Investigation into the circumstances surrounding the death of a prisoner at HMP Leeds in March 2005

Report by the Prisons and Probation Ombudsman for England and Wales

November 2005

This is the report of an investigation into the death of a prisoner. He died, apparently at his own hand, in the segregation unit at HMP Leeds in March 2005.

The death of a loved one is always difficult to bear. This can be compounded when a family has had to help someone battle addiction, with all the heartbreak that can bring. I offer my sincere condolences to the man's family and friends.

I would like to thank the Governor and staff who cooperated fully with the investigation. Thanks also go to the doctor who completed a clinical review into the man's healthcare needs whilst at Leeds.

Sadly, elements of the man's story are common amongst many of those in prison. Drug addiction had blighted his life for many years, leaving him suffering from drug-induced psychosis that often resulted in unpredictable behaviour. I was pleased to learn during the course of this investigation that Leeds staff appeared to be aware of his individual needs. However, there was a lack of communication between healthcare staff due to poor recording practices.

The number of prisoners that have died, apparently at their own hand, in segregation units causes me great concern. It is manifest that a period in segregation can have a seriously damaging effect on a prisoner's mental health.

I make five recommendations, and acknowledge three examples of good practice.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN **NOVEMBER 2005**

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Summary

The man who died was born in 1976. He was only 29 when he died in March 2005 in the segregation unit at HMP Leeds. He had previously served several sentences in Leeds, largely for drug related offences. He had also spent some time in a psychiatric hospital in 2003-04.

At the beginning of January 2005, the man was sentenced to five years imprisonment. This was a far longer sentence than he had been expecting. His behaviour in prison could be unpredictable. He would isolate himself and become rather paranoid. This would often result in some sort of outburst, sometimes in an act of self-harm, sometimes in violence towards others.

In February, it was thought the man had gained access to illicit drugs and he was assessed as suitable for a detoxification programme. He did not complete this. In March, his behaviour became more erratic and at one point he attempted a hunger strike of sorts. He felt people were watching him and it appeared he was not sure who he could trust.

On 17 March, he was prescribed a small dose of anti-psychotic medication, as well as medicine to help him sleep, after staff became concerned by his strange behaviour. Later that night he set fire to his cell, after blocking the cell door with toilet paper. Prisoners on a higher landing alerted staff to the fire as smoke was coming into their cells (smoke was not visible from the wing). When staff opened the cell door, they could get no response from the man. Then he suddenly ran out, and it is alleged he became very aggressive and tried to assault staff. He was restrained and taken to the segregation unit.

He had his adjudication (prison disciplinary hearing) a few days later. He said that the cell fire had been a suicide attempt. He was put on a F2052SH (a document used by the Prison Service to monitor and support prisoners thought to be at risk of suicide or self-harm) and was supervised more closely. Despite this, at 9.30pm, he was found to be hanging from a very thin ligature made from his bedsheet. Attempts were made to resuscitate the man, and he was taken to outside hospital by ambulance. He was pronounced dead shortly after his arrival at hospital.

Staff were generally aware of the man's needs. However, when he was moved to the segregation unit, there was no risk assessment relating to what he was able to have in his cell. The cell was in poor condition, and had a number of avoidable ligature points. There is a lack of safer cell facilities in Leeds for use by at risk prisoners. My investigator also found poor recording practices on the part of healthcare staff.

The duty governor visited the man's family in person to break the sad news of his death. In very difficult circumstances, this was an example of good practice.

Investigation process

I appointed two members of my team as the investigators into the man's death. They visited Leeds prison, where they received a briefing from the deputy governor. They collected a range of information relating to the man and inspected the cell where he had been held in the segregation unit. They also met with members of the Prison Officers' Association (POA) local branch committee and the Independent Monitoring Board (IMB).

Notices were issued to both prisoners and staff, inviting anyone whom might have information relating to the man's death to make themselves known to the inquiry.

Along with one of my investigators, one of the Ombudsman's family liaison officers visited the man's family to establish any concerns they had. They were concerned at the state of his cell and the number of ligature points. They said they had been deeply disturbed when they had visited the prison and another prisoner shouted from his cell. They also had questions about the detoxification treatment that he had received.

A number of staff and prisoners were interviewed formally and informally. A check was also made against Prison Service policies and procedures.

A clinical review of the man's health care whilst in prison custody was undertaken by Leeds Primary Care Trust.

Background

The man who died was born in 1976, and was 29 years old at the time of his death. He had four sisters, and a brother. He also had a girlfriend and a daughter who was four at the time of his death.

His family told us that he had started using drugs aged 16. Over time, he became addicted and began to commit crime to support his addiction. He was a strong and loving person, but drugs gradually took over his life and he spent several periods in custody. Outside of prison, he spent time living with his mother, and with two of his sisters, but his behaviour was unpredictable and despite their efforts he returned to drugs.

As time passed, he began to suffer from drug induced psychosis and various mental health problems. He also attempted suicide by hanging. This led to him being admitted as an inpatient at a psychiatric hospital in 2003, being discharged at the beginning of January 2004.

In that same month, further offences led him back to Leeds prison. On reception at Leeds, he admitted to smoking heroin and cocaine daily. On his healthcare reception screen, he was identified as having suicidal risk factors and staff opened a F2052SH.

During 2004, the man spent most of his time in Leeds prison. There were numerous occasions where there was need for him to be placed on a F2052SH due to his suicidal ideation.

His final period in Leeds began on 28 October 2004. He arrived at Leeds and underwent the reception process. He reported that his drug use had increased from his previous spell in custody. During his health screen, he was asked a series of questions which relate to a scoring system as to risk factors for suicide and self harm. On this occasion, and unlike in the past, he did not score highly enough to warrant opening a F2052SH. The man's urine tested positive for opiates, and was assessed by the medical officer as not being suicidal or depressed at this time. We were unable to find any recorded evidence that he underwent a detoxification programme. It was 9 November before he had an assessment with a via Care Assessment Referral Advice and Throughcare (CARAT) worker.

He asked to be placed on Rule 45 (when a prisoner is separated for his own protection). On previous periods in custody, he had been held on the vulnerable prisoner unit (A wing) on rule 45. He said this was because he had witnessed a family member killed in a gangland shooting, and he was concerned that others might target him. He was duly located on A wing.

In November, the man had to be restrained following his destroying furniture in his cell and being particularly violent.

During December, he underwent a health screen update and was noted to be withdrawn and depressed. Towards the end of the month, he went to court on

several occasions, culminating in him being sentenced on 4 January 2005 to 5 years imprisonment. This was a far longer sentence than he had anticipated.

In February, a sniffer dog indicated that drugs had been present in his cell. Swabs were taken and they tested positive for heroin and cannabis. The man was subsequently assessed by the detoxification nurse, and it was identified that he was eligible for a detoxification programme. However, he did not attend any appointments. No reason for his non-attendance is recorded, and whether there was any follow up action is not clear.

Events leading up to the man's death

Staff on A wing knew the man who died well due to his previous times in custody spent on the same wing. He was known to suffer from mental health problems, and for displaying unpredictable behaviour which could result in violence. An officer on A-wing described his behaviour:

> *Sometimes he would withdraw into himself and become very hard to communicate with and we needed a little bit more time with him ... He did display violent outbursts as well. I've seen him attack members of staff prior to this incident where he just exploded ... He was either way. You couldn't gauge which way he was thinking, whether he'd go into himself or explode.*

On 8 March, the man stated he did not want to eat his dinner as he was on hunger strike. The officer asked why, but the man would not or could not explain. The officer checked what the procedure was for someone on hunger strike and explained this to the man. Over the next few days, staff checked on him regularly and he started eating again although he kept exhibiting strange behaviour.

Staff who knew the man well knew when something was building up as he became very insular. Another A-wing officer reported that at times the man appeared to suffer from psychosis and this was more apparent on this sentence:

> *Upon speaking to him, he was convinced that there were people out to get him, which he thought were some higher authority, some government agency kind of thing, not like the prison staff, but we were in on it because we were prison staff, some of the prisoners were in on it and he thought he was always being listened to in his cell.*

On 17 March, the second A-wing officer was on duty and noticed that the man did not want to leave his cell, so he went to check he was okay. The man said that he wanted to be by himself. When the officer went to check on him later, the man became aggressive. After talking for a while, the man mentioned a previous time that the officer had helped him by referring him to the mental health in reach team and told him, "*I need to get things sorted again".* The officer completed the referral to healthcare for a mental health assessment. A little later, the man rang his cell bell and asked the officer if he had referred him which the officer confirmed.

On the same day, a registered mental health nurse (RMN) visited the man due to the concerns raised by wing staff. The nurse said that the man found it difficult to express himself and was not specific about what was bothering him just that he was having "thoughts about other people". The nurse felt that the man was exhibiting strange behaviour: he was smiling throughout this conversation although he was obviously trying to tell him something. As the nurse did not feel he could get to the bottom of the man's problems, he asked the doctor to see him.

A doctor was on duty in reception and said he could see the man. The nurse was present at this consultation and explained that the man still was not able to express himself. The doctor spent about 15 to 20 minutes talking to him. The doctor concluded that this inability to express his concerns might, in itself, represent some

symptom of mental ill-health. The doctor concluded that the most appropriate way forward was to refer the man for a mental health assessment. It was the doctor's opinion that the symptoms that the man was displaying might have been psychotic and he therefore prescribed some anti-psychotic medication and tablets to help him sleep (Olanzapine 5mg and Nitrazepam 5mg). The doctor took the view that these drugs would assist the man in the short term and, if it did later transpire that psychosis was an issue, then this would start to address his longer term treatment. The nurse took him back to his cell, and explained he might not get the medication until the next day as the pharmacist had finished for the day. The nurse did not record any of his dealings with the man. The doctor reported that he recorded the consultation on a medical record sheet as he did not have the medical records with him at the time. We were unable to locate this.

At about 11pm, the man pressed his cell bell. The A-wing officer answered it and said that the man was still behaving strangely, as he would not talk to him after pressing the bell. Knowing that the man had seen healthcare staff earlier in the day, he asked the nurse to come and see him. A nurse attended. The nurse spoke with the man who was asking when he might receive his medication. The nurse was able to supply some Nitrazepam as it was in stock, but explained he would have to wait till the morning for the Olanzapine when the pharmacist would be in.

Soon after midnight, prisoners on A4 landing, two floors up from his cell, informed staff that smoke was coming into their cells. Staff looked for smoke coming out of any cells onto the landing and could not see any. Some staff started to check cells individually, and some went outside to see if they could ascertain which window it was coming from. They soon discovered it was coming from the man's cell. The fire brigade was called, and an officer fetched the hose. Staff tried to open the inundation point so they could insert the hose, but could not get it open so they used their staves to smash the glass panel in the observation flap. The officer pushed the hose through the glass and sprayed the cell. The officer stated that he knew he was not allowed to open the door at this stage as it could result in a back draft in the fire. He could not see the man due to the large amount of smoke. Staff were calling to him but got no response. There was a large volume of water in the cell as it was coming out under the door onto the landing.

The fire brigade arrived within approximately 10 minutes and declared it safe to open the door. The smoke started to clear but he still did not move. He lay still on his bed. The officer was still hosing the cell and as he brought the hose round, the man was doused with water. At this point, he came out of his cell running, shouting and waving his arms around. All Officers involved in the fire incident described this as strange as he had been so still and quiet.

The man was restrained and taken to the segregation unit, which was one floor beneath his cell. The man was shouting at staff as he was taken to the segregation unit.

He was placed in a special cell that had a camera, although this was not working at the time. He was strip searched. A nurse spoke to the man to check that he did not have any injuries but the man did not want to talk to him. A nurse returned again

later. The man said he did want to talk but not through the door, so the nurse referred him to healthcare to be seen the following day.

As the camera was not working, he was checked every 15 minutes by the Operational Support Grade (OSG). When asked, there was some confusion amongst the officers about whether prisoners who start cell fires are assessed as to self harm issues or if a fire is a disciplinary matter only. The consensus was that, in this man's case, this was a disciplinary incident, particularly as he had attempted to assault staff and displayed violent behaviour on leaving the cell.

On Friday 18 March, the man had a shower, was given clean clothes and moved to a normal cell in the segregation unit. The cell was in poor repair with many ligature points.

Other prisoners and some staff commented that he kept asking for a lighter so he could have a cigarette. There appeared to be some confusion between staff as to whether he was allowed a cigarette as he had started a cell fire.

A nurse told the investigation that he visited the man in the segregation unit on the Friday afternoon. The man was allowed out of his cell so they could talk face to face. The nurse said that he seemed okay at this point. Again there are no records of this meeting.

The day the man died

A second nurse and a doctor visited the segregation unit in the morning to issue medication to prisoners. They told my investigator that the man did not raise any issues. This visit was not recorded.

The man's adjudication was conducted by a governor. The man was charged with setting fire to his cell and threatening to assault staff. The governor decided to refer the charge regarding the fire to the independent adjudicator (a district judge), as it was particularly serious. He denied the charge relating to the threats to assault staff, and the governor adjourned the adjudication until witnesses could be present and the evidence could be evaluated.

During the adjudication, the governor probed the man about the cell fire, and he eventually told him that the fire was a self-harm attempt:

> *It was through probing and questioning that it was clear that he intended to harm himself. He said things like, for example, that he'd stuffed toilet paper or tissue paper into his cell door, he said that he wanted to smoke himself out - those were his first words. His answers were fairly short and cursory. So I asked him what he meant by smoking himself out and he qualified that along the terms of, "Well, to harm myself". I asked for what reason or purpose and then he indicated that it was to not only harm himself but to kill himself.*

Following the adjudication, the governor opened a F2052SH on the man. It was standard for prisoners in the segregation unit on a F2052SH to be checked by staff every 15 minutes, and this is what they applied to him.

The governor also decided that the man should be held in the segregation unit for the Good Order or Discipline (GOoD) of the prison. This was to be assessed two days later to see if he was ready to be moved back to A wing.

During the afternoon, staff checked on him frequently. He was given his canteen (items from the prison shop) and was reported being in good spirits at this time. He mainly lay on his bed in the afternoon. One of the officers commented that he had complained that he was not allowed a lighter several times. Other prisoners also comment that he was shouting at one point about wanting a lighter.

The Operational Support Grade (OSG) and the Senior Officer (SO) had spoken to the man in the early evening as he had a lighter from a taper made from toilet paper rolled tightly together and provided by another prisoner. This meant he could smoke cigarettes. By the evening he appeared calmer.

The OSG checked on the man every 15 minutes from 7.45pm by looking through the observation panel. He spoke to him on several occasions and reported he seemed okay. He had enquired about his medication and this was referred to the nurse.

At 9pm, the OSG looked through the observation panel into the man's cell and saw that he was standing at the back by the window. He looked at the OSG. A nurse came to the segregation unit to see two prisoners who had requested to see him.

The first he spoke to for several minutes, then he went to the man's cell. The man was still standing at the back of the cell, but when the nurse spoke to him, the man did not reply. The nurse did not think this unusual because of previous dealings with him. He thought the man would speak when he was ready, so he just told him that he had checked the prescription chart and seen the man had been given his medication for the day. He then went and told the OSG that the man had not spoken to him. The nurse was not aware that the man was on a F2052SH.

Just before 9.30pm, the OSG went to check on the man again. Although the OSG could not see a ligature, he knew from the man's face that something was wrong. He called out to him but he did not answer. The OSG ran upstairs to get an officer on A-wing who he was aware knew the man well. The officer and the OSG were back at the man's cell within seconds. The officer looked through the observation panel. He saw the man was standing at the back of his cell. His feet were on the floor and his head was level. He looked as if he were just standing at the back of his cell. He still would not respond when the officer called out to him. The officer turned to look from another angle and saw that the man's eyes were closed, and saw a very thin ligature at the back of the cell, in line with the window bars. He shouted to the OSG who put out a call on the radio for urgent assistance.

At night, only the night orderly officer has keys. Certain doors in the prison are left open for access. Officers have a cell key in a sealed pouch for use in emergencies. OSG's do not hold keys and are not trained in first aid or control and restraint techniques. Due to the man's previous violence, the officer waited for other trained staff to be present. This was only a matter of seconds. Another officer arrived and took the key out his pouch as the first officer was struggling to get his out. Closely behind the second officer was the night orderly officer.

They entered the man's cell with some caution. The night orderly officer touched the man's hand, and noticed it was warm, but heavy and clammy. He cut the ligature with his fish knife (anti ligature knife). By this point the nurse had arrived, and the second officer and the nurse commenced cardio pulmonary resuscitation (CPR).

Paramedics arrived at approximately 9.40pm and they continued CPR. The man was taken to hospital, leaving the prison at approximately 9.52pm. Two officers accompanied him. They reached the hospital just after 10pm having continued CPR during the journey. He was pronounced dead at 10.07pm.

Contacting the man's family

The duty governor arrived at the prison at 10.45pm. He checked the man's core file and it transpired that he had actually given a false address. The governor asked the police to try and find his next of kin. It was a busy Saturday night so it took some time. The police looked through their custody records, and found their last next of kin contact for the man who died was given as one of his sisters. After conducting a short debrief, the governor drove to Halifax police station.

The governor had to wait for about an hour for the police to be able to release an officer to go with him. The man's sister was not in at her home address, and the governor was given her work address. After breaking the sad news of her brother's death to the man's sister, they then went with her to the man's mother's house to break the news to her.

Whilst there is never an easy way to break or receive the news of the death of a loved one, it is best practice for a member of prison staff to break the news in person wherever possible rather than over the phone, or by the asking the police. In the circumstances of this man's death, his family were enabled to ask some immediate questions which the governor could answer. It also meant they were provided with a contact point in the prison.

The Aftercare of staff

The duty governor conducted a short debrief and asked the night orderly officer to check on staff. Devolving some of these responsibilities to the night orderly officer was necessary so that the governor could visit the man's family.

All contingency plans were followed effectively.

From interviews with staff, they seemed aware of how to contact the staff care and welfare team. However, some did not feel they had been very supported by senior management. Staff who attended to the man who died completed one more night shift before having a week of rest days. It had been a particularly difficult set of nights, which had seen other health and self harm problems arising with other prisoners, as well as other cell fires. A phone call or letter from the Governor would have been an appropriate and kind gesture to acknowledge the actions of his staff.

Findings and Conclusions

The cell fire

The man who died set fire to his cell. At his adjudication two days later he admitted that this was an attempt at self-harm. Staff dealt with the fire appropriately. However, no one appeared to consider the lack of smoke on the wing as an issue. It is disappointing that he was not asked the reasons he started the fire before his adjudication. It was two days before the adjudicating governor established it was a self harm attempt and appropriately opened a F2052SH.

The violent behaviour that he displayed when he left the cell to some extent took over from the fire itself. However, there did seem to be some confusion between staff as to why he was then observed every 15 minutes when moved to the segregation unit. Some appeared to believe it was because a cell fire is seen as a possible act of self-harm and some believed it to be procedure.

In the suicide prevention training, a number of risk factors are highlighted. Although it is rare, there have been incidents of self-harm and even death by fire in prison. It would be sensible for staff to be advised to consider the reasons behind cell fires, and not view them automatically as discipline issues only.

I recommend that the suicide prevention training be amended to include fire as a possible method of self-harm.

The Segregation Unit

In general, my investigator found the segregation unit to be clean and well organised. A doctor visited every day except on Sundays, and nurses were available. There was a Listener (a prisoner trained by the Samaritans) who lived on the unit and the Chaplain visited daily.

There are, however, several issues regarding the segregation unit that warrant further consideration.

- Where the man was located

Following his adjudication where it was identified that the cell fire had been a suicide attempt by the man and he was placed on a F2052SH, he was held in the segregation unit for the good order or discipline of the prison. However, PSO 2700 states:

> *4.1.2.1 Prisoners who are at risk of suicide or self-harm must not be routinely held in the segregation unit under Rule 45 GOOD (YOI Rule 49) unless, exceptionally, they are such a risk to themselves or others that no other suitable location is appropriate. Such prisoners must only be placed in a segregation unit in exceptional circumstances, or where all other options have been tried, but considered inappropriate and only where it is possible to provide the degree of continual care identified as necessary in the prisoners' care plan. A case review must be held as soon as possible to take account of*

events leading up to the decision to segregate. If the decision is taken to locate prisoners at risk of self-harm within the segregation unit this must be for as short a period of time as possible, and the temporary nature of this must be reflected in the care plan.

The man who died was on rule 45 for his own protection which meant he was generally held on A wing, and it would not have been advisable for him to have been held on any other residential location. The only other real possibility for him was to go healthcare, or return to A wing, which was full, and he was assessed as being unsuitable for shared accommodation.

In his wing record, there appears to be some confusion over where he was to be located. There is an entry by the adjudicating governor on 19 March stating *"seen on adjudication. Agree to him returning to normal location. Due to statement in relation to fire/self harm today, 2052 SH to be opened."* There is also an asterisk by the word location, adding; *"(in two days time) if he behaves throughout the weekend. GOOD to (two days time)".* The adjudicating governor said in interview that the comment by the asterisk was made simultaneously to the original entry.

Following the entry, an officer made an entry that afternoon stating; *"no spaces available on A wing. Placed on GOOD until space comes up."* In interview, he said he checked if there were any spaces at the adjudicating governor's request.

The adjudicating governor stated the reason for placing the man on GOOD was to keep him on the segregation unit until two days later. If he could rest, behave and be co-operative with staff for a period of assessment, he would then be returned to normal location. This was because he had shown unpredictable and volatile behaviour. He also reported that he explained to the man that he would stay in the unit for the following two days. This is also recorded in the unit log book.

During interview, the adjudicating governor demonstrated that he had considered options for where the man should be located. At Leeds, prisoners are only located in the healthcare centre due to illness that cannot be treated on the wings. The adjudicating governor judged that there was no medical reason to send the man to the hospital at that stage. The segregation unit certainly gave him a higher level of staff contact than he would routinely receive on normal location within the prison: *"in my view, that was the best option in terms of keeping a close eye on him, giving him support and staff contact through the weekend during the period of his assessment."*

- Accommodation in the segregation unit

The segregation unit is generally well maintained and clean. However, on inspecting his cell my investigator found it was in poor repair. There were toothpaste marks all over the wall, and there were also a number of ligature points (the two windows in main cell, window in the toilet area, the bunk bed and a number of brackets on the wall). Although the cells cannot become fully safe without significant investment, a number of these things are easy to remedy. There is no reason for brackets to be on the wall, for example. Nor is there a good reason to have bunk beds in a unit where prisoners do not share cells. It is quick and easy to paint the cell. These aspects can and should be improved upon. (Following a further death in Leeds's segregation

unit, and a visit I made personally, I am pleased to report that the governor has arranged for the bunk beds to be removed.)

I recommend that the Governor inspects the cells in the segregation unit, and considers what cosmetic improvements are needed and whether further action can be taken to remove ligature points.

There are no 'safer cells' in the Leeds segregation unit. These are cells which are designed to be safer for those at risk of suicide or self-harm, for example by removing ligature points. The safer cells are concentrated on D wing, the first night centre. There are also two safer cells in the healthcare centre. Whilst I appreciate that prisoners are generally at higher risk of suicide and self harm in their first few days in custody, it is disappointing that there is a lack of safer cells on the other wings.

Over the past two years, nearly a quarter of all apparently self-inflicted deaths in prisons have occurred in segregation units. I strongly discourage the use of segregation for prisoners considered at risk of suicide or self-harm. However, I accept that there will be exceptional occasions when at risk prisoners may require a short period of segregation for the good of others.

I recommend that consideration is given to convert at least one cell in the segregation unit as a safer cell.

- Safeguarding the man's mental health whilst in segregation

If a decision to locate a prisoner in the segregation unit has been taken, then further careful consideration must be given to safeguarding their mental health and well being.

PSO 1700 states that:

> *A restriction of normal facilities (e.g. Substituting cell furniture with cardboard furniture/ not allowing a prisoner a lighter or matches for cigarettes) must be supported by a risk assessment that clearly states why the restriction is being placed on that prisoner and how often the assessment will be reviewed.*

The man who died was taken to the segregation unit following the cell fire on A wing. It would appear he was not allowed lighting materials in his cell. However, this was not written in his wing record or the handover book, and there was no documentation of a risk assessment. There appeared to be some confusion regarding this matter. The man was not allowed matches in his cell, but officers could have lit a cigarette for him to smoke. For someone who is addicted to nicotine, and under going a stressful experience, being able to smoke can take on a high level of importance. Indeed, prisoners and staff report him shouting about wanting to smoke whilst in the segregation unit.

Some 36 hours after the man's admission to the segregation unit, the adjudicating governor opened a F2052SH. He comments that the man should have no access to matches or a lighter over the next few days. In interview, the Governor clarified this

by saying that the man should have been allowed to smoke but not have lighting materials in his cell. At some point that evening, the man got access to lighting materials from another prisoner who provided a home-made taper. This was far more dangerous in terms of a potential fire hazard that an officer lighting a cigarette for him.

When a prisoner is taken onto the segregation unit, after the initial search an assessment of what they may have in their cell should be considered. If someone is prohibited from having certain articles in their cell, a note of this assessment should be made in the handover book. With regard to cigarettes, if a prisoner is allowed to smoke, but an officer must light his cigarette, this should also be communicated through the handover book. In the man's case this would have reduced some of his stressful feelings, and might have prevented some of the shouting from him during the time he was in the segregation unit.

Furthermore, he was on a standard regime. This would have meant that he had a television in his cell on A wing. The cell was sealed after the fire and therefore the television was sealed inside the cell. However, he was still entitled to a standard regime in the segregation unit. The man did not have a radio or reading materials in his cell. These might have provided important relief from boredom or thinking too much at a particularly vulnerable time. There is no evidence an assessment of these needs was carried out.

I recommend that the Governor reminds segregation staff of their responsibilities to undertake a risk assessment of a prisoner's needs and entitlements whilst in segregation. This risk assessment must be recorded.

Record keeping

There were several examples of poor record keeping in regard to the man's medical record. In February, he was assessed as being suitable for a detoxification programme. He did not attend appointments regarding this, but it was not clear if this was followed up. He apparently underwent a detoxification programme when he came into Leeds in October 2004. However, my investigator could find no written documentation regarding this.

Nursing staff in Leeds are kept extremely busy. They are intelligently deployed. It is to their credit that they are so accessible to prisoners, and for staff to contact with any concerns they might have. In these circumstances, I understand that it may be difficult to make notes immediately as staff may not have the medical records of every prisoner that they see to hand. It would be advisable to have a stock of medical record sheets that can be written on, and inserted into the relevant medical record later in the day.

A nurse saw the man two days prior to his death during the day, and acted appropriately in referring him to the doctor. The nurse then followed this visit up by checking on him the following day. However, these visits were not recorded. In interview, he commented that his reason for not noting the visits may have been due to being very busy, and that he does not always note visits down unless they are important.

In the man's case, it meant that the second nurse could not refer to any notes of the assessment of the man when he then saw him. It meant that pieces of the jigsaw were missing when the second nurse assessed the man on the wing and then in the segregation unit. It should be noted that the second nurse made comprehensive and respectful notes of his dealings with the man.

When the investigators read the documentation relating to the man who died, the only documented recent contact with healthcare staff was his dealings with the second nurse. In fact, in the period from two days prior to the man's death, and in addition to the second nurse, the man saw the first nurse twice, a doctor in reception, and a doctor and a third nurse in the segregation unit twice.

The nurse who accompanied the doctor to the segregation unit made a note of seeing the man to issue medication. It was written the following day, after he had died. The nurse said that Saturday was always busy and Sunday was quieter, and she often took this opportunity to write up her notes from the previous day.

The head of healthcare acknowledged that there were significant problems with record keeping and that efforts were being made to address this. One improvement was the introduction of computerised records. The aim would be to have terminals in the wing treatment rooms, and therefore clinical staff would have ready access to all records and be able to add notes easily. At the present time, it did mean that some notes were computerised and others handwritten which could be confusing.

I recommend that all healthcare professionals are reminded of their record keeping responsibilities and the importance of it in accordance with the standards required by their professional bodies.

Crisis management

On the evening of his death, the man was checked every 15 minutes. At 9pm, when the OSG checked the man, he was standing at the back of his cell but the OSG is sure the man looked at him. At 9.15pm, a nurse, unaware of the man's F2052SH status, went to his cell. The man was standing at the back and did not respond to the nurse. The man had ignored the nurse on previous occasions. At the time, he felt there was nothing unusual about him. When staff entered the man's cell, he was still warm and staff, including the nurse, believed they had a chance of saving him.

The A-wing officer waited for other trained staff to be present before entering the cell. This was because of the stance of the man, his feet were on the ground and his head was upright. The officer was wary after the events of the night of the cell fire. However, the delay in entering the cell amounted to just seconds and given the circumstances was understandable.

Staff were on the scene quickly, including the nurse. This is because Leeds has two nurses on at night - one on the healthcare centre and one situated in the main part of the prison to enable a quick response to wings.

Furthermore, all night staff carried fish knifes (to cut ligatures) as standard issue. This prevented any delay in fetching one from a box in a wing office. This is an example of good practice.

Contacting the man's family

The duty governor chose personally to break the news of his death. In the man's case, the family could not have been informed quicker by any other means. Receiving the news of a death of someone you love is a devastating experience. As the governor visited personally, it meant the sad news was broken in the most sensitive way possible. Symbolically, it acknowledged that the man was in the care of Leeds when he died. It also enabled the family to establish a meaningful contact point. It is an example of good practice.

It should also be acknowledged that most staff are not trained to break such news and is likely to affect them. Appropriate support and acknowledgement should be provided by the Governor.

Staff

From interviews with staff, they seemed aware of how to contact the staff care and welfare team. However, some staff did not feel they had been very supported by senior management. Staff who attended to the man who died completed one more night before having a week of rest days. Given that it had been a particularly difficult set of nights, a phone call or letter from the Governor could have acknowledged the actions taken by staff during this period.

List of recommendations

Operational

I recommend that the Governor inspects the cells in the segregation unit, and considers what cosmetic improvements are needed and whether further action can be taken to remove ligature points.

I recommend that consideration is given to convert at least one cell in the segregation unit as a safer cell.

Policy

I recommend that the suicide prevention training be amended to include fire as a possible method of self-harm.

I recommend that the Governor reminds segregation staff of their responsibilities to undertake a risk assessment of a prisoner's needs whilst in segregation. This risk assessment must be recorded.

Health

I recommend that all healthcare professionals are reminded of their record keeping responsibilities and the importance of them in accordance with the standards required by their professional bodies.

All recommendations have been accepted by the Prison Service and an action plan for their implementation has been established.

Good practice

All night staff carried fish knifes (to cut ligatures), as standard issue. This prevented any delay in fetching one from a box in a wing office.

The Governor visited the man's family to personally break the news of his death. Whilst this is a devastating experience, the Governor enabled the news to be broken in the most sensitive way, and acknowledged that the man had been in the care of Leeds when he had died. This good practice should be shared across the Prison Service estate.

On the back of the initial reception healthcare assessment, is a long section relating to self harm. It establishes a scoring system for risk factors. This ensures important questions are asked, at a particularly busy time, and helps identify risk in those first few days. Although this was not pertinent in this man's case, it is an example of good practice from which other prisons can learn. This too should be shared across the Prison Service estate.