fully assessed by the mental health team.

34. The man was located for two nights in the segregation unit following reception. At the time this provided the only place where he could be

constantly observed. On the evening of 5 February, he was assessed by a Prison Doctor who provisionally assessed his suicidal ideas as being related to a personality disorder rather than depression. As the general practice surgery was closed at the time, the Prison Doctor telephoned the man's mother to confirm the dosage of his medication. He recorded that the man was happy to continue taking his medication which he found helpful. When questioned about his suicidal intentions, the man acknowledged that, although he might kill himself, this would be a drastic step as he had been expecting a longer sentence and was pleased to have only 15 months to serve.

35. In accordance with the ACCT procedures, there was a multi-disciplinary review of the man's plan the following morning on 6 February. A caremap and care plan was completed with actions which included maintaining the constant observations, moving to the safer custody cell on D wing, a gradual move to normal location, use of bereavement counselling, and further assessment by the mental health in-reach team. The ACCT review was signed by the suicide prevention co-ordinator and the man.

36. A Registered Mental Nurse (RMN) saw the man following the review and, with his agreement, further developed the care plan. This included a referral to a counsellor for bereavement counselling, and consideration of a move to share a cell with his brother-in-law. She recorded the possibility that the man might be suffering post traumatic stress disorder, which she discussed with the prison doctor. In line with the doctor's diagnosis, the RMN had seen no signs of mental illness nor thought disorder.

37. The ACCT plan was reviewed again on 7 February. The man's move to D wing (the induction wing) safer custody cell was agreed that day, some association time would take place with his brother-in-law prior to his move to F wing, and plans were made for him to attend a family learning and social and life skills course. Constant observations continued over the weekend. The RMN recorded on 7 February that the man was "much more alert and responsive" and he said he wanted to get better as he had his children and partner to think of. He had also said that he had no thoughts of suicide.

38. On 8 February, the man was seen by another RMN and offered the safer custody programme. The man agreed to do this, although he is recorded as saying that he "prefers to get a job". It was agreed he could begin the programme on 11 February unless he found a job he wanted. He said that he felt more positive, was looking forward to seeing his family, and thinking about the future.

39. The man's ACCT was reviewed again on 11 February. It was confirmed that most plans had been actioned, although assessment by the mental health in-reach team needed to be followed up. The review agreed that,

considering the progress made, the ACCT observations could be reduced to once hourly.

40. Also on 11 February, the man had his first counselling session with the counsellor he had previously seen. The counsellor recorded that he was positive and responsive, making a good start and wished to meet again. He had discussed his family and children. The bereavement process was looked at briefly, and the man described how finding his brothers' bodies had made him feel their loss even more. Other records indicate he was pleased to commence his counselling, was having supportive contact from his partner, and was happy with his cell sharing arrangements.

41. On 12 February, the man was formally assessed for the safer custody programme by a member of staff from healthcare. He said that he was happy to attend as soon as possible as it might be beneficial for him.

42. The ACCT record shows that the man was happy to have moved to normal location on 15 February. He now shared a cell with his brother-in-law. The same record indicates he had shown emotion when talking about his brothers on 18 February. The second scheduled counselling session with his counsellor on 18 February was recorded as a 'failed encounter' due to the man being in a meeting and unable to attend. Two days later, the man started education classes.

43. The ACCT was formally reviewed and closed on 21 February. The review recorded that the man was in good spirits and seemed settled. He had received a visit from his partner and mother and was in regular contact with them. The review noted that he had commenced education classes. The man said he had no intentions of suicide, and that he had been initially shocked by his sentence as, after advice from his solicitor, he had been expecting to go home. However, he had come to terms with the sentence and was positive now.

44. On 25 February, the man was again scheduled to attend a counselling session with his counsellor. This was also recorded as a 'failed encounter', as he had gone to work and could not attend.

45. Late in the morning of 2 March, the man pressed his cell bell and an officer attended. The man told the officer that he felt suicidal and did not want to be left alone as he felt he could do something to harm himself. The officer left the cell door open, and called for assistance. An ACCT review was undertaken by an officer and attended by the Nurse that saw him on reception. (This ACCT review was recorded in the man's medical notes, although there is no other record of it taking place.) It was noted in his medical record that he was not getting on with his brother-in-law, and intended to kill himself when his brother-in-law was asleep as he wanted to be with his deceased brothers. It was agreed to place the man back on constant watch, and he was moved to the healthcare unit for the night.

46. The man was relocated the following day to D wing, where he was first placed in a safer cell and subsequently in a shared cell. The D wing observation book records between 3 March and 5 March that the man was on an open ACCT, although there is no record of this being formally reopened.

47. The Suicide Prevention Co-ordinator told the investigator that she and another senior officer from D wing reviewed the man on 3 March when he was back on D wing. She recalls that the man said he wanted to be back on D1 wing as it was his 'safe haven'. He made some reference to being bullied by his brother-in-law. No bullying incident report was raised on this occasion as the man had already been moved from F wing, and the Suicide Prevention Co-ordinator considered that confronting his brother-in-law might raise further problems.

48. The last CSRA, undertaken by the officer who carried out the initial review of the man's ACCT, on 3 March recommended that the man return to normal location. He was happy to share with anybody, feeling that he would get extra support from a suitable cell mate. The management review booklet also undertaken at this time identified his level of risk as medium. The next review for the CSRA was set for 2 April.

49. A member of staff from healthcare undertook a review of the man on 4 March. He found that he was no longer feeling suicidal, but was still waiting for counselling. The member of staff amended his medication.

50. The D wing observation book records that the man started work as a wing cleaner on 6 March. Because of his job, he decided not to start on the safer custody programme. The RMN who offered the man the safer custody programme recalled that she told the man he could begin the programme whenever he wished, but that he was content having started work.

51. On 10 March, a Community Psychiatric Nurse (CPN) from the mental health in-reach team undertook a full mental health risk assessment. She recorded the man's previous history of suicide attempts and his level of engagement with psychiatric services. She documented his care in the community by his Doctor and the name of his CPN in the community mental health team. Her care plan identified the need for bereavement counselling and liaison with the community mental health team. Her assessment also recorded the anniversaries of the deaths of the man's brothers as 15 December and 16 March, and she identified his vulnerability around these dates.

52. A week later, on 17 March, the man's cell mate caught him stealing an ounce of tobacco and some hair gel from his cell. The cell mate told the investigator that he had known the man for about a month and had shared a cell with him for about a week. The man's cell mate was also a

cleaner and was a trained Listener, although he did not act in that capacity with the man. The cell mate said that the man told him that he had stolen the items as he was being bullied.

53. The man also told the Suicide Prevention Co-ordinator that he had been bullied. However, when questioned, the man was unable to identify any individual. Consequently, a bullying incident report was not raised on this occasion. The Suicide Prevention Co-ordinator told the investigator she considered the man to have mixed well both with other cleaners and with staff and, from her knowledge of him she thought he would have been able to ask for help from staff if he was being bullied.

54. Action had to be taken following the theft. The Suicide Prevention Co-ordinator explained to the investigator that it was decided not to place the man on a disciplinary report because of his vulnerability. Additionally, she took account that the man had lost his job, and decided that no formal investigation need take place. Instead, it was decided to move the man from D wing to C wing.

55. The Suicide Prevention Co-ordinator ensured that the ACCT was formally reopened by an ACCT assessor on 17 March as the man had been relocated from the more supportive environment of D wing to normal location. Half hourly observations were started as he was allocated a single cell.

56. The ACCT ongoing record shows an appropriate level of observations and conversations took place with the man. On 19 March, a prison officer had a fuller conversation with the man recalling his brothers whom the officer had known in the past. No adverse reaction to this conversation is recorded.

57. The next day, the man's mother decided to tell him about the suicide of one of his friends. She believed that it would be better for him to hear the news from her rather than through the prison grapevine, and she urged him to speak to staff about it. Following this telephone call she telephoned the prison to ask staff to speak with the man as she was concerned about his reaction to the news.

58. The man had by then been relocated to F wing, although it is not clear why. A SO recorded in both the ACCT ongoing record and the C wing observation book that he had had a lengthy discussion on 20 March with the man regarding his mother's call. The SO asked him how he felt as his mother had expressed concerns about his low mood. The man said he was 'ok' and was not thinking of harming himself.

59. The following day, having been given his lunch, the man told the SO that he had taken his cell mate's medication the night before in the hope he would not wake up. He complained of feeling unwell and scared. The SO alerted healthcare and a Nurse quickly came to the wing. She recorded in the medical record that the man had explained he had taken

the medication after hearing his friend had committed suicide, but had vomited afterwards. After consultation with the local poisons unit, the man was transferred to hospital overnight for monitoring.

60. The man returned to Leeds on the evening of 21 March. Hospital tests had shown that his blood levels were normal, and no further action was required. The man was recorded in the ongoing ACCT record as saying that he was 'ok and just wants to get his head down'.

61. An SO undertook an ACCT review on 24 March. This review took place with the man and an officer, but without any healthcare or mental health staff in attendance. The SO recorded that the man said that he was settling well on F wing and that he was 'ok'. The man also said that he would talk to staff if he had any problems. The SO closed the document, and recorded this closure with a summary in the F wing observation book and the wing history sheet, noting that 'communications' had also been notified. The post-closure interview date was set for 31 March.

Events of 26 March and 27 March

62. The man was seen by staff during the day on 26 March. They noticed nothing unusual about him. At 10.13 when he was locked in his cell, the man pressed his cell alarm and an officer noticed his cell light was on. She responded and asked the man what was the matter. He alleged that his cell mate had assaulted and verbally abused him. He asked if he could be moved out of that cell and placed with his brother-in-law, who was also on F3 landing. The officer looked at his head briefly, but was unable to see any marks.

63. The officer reported the allegation to a SO who, having confirmed that the man's cell mate was not in the cell as he was on a legal visit, indicated he would investigate the matter later after other matters had been dealt with. She completed the appropriate paperwork (incident report, bullying incident report and history sheet).

64. The officer told the man that the allegations would have to be investigated before any consideration was given to him moving cells. She assured him that a Nurse would also examine him after medications had been dispensed. She told the investigator that "he seemed quite happy with that, and thanked me for it", and she locked him back in his cell. As far as she was aware, the man had neither requested a cell move prior to this nor made any complaints about his cell mate.

65. Later that morning, shortly before 11.10am, another prisoner, went to the man's cell by accident. He saw the man hanging and went to the officer to tell her. The officer immediately ran to the cell and saw that the man was hanging from the window bars. She shouted for other staff to help, opened the cell door, and immediately tried to cut him down.

66. Another officer was supervising medications at the treatment hatch. The officer heard the shout from the officer that previously reported the man concerns about bullying down the corridor and saw her entering the cell. He immediately raised a coded alarm on the prison radio for emergency assistance. He rushed to assist the officer free the man from the ligature and place him on the floor. The Nurse that previously saw the man when he reported he was being bullied came directly over from the treatment hatch and commenced cardio-pulmonary resuscitation (CPR).

67. The wing SO arrived within a minute with an officer. The SO assisted the Nurse with CPR until another Nurse arrived with other healthcare staff shortly afterwards, took over at about 11.15am.

68. The locum doctor at Leeds also responded to the emergency call and reached the cell at 11.18am. The nurses initially found no pulse, but established some carotid pulse (in the artery supplying the head with blood) after administering CPR. They applied the automated external defibrillator (a machine that applies electrical impulses to the heart and advises whether there is any rhythm which might be stimulated), but did

not find a shockable heart rhythm. The Doctor administered adrenaline intravenously, and then found a stronger carotid pulse. CPR was maintained by the second Nurse to arrive on the scene and the SO until the paramedics arrived in the cell at 11.35am. The paramedics applied mechanical ventilation to the man a few minutes later, and he was taken to Leeds General Infirmary at about 11.56am, accompanied by prison staff. It was recorded in his medical notes that he had cardiac output, but was not breathing spontaneously when taken to hospital.

69. The Duty Governor instructed that the man's cell mate be moved to the segregation unit as she was unsure whether he had left the cell before the man had harmed himself. (This follows another death at Leeds, in which a prisoner had been implicated in the death of his cell mate; the Duty Governor felt it necessary to preserve evidence in the first instance). Once it became clear that the man had been seen alive and well after his cell mate had left for his legal visit, the cell mate was released from the segregation unit. The Duty Governor confirmed that while he was in the segregation unit, the man's cell mate was unaware of his attempt to harm himself. The cell was secured at mid-day in order to preserve evidence and allow the police to investigate.

70. A member of staff from the healthcare unit telephoned the man's mother and sister at about 12.15pm. She told them that the man had attempted to hang himself and had been taken to LGI. She informed them that he was still alive on leaving prison, and they said they would go to the hospital. The member of staff gave them her telephone number should they need to call her again.

71. Shortly before 2.15pm, the man was moved to the intensive care unit at LGI, following scans and continuing emergency treatment. The member of staff who contacted his mother telephoned the unit at 2.15pm and was told that his mother and sister were with him. Medical staff were considering a trial without ventilation to test if the man could breathe independently. The member of healthcare staff had a further discussion with the unit at 3.40pm. She was informed that the scan showed the man might have severe brain damage.

72. The RMN who saw the man after his initial assessment in prison made another telephone call to the unit at 7.30 pm. She was informed that the scan showed severe brain damage, there had been no improvement since the removal of sedation, and the man's condition would be re-assessed in the morning. The RMN was told that all the man's family were with him.

73. The bedwatch officer told my investigator that free access was given to the family all night, and the family were with the man when his condition deteriorated at about 4.50am.

74. At 5.00am on 27 March, the man died. After his death, the bedwatch officer was given an official notification by a hospital doctor. He reported the news to the prison and then left the hospital.

75. A ‘hot debrief’ was organised for staff on 26 March at about 12.20pm. It was attended by all staff immediately involved. Staff recall that a ‘critical incident debrief’ was organised some weeks later to provide additional support to staff involved with the man. The meeting was run by a member of the care team. All staff interviewed considered they had sufficient support. The Duty Governor spoke with the brother-in-law, and explained what had happened. An ACCT was opened for him as a result.

76. The post-mortem report, dated 13 June and prepared by a Professor noted that the man had complained of bullying and being clipped around the ear to a prison officer after 10.00am, before being found hanging at 11.10 am. The Professor identified hypoxic brain damage as the immediate cause of death, and this due to self-suspension by hanging. He found no natural disease, and only the presence of normal therapeutic drugs. He also found there were no other injuries to indicate restraint or an attack by a third party.

77. Following the man’s death, the prison’s Family Liaison Officer visited the mans’ mother’s house with the chaplain. The prison offered to cover the cost of the funeral expenses. The man’s partner subsequently visited the prison to visit his cell, and was accompanied by the Governor.

ISSUES

Family concerns

78. When the FLO and the original investigator met the man's family on 19 May 2008, they were given a list of questions that the family wished to be answered. Subsequently, the family's solicitors provided the investigator with statements from the man's mother and partner raising further issues. I hope that this report has addressed them as far as it can. I am aware, however, that there are still some important issues that have yet to be considered because of the unavailability of certain witnesses.

79. The family's original questions were:

- Why was the man taken off 'suicide watch'?
- Why was he moved five times in seven weeks?
- Is this normal to be moved so many times?
- Why was he put back on F wing when he did not want to be there?
- For how long did staff give him CPR?
- Why did the member of staff from healthcare that contacted the man's mother tell them he was still breathing when it should have been obvious his chances of survival were so low?

80. The ACCT review of 24 March is considered below. I hope the report shows why the man was moved so many times in a short space of time. Given that staff appear to have been acting in his interests on each occasion, I am satisfied that the moves were appropriate (albeit it is not normally considered desirable for prisoners to change cell locations so many times in so short a period). However, it is not clear why the man moved to F wing on 20 March, but he was seen by an SO within three hours of his arrival there and did not express any concerns about it. I hope that the Key Events section has answered any questions about the treatment the man was given after being found on 26 March.

81. It is very unfortunate that the family feel that they were given false hope during the initial telephone call. However, having reviewed the evidence, I am satisfied that when the member of staff made the call the information she had been given may well have led her to believe that the man was alive. As such, I do not make a recommendation. The Governor may wish to consider, however, how families are contacted in such circumstances and what information they are given to avoid such misunderstandings.

82. A further matter came to light following the submission of statements from the family's solicitors. This concerned a collection that had been made by prisoners in respect of the man. The family have said that the Prison's Family Liaison Officer telephoned them and asked if they could accept the money by cheque. As they did not have a bank account, they asked if the money could be given as cash, and they say that the

Prison's Family Liaison Officer agreed to deliver the money. However, they say that he did not do so. Although the initial investigator tried to speak to the Prison's Family Liaison, he was unsuccessful. On reviewing the first draft report, the second Assistant Ombudsman assigned to this case noticed that this issue had not been addressed, and that the Prison's Family Liaison Officer had not been interviewed. Although the Assistant Ombudsman has subsequently visited Leeds to interview the Prison's Family Liaison, unfortunately the officer was off sick. In response to a previous version of this report, Leeds said that there is no record to suggest that there was a collection, and that the only money recorded within the finance office and given back to the family was the money from the man's account. Clearly, the versions of the prison and the family conflict, and in the absence of any other evidence, I am unable to resolve this matter. While not making a formal recommendation, the Governor may wish to contact the man's family directly to see if there is any other way this matter can be resolved.

Sentencing

83. It would not be appropriate for the Ombudsman to discuss the merits of the sentence given to the man on 5 February 2008, and I have not seen the transcript of the judge's comments. I have, however, seen the pre-sentence report written by the man's probation officer in which she makes a clear case for him to be given a community sentence based on the likelihood of his attempting suicide if sent to prison. The probation officer then reinforced her opinion in a second report that was received before sentencing, and her reports were faxed to Leeds after he was sentenced. The man's probation officer made every effort to bring her concerns about the man's welfare to the attention of the court and prison, and I commend her for this.

Clinical care

84. As noted earlier, a clinical review was undertaken by a Doctor on behalf of Leeds PCT. The clinical reviewer identifies some areas of good practice. Specifically, he finds that an ACCT plan had been appropriately opened on several occasions, including the use of constant observations on two of those occasions. The Clinical Reviewer also recognises the professional response of the prison team in resuscitating the man both in March 2008 and in August 2007. I concur with these conclusions.

85. However, the Clinical Reviewer has drawn a number of critical conclusions in respect of the overall organisation of the man's clinical care. I agree with his conclusion that the man should have been assessed and cared for by a consultant forensic psychiatrist. The man clearly presented a known, and very high, risk of suicide. There had been a community psychiatrist assessment diagnosing an 'adjustment disorder with prolonged grief reaction'. I judge that the man should have been re-assessed by a psychiatrist within the prison. Whilst the

medication regime prescribed by the community psychiatrist was maintained within HMP Leeds, this had not been reviewed by a psychiatrist since the man's imprisonment.

86. This initial failure was compounded by the lack of a follow up dynamic mental health assessment and review. One action identified both by the mental health in-reach team and within the man's ACCT plan was provision of bereavement counselling. However, the man only attended one counselling session, with two further sessions recorded simply as 'failed encounters'. Following these, on at least one occasion the man was recorded as asking when his counselling was to recommence. It appears there was no system in place to ensure that these problems with the counselling sessions was reviewed either by a psychiatrist, the mental health in-reach team, or as part of the ACCT review process.

87. Had there been assessment and review by a psychiatrist which, together with co-ordinated input from the mental health in-reach team, informed a robust multi-disciplinary ACCT review process, it might have been possible to assess two further issues. First, as part of the ACCT ongoing record, it was repeatedly recorded that the man asked to be taken off ACCT. On one occasion, when making this request, he explicitly used the language of his community psychiatric diagnosis of an 'adjustment disorder', when he said "I can adjust now". That this statement was not considered thoroughly in a review is symptomatic of the lack of a mental health perspective informing ACCT planning.

88. Secondly, there was no consideration of the potential use of cognitive therapy (beyond bereavement counselling) to address, alongside medication, either the already diagnosed 'adjustment disorder', or the possibilities considered by healthcare staff following his reception that the man was suffering post-traumatic stress or another personality disorder. A full assessment by a psychiatrist could have prompted a psychologist's assessment of an appropriate course of cognitive therapy.

89. I agree also with the Clinical Reviewer's conclusion that the man should have been monitored under ACCT procedures on 24 March. The Clinical Reviewer says that the clinical assessment on the man's return from hospital on 22 March after taking an overdose was unsatisfactory. Whilst it is the case that the prison knew from LGI that blood tests had proven negative, this was taken to suggest that the man had not taken an overdose, and his claim that he had was not fully assessed.

90. In fact, the man was already on an ACCT at the time he had allegedly taken an overdose and on his return to Leeds on the evening of Sunday 22 March. Given his history of vulnerability, and despite the difficulties to the prison of his return on a Sunday evening, there should have been an immediate review of his ACCT with consideration given to his location either in the healthcare centre or in a safer custody cell, allowing for further assessment.

91. A full review of the man's ACCT was due the following week. This review should have been informed by both clinical and mental health assessments, particularly regarding his alleged overdose. In the event, the review was informed by no such perspective.

92. The Clinical Reviewer concludes that, had the man been located in a safer custody cell, this might have reduced the chance of him hanging himself. I agree with this conclusion. The opportunity to use this option was missed because of the failure to undertake an immediate review of the ACCT on the man's return from hospital, and the subsequent failure to ensure a full assessment of his alleged overdose informed the full ACCT review which was due.

93. I therefore make the following recommendations:

The Governor should liaise with the healthcare manager to ensure that timely psychiatrist assessments are made of all prisoners who have a substantial history of suicide attempts and where there is a history of suicide within the prisoner's family or amongst friends.

The safer custody co-ordinator should liaise with the healthcare manager to ensure a system is in place which monitors the take-up of counselling identified in an ACCT plan, and that feedback is provided as part of multi-disciplinary review of ACCT plans.

The Governor and safer custody co-ordinator should ensure that an immediate ACCT review which considers safer locations is undertaken on prisoners on an open ACCT on their return from a hospital following an alleged suicide attempt.

ACCT plans, processes and the significance of anniversaries

94. I believe that both clinical and discipline staff at Leeds invested considerable resources and time in supporting the man and that he benefited from this during his time at Leeds. There are three ACCT plans on record, one of them from his time on remand. Staff appropriately opened an ACCT immediately upon his reception at Leeds.

95. The decision to close the first ACCT on the man's transfer to F wing was reasonable. However, instead of simply reviewing this closed ACCT plan following the man's transfer back to D wing after he disclosed suicidal thoughts and feelings, a new ACCT plan should have been commenced. Opening a new ACCT plan on 17 March on his transfer to C wing was appropriate, particularly due to the circumstances of his transfer. Given that the man returned from hospital only three days earlier having said he had taken an overdose, the closure of the ACCT on 24 March was, I believe, premature.

96. The investigator found two areas in which the quality of the ACCT plans and processes could have been improved. First, mention has already

been made of the need for a more robust mental health perspective, backed by a psychiatrist's assessment, to have informed both the plans themselves as well as review meetings. This was particularly so on the man's return from hospital on 22 March and the review undertaken two days later.

97. Secondly, the initial plan from his reception on 5 February through to 21 February failed to identify adequately any 'trigger points'. This failure was carried through to the second plan opened on 17 March. Specifically, both ACCT plans failed to record significant anniversaries. It was known that the man was facing the difficult anniversary of the death of one of his brothers in March, and this was made clear during his interview with the SO who assessed his ACCT on 2 March. However, the actual date was not recorded in the ACCT plan as a potential 'trigger point', nor were any specific plans put in place to support and monitor the man through this period.

98. In fact, the precise dates of both the man's brothers' suicides were recorded by the CPN in her mental health assessment as 12 December 2006 and 16 March 2007. A further significant anniversary was completely unknown to the prison. The anniversary of the man's brother's funeral was March. This was the date on which the man was to take his own life.

99. These significant anniversaries should have been explicitly recorded in the ACCT plans as 'trigger points', allowing for specific support and monitoring to be planned for the man. Had they been identified, the man's inadequately explained behaviour in stealing tobacco from his cell mate on 17 March might have been better understood. Additionally, knowledge of the date of his brother's funeral would have informed a full assessment of his actions when he allegedly took an overdose on the weekend of 21 March, allowing for specific planning for 26 March.

100. PSO (Prison Service Order) 2700 on Suicide Prevention and Self Harm Management refers to the need to identify 'trigger points', and plan accordingly (in section 9.4 "Care-planning and general approach to behaviour management"). These were not adequately identified in the man's ACCT at Leeds.

101. However, it is arguable that PSO 2700 does not adequately indicate the necessity of identifying, recording and planning for 'significant anniversaries' which may challenge prisoners with a history of suicide in their family or amongst their friends. I make no formal recommendation but draw this to the attention of the NOMS Safer Custody and Offender Policy Group.

102. Whilst I take account that the Independent Monitoring Board at Leeds has reported on the development of a significant dates diary, I make the following recommendation:

The Governor should improve the quality of ACCT plans by ensuring all documents identify and record 'trigger points' with identified support plans for each, and that these must include the recording of significant anniversaries

103. The man's ACCT plan was closed by an SO who undertook its review on the 24 March. The investigator found that this review was flawed, as it was not multi-disciplinary and the CAREMAP action (to follow up when the man would next have a meeting with the counsellor) had not been completed. PSO 2700 specifically says, "the ACCT Plan can only be closed once all the CAREMAP actions have been completed and the Case Review Team judges that it is safe to do so" (Annex 8g). This guidance was not followed.

104. The SO's review with the man also failed to adequately take into account that he had only days before allegedly taken an overdose, and returned from hospital, which followed on from the suicide of his friend. There was no mention of this in the review.

105. Unfortunately, the first investigator did not interview the SO who carried out the review during the initial investigation. Subsequent attempts by the second Assistant Ombudsman appointed to the case to speak to the SO, either in person or on the telephone, have been unsuccessful. I would have preferred to have given the SO the opportunity to respond to these points before the publication of this report, but have been unable to do so.

106. Given this, I have to make a judgement on the quality of the decision to close the ACCT on 24 March based solely on the documentation. I believe that the decision itself was flawed. Although the man had not actually taken an overdose, the fact that he claimed that he had should have been enough to have alerted staff that there might be ongoing problems, and that further support was warranted. Furthermore, the ACCT should not have been closed without the action on the CAREMAP being completed. While it does appear from the ACCT that it might not have needed to be opened in the first place (the man did not report having any issues with losing his job and expressed no thoughts of harming himself), there had been a change in circumstances which should have been enough for the ACCT to have remained open.

107. I therefore recommend that:

The Governor at HMP Leeds should ensure the SO undertakes further training in ACCT processes.

Bullying and violence reduction

108. There were three occasions when the man alleged that he was being bullied. First, after disclosing suicidal thoughts and requesting a transfer

away from his brother-in-law on F wing, back to D wing. Secondly, to explain his stealing tobacco on D wing. And, thirdly, within the hour before hanging himself on F wing. The investigator found the responses to these complaints were reasonable within the terms of the requirements of PSO 2750 Violence Reduction Strategy.

109. On the first occasion, there is evidence that the man himself told staff that he knew he might be able to achieve a move back to D wing by disclosing some form of suicidal ideas. The Suicide Prevention Co-ordinator made a clear decision not to pursue the man's allegation of bullying on the grounds that he was now safely on D wing and pursuing the allegation might have worsened the levels of stress. Whatever pressure the man may have been under from his brother-in-law at the time remains unknown. However, on 26 March, the man made a request to return to sharing a cell with his brother-in-law.

110. The man alleged bullying as the explanation for stealing tobacco from his cell mate. The Suicide Prevention Co-ordinator questioned the man regarding these allegations, and the man did not substantiate them by identifying an individual responsible. She decided, therefore, that no action could be taken. Due to his abuse of trust, however, the man was relocated from D wing to C wing.

111. Again, due to concern regarding the levels of stress the man may have been under, particularly as this relocation meant he also lost his job as a cleaner, the Suicide Prevention Co-ordinator decided not to place the man on a disciplinary report. I believe that this decision was entirely proper, although it did mean the man was not held fully to account for his action in stealing tobacco, and the explanation remained inadequate. As identified above, the opportunity to question whether his theft was related to the fact that it had been the anniversary of his brother's suicide was missed.

112. The man made his last allegation of bullying and of being assaulted by his cell mate between 10.10am and 10.30am on 26 March. These allegations were duly recorded by an officer, and were to be investigated by a SO. This investigation did not take place. The investigator examined the man's cell mate's cell sharing risk assessment. He had been assessed as presenting a low risk in sharing a cell. No marks were found on the man which were consistent with his having been assaulted.

113. The investigator found that the man had said, following his first attempt at hanging himself at Leeds in August 2007, that he had deliberately waited until his then cell mate was out of the cell at education classes.

114. I make no formal recommendation about this. However, I draw to the attention of the Governor and the Safer Custody Co-ordinator that it

would have been useful to have highlighted within the ACCT document that the man had previously attempted to hang himself when his cell mate was out.

115. No substantial evidence that the man was subject to bullying was found by this investigation.

CONCLUSION

116. The man had a history of making attempts on his own life, both in the community and while on remand. Two of his brothers had committed suicide, and the man had found them. Before he was sentenced, both doctors and probation staff had warned that he would be at risk of suicide should he be given a term of imprisonment.

117. When he returned to prison, he was immediately placed on an ACCT. After appearing to settle, he was taken off the ACCT, but then stole some tobacco from a fellow prisoner and the ACCT was reopened.

118. Two days later, the man told staff that he had taken an overdose of medication. He was taken to hospital, but no evidence was found that he had taken anything. He returned to Leeds, and on 24 March the ACCT was closed. On 26 March, the man killed himself.

119. This investigation has found that the ACCT process could be improved at Leeds. It has also found that there should be improvements in the psychiatric services to prisoners who present a clear suicide risk.

RECOMMENDATIONS

1. The Governor should liaise with the healthcare manager to ensure that timely psychiatrist assessments are made of all prisoners who have a substantial history of suicide attempts and where there is a history of suicide within the prisoner's family or amongst friends.

Partially accepted: "The Governor will liaise with the healthcare manager and the mental in-reach team manager to ensure that timely psychiatric assessments are made of prisoners who have a substantial history of suicide attempts and where there is a history of suicide within the prisoner's family or amongst friends". (By May 2010)

2. The safer custody co-ordinator should liaise with the healthcare manager to ensure a system is in place which monitors the take-up of counselling identified in an ACCT plan, and that feedback is provided as part of multi-disciplinary review of ACCT plans.

Accepted: "Safer Prisons PO to meet Health Care Manager to implement the required healthcare monitoring system". (By August 2010)

3. The Governor and safer custody co-ordinator should ensure that an immediate ACCT review which considers safer locations is undertaken on prisoners on an open ACCT on their return from a hospital following an alleged suicide attempt.

Accepted: "A protocol to be written by 31/05/2010".

4. The Governor should improve the quality of ACCT plans by ensuring all documents identify and record 'trigger points' with identified support plans for each, and that these must include the recording of significant anniversaries

Accepted: "ACCT reviews are now completed by dedicated team. A record of significant dates is maintained. All available documents are now checked."

5. The Governor at HMP Leeds should ensure that the SO that closed the man's ACCT undertakes further training in ACCT processes.

Accepted: "The SO will receive ACCT training by March 31st 2010".